



2020 Council Resolutions
2020 Virtual Council Meeting
Saturday, October 24 – Sunday, October 25, 2020

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

Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council and are for information only.

Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Here is our plan for conducting the Reference Committees this year:

1. October 14 (or sooner if possible) – a communication portal will be open where members can provide testimony or recommendations for amendments on any of the resolutions assigned to a Reference Committee. A notification will be sent when this communication portal is open.
2. October 21 – the asynchronous testimony will end at 12:00 pm Central (1:00 pm Eastern, 11:00 am Mountain, 10:00 am Pacific, 7:00 am Hawaii) and the Reference Committees will meet by Zoom to deliberate and develop a preliminary report that will be published to the Council the following day.
3. The preliminary report will serve as the launching point for synchronous “live” testimony during the virtual Reference Committee hearings on Saturday, October 24, the first day of the Council meeting.
4. October 24 – The Reference Committee hearings will occur in succession – A, B, C – so everyone can participate. One hour per Reference Committee has been allotted. **It is expected that everyone will make good use of the asynchronous communication prior to the meeting to make their statements and will not repeat those statements during the virtual hearings on Saturday.**
5. After the virtual hearings, each Reference Committee will convene in executive session to amend their preliminary report based on the live testimony. The final report will be published to the Council that evening.
6. October 25 – During Sunday’s Council meeting, the Reference Committee chairs will present the final Reference Committee reports in succession – A, B, C. One hour per Reference Committee has been allotted.

Your Council officers,

Gary R. Katz, MD, MBA, FACEP
Speaker

Kelly Gray-Eurom, MD, MMM, 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.

REFER

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

NOT ADOPT

Defeat (or reject) the resolution in original or amended form.

**2020 Council Meeting
Reference Committee Members**

**Reference Committee A
Governance & Membership
Resolutions 9-23**

Andrea L. Green, MD, FACEP (TX), Chair
Bradley Burmeister, MD (WI)
Angela P. Cornelius, MD, FACEP (TX)
Douglas M. Char, MD, FACEP (MO)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Michael Ruzek, DO, FACEP (NJ)

Leslie Moore, JD
Maude Surprenant Hancock
Shari Purpura

**Reference Committee B
Advocacy & Public Policy
Resolutions 24-39**

Ashley Booth-Norse, MD, FACEP (FL), Chair
Sara A. Brown, MD, FACEP (IN)
John M. Gallagher, MD, FACEP (KS)
William D. Falco, MD, FACEP (WI)
Heidi C. Knowles, MD, FACEP (TX)
Jay Mullen, MD, FACEP (ME)

Ryan McBride, MPP
Jeff Davis
Brad Gruehn

**Reference Committee C
Emergency Medicine Practice
Resolutions 40-52**

Hilary Fairbrother, MD, FACEP (TX) Chair
Shamie Das, MD, FACEP (GA)
Heather M. Heaton, MD, FACEP (MN)
Todd Slesinger, MD, FACEP (FL)
Alison Smith, MD, MPH, (UT)
Nicole A. Veitinger, DO, FACEP (OH)

Margaret Montgomery, RN, MSN
Paul Krawietz
Mandi Mims, MLS
Travis Schulz, MLS, AHIP

2020 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Stephen H. Anderson, MD, FACEP <i>Washington Chapter</i>	
2	Commendation for James J. Augustine, MD, FACEP <i>Ohio Chapter</i>	
3	Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP <i>Maryland Chapter</i>	
4	Commendation for Janyce M. Sanford, MD, MBA, FACEP <i>Alabama Chapter</i>	
5	Commendation for Dean Wilkerson, JD, MBA, CAE <i>Board of Directors</i> <i>Council Officers</i>	
6	In Memory of Walter J. Bradley, III, MD, MBA, FACEP <i>Illinois College of Emergency Physicians</i>	
7	In Memory of Lorna Breen, MD, FACEP <i>New York Chapter</i>	
8	In Memory of Col (ret) Christopher Scharenbrock, MD, CPE, FACEP <i>Government Services Chapter</i>	
9	ACEP Committee Quorum Requirement – Housekeeping Amendment – Bylaws Amendment <i>Board of Directors</i> <i>Bylaws Committee</i> <i>Todd B. Taylor, MD, FACEP</i>	A
10	Commendation and Memorial Resolutions – Council Standing Rules Amendment <i>Council Steering Committee</i>	A
11	Council Resolution Sponsors and Cosponsors - Bylaws Amendment <i>Council Steering Committee</i>	A
12	Council Resolution Sponsors and Cosponsors – Council Standing Rules Amendment <i>Council Steering Committee</i>	A
13	Counting Fellowship Training Time Toward FACEP – Bylaws Amendment <i>Zachary Jarou, MD, MBA</i> <i>Kurtiz Mayz, MD, JD, MBA, FACEP</i> <i>Emergency Medicine Residents' Association</i> <i>Young Physicians Section</i>	A

Resolution #	Subject/Submitted by	Reference Committee
14	Ethics Procedures – Bylaws Amendment <i>Ethics Committee</i> <i>Board of Directors</i>	A
15	Procedures for Addressing Charges of Ethical Violations and Other Misconduct – College Manual Amendment <i>Ethics Committee</i> <i>Board of Directors</i>	A
16	Special Board of Directors Meetings – Bylaws Amendment <i>Board of Directors</i>	A
17	Unanimous Consent Agenda – Council Standing Rules Amendment <i>Council Steering Committee</i>	A
18	ACEP Membership and Leadership <i>Diversity, Inclusion, & Health Equity Section</i> <i>Emergency Medicine Residents’ Association</i> <i>District of Columbia Chapter</i> <i>Puerto Rico Chapter</i>	A
19	Framework to Assess the Work of the College Through the Lens of Health Equity <i>California Chapter</i> <i>Maryland Chapter</i> <i>Massachusetts College of Emergency Physicians</i> <i>Minnesota Chapter</i> <i>Missouri College of Emergency Physicians</i> <i>Pennsylvania College of Emergency Physicians</i> <i>New York Chapter</i> <i>Diversity, Inclusion, & Health Equity Section</i> <i>Social Emergency Medicine Section</i> <i>Emergency Medicine Residents’ Association</i>	A
20	Kayce Anderson Award for Excellence in Innovations in the ED care of Patients with Substance Use & Behavioral Health Issues <i>John Bibb, MD, FACEP</i> <i>Fred Dennis, Md, MBA, FACEP</i> <i>Emergency Medicine Residents’ Association</i> <i>Florida College of Emergency Physicians</i> <i>Pain Management & Addiction Medicine Section</i>	A
21	Medical Society Consortium on Climate & Health <i>Marc Futernick, MD,FACEP</i> <i>Katelyn Moretti, MD, MS</i> <i>Nikhil Ranadive, MD, MS</i> <i>Caitlin Rublee, MD, MPH</i> <i>Joshua Weil, MD</i> <i>California Chapter</i> <i>Wisconsin Chapter</i>	A
22	State Media Training for Emergency Physicians <i>Illinois College of Emergency Physicians</i> <i>Massachusetts College of Emergency Physicians</i> <i>Minnesota Chapter</i> <i>Ohio Chapter</i> <i>Pennsylvania College of Emergency Physicians</i>	A

Resolution #	Subject/Submitted by	Reference Committee
23	<p>Subspecialty Faculty for ACEP Educational Programs <i>Tracy Legros MD, PhD, FACEP</i> <i>J. Richard Walker, III, MD, MS, FACEP</i> <i>Undersea & Hyperbaric Medicine Section</i></p>	A
24	<p>911 Awareness and Policy <i>Adam Ash, DO, FACEP</i> <i>Alexander Chiu, MD, MBA, FACEP</i> <i>Joo Yup Shaun Chun, MD, FACEP</i> <i>Gaston Costa, MD, FACEP</i> <i>William Holubek, MD, FACEP</i> <i>Nizar Kifteh, MD, MBA, CPE, FACEP</i> <i>Mark Kindschuh, MD</i> <i>Jay Rao, MD, FACEP</i> <i>EMS-Prehospital Section</i> <i>Louisiana Chapter</i> <i>Maryland Chapter</i> <i>Puerto Rico Chapter</i> <i>Vermont Chapter</i> <i>Wyoming Chapter</i></p>	B
25	<p>Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage <i>Arizona College of Emergency Physicians</i> <i>Florida College of Emergency Physicians</i> <i>Illinois College of Emergency Physicians</i> <i>Indiana Chapter</i> <i>Ohio Chapter</i> <i>Pennsylvania College of Emergency Physicians</i> <i>Texas College of Emergency Physicians</i> <i>Virginia College of Emergency Physicians</i> <i>Wisconsin Chapter</i> <i>Air Medical Transport Section</i></p>	B
26	<p>Addressing Systemic Racism as a Public Health Crisis <i>District of Columbia Chapter</i></p>	B
27	<p>Attributing the Unqualified Term “Resident” to Physicians <i>Emergency Medicine Residents’ Association</i></p>	B
28	<p>Banning of Choke Holds <i>American Association of Women Emergency Physicians Section</i> <i>Diversity, Inclusion, & Health Equity Section</i> <i>Young Physicians Section</i> <i>Florida College of Emergency Physicians</i></p>	B
29	<p>Billing and Collections Transparency in Emergency Medicine <i>Robert McNamara, MD</i> <i>Thomas Scaletta, MD, FACEP</i></p>	B
30	<p>Protection and Transparency <i>Louisiana Chapter</i> <i>Emergency Telehealth Section</i></p>	B

Resolution #	Subject/Submitted by	Reference Committee
31	Insurer Accountability/Policy Weakness Disclosure <i>Louisiana Chapter</i> <i>Emergency Telehealth Section</i>	B
32	Loss of Health Insurance Due to COVID-19 <i>Harrison Alter, MD, FACEP</i> <i>Larry Bedard, MD, FACEP</i> <i>Chris Buresh, MD, MPH, FACEP</i> <i>Kathleen Cowling, DO, MS, MBA, FACEP</i> <i>Gregory Gafni-Pappas, DO, FACEP</i> <i>Gregory Luke Larkin, MD, MS, MSPH, FACEP</i> <i>Jacob Manteuffel, MD, FACEP</i> <i>James Maloy, MD</i> <i>James Mitchiner, MD, MPH, FACEP</i> <i>Charles Pattavina MD, FACEP</i> <i>Megan Ranney, MD, MPH, FACEP</i> <i>Rachel Solnick, MD, MSc</i> <i>Robert Solomon, MD, FACEP</i> <i>Peter Viccellio, MD, FACEP</i> <i>Bradford Walters, MD, FACEP</i>	B
33	Metrics, Measures, and Pay-for-Performance Programs <i>Aimee Moulin, MD, FACEP</i> <i>John Rogers, MD, CPE, FACEP</i>	B
34	Public/School Bleeding Control Kit Access and Training <i>New York Chapter</i>	B
35	Supporting the Development of a Seamless healthcare Delivery System to Include Prehospital Care <i>Sara Brown, MD, FACEP</i> <i>Angela Cornelius, MD, FACEP</i> <i>John McManus, MD, FACEP</i> <i>Gina Piazza, DO, FACEP</i> <i>Allen Yee, MD, FACEP</i> <i>Air Medical Transport Section</i> <i>EMS-Prehospital Care Section</i> <i>Alaska Chapter</i> <i>Georgia College of Emergency Physicians</i> <i>Government Services Chapter</i> <i>Indiana Chapter</i> <i>Kansas Chapter</i> <i>Maryland Chapter</i> <i>Texas College of Emergency Physicians</i>	B
36	Telehealth Free Choice <i>Emergency Telehealth Section</i> <i>Louisiana Chapter</i>	B
37	Telehealth Implementation, Reimbursement, and Coverage <i>Government Services Chapter</i> <i>Illinois College of Emergency Physicians</i> <i>Minnesota Chapter</i> <i>Missouri College of Emergency Physicians</i> <i>Ohio Chapter</i> <i>Pennsylvania College of Emergency Physicians</i> <i>Emergency Telehealth Section</i>	B

Resolution #	Subject/Submitted by	Reference Committee
38	Universal Access to Telehealth Care <i>Government Services Chapter</i> <i>Illinois College of Emergency Physicians</i> <i>Minnesota Chapter</i> <i>Missouri College of Emergency Physicians</i> <i>Ohio Chapter</i> <i>Pennsylvania College of Emergency Physicians</i> <i>Diversity, Inclusion, & Health Equity Section</i> <i>Emergency Telehealth Section</i> <i>Rural Emergency Medicine Section</i>	B
39	Urging the Prohibition of Law Enforcement Use of Rubber Bullets and Tear Gas for Crowd Control <i>Marisa Dowling, MD</i> <i>James Maloy, MD</i>	B
40	Addressing Critical Need for PPE by Emergency Physicians During a Pandemic <i>Pennsylvania College of Emergency Physicians</i>	C
41	Personal Protection Equipment <i>Louisiana Chapter</i> <i>Emergency Telehealth Section</i>	C
42	Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians <i>Florida College of Emergency Physicians</i> <i>Ohio Chapter</i> <i>Pennsylvania College of Emergency Physicians</i>	C
43	Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions <i>District of Columbia Chapter</i> <i>Maryland Chapter</i> <i>Diversity, Inclusion, & Health Equity Section</i>	C
44	Due Process in Emergency Medicine <i>Robert McNamara, MD</i> <i>Thomas Scaletta, MD, FACEP</i>	C
45	Emergency Licensing and Protection in Disasters <i>Emergency Telehealth Section</i> <i>Louisiana Chapter</i>	C
46	Employment Information <i>Louisiana Chapter</i> <i>Emergency Telehealth Section</i>	C
47	Honoring Employment Contracts for Graduating Emergency Medicine Residents <i>Emergency Medicine Residents' Association</i> <i>Pennsylvania College of Emergency</i>	C
48	Residency Program Expansion <i>New York Chapter</i>	C

Resolution #	Subject/Submitted by	Reference Committee
49	Strangulation Policy Statement and Educational Resources <i>Forensic Medicine Section</i> <i>William Green, MD, FACEP</i> <i>Sally Henin, MD, FACEP</i> <i>Ralph Riviello, MD, FACEP</i> <i>Heather Rozzi, MD, FACEP</i> <i>William, Smock, MD</i> <i>Michael L. Weaver, MD, FACEP</i>	C
50	Support for Expedited Partner Therapy <i>Alan Heins, MD, FACEP</i> <i>Rachel Solnick, MD</i> <i>American Association of Women Emergency Physicians Section</i> <i>Observation Medicine Section</i> <i>Vermont Chapter</i>	C
51	Telehealth Disaster Pilot and Educational Resources <i>Emergency Telehealth Section</i> <i>Louisiana Chapter</i> <i>Pennsylvania College of Emergency Physicians</i>	C
52	The Corporate Practice of Medicine <i>Robert McNamara, MD</i> <i>Thomas Scaletta, MD, FACEP</i>	C

Late Resolutions

53 In Memory of Lindsey J. Myers, MD



RESOLUTION: 1(20)
SUBMITTED BY: Washington Chapter
SUBJECT: Commendation for Stephen H. Anderson, MD, FACEP

1 WHEREAS, Stephen H. Anderson, MD, FACEP, has served the American College of Emergency Physicians
2 with highest distinction since becoming a member in 1997; and
3

4 WHEREAS, Dr. Anderson provided outstanding leadership to the Washington Chapter through his service as
5 an alternate councillor in 2008, councillor 2009-14, the Board of Directors 2008-17, as chapter president 2011-12, and
6 has maintained an active presence in the chapter; and
7

8 WHEREAS, While serving on the Washington Chapter's Board of Directors, Dr. Anderson fought flawed
9 public policies surrounding restricted access to care for state Medicaid patients, boarding of behavioral health patients
10 in the ED, and co-authored the "Washington State 7 Best Practices," which many states now use as a template to
11 increase patient access, coordinate care of high utilizers, save lives, and save Medicaid costs; and
12

13 WHEREAS, Dr. Anderson was elected to the national ACEP Board of Directors in 2014, re-elected in 2017,
14 served as Secretary-Treasurer 2017-18, and as chair of the Board 2018-19; and
15

16 WHEREAS, Dr. Anderson has served as a member and Board Liaison to numerous ACEP committees, task
17 forces, and sections; and
18

19 WHEREAS, Dr. Anderson served on the Emergency Medicine Foundation Board of Trustees 2016-20 and as
20 its chair in 2019 and continues to support his commitment to emergency medicine through contributions and
21 participation in the Wiegenstein Legacy Society; and
22

23 WHEREAS, Dr. Anderson has shown his commitment to emergency medicine advocacy initiatives by his
24 contributions to the National Emergency Medicine Political Action Committee; and
25

26 WHEREAS, Dr. Anderson has been an articulate spokesperson for ACEP and received ACEP's
27 Spokesperson of the Year Award in 2013; and
28

29 WHEREAS, Dr. Anderson is a passionate advocate for patients and is committed to addressing coordination
30 of care and social determinants of care with particular emphasis on opioid use disorder and behavioral health
31 emergencies; and
32

33 WHEREAS, Dr. Anderson has diligently devoted his heart, energy, humor, and dedication; and
34

35 WHEREAS, Dr. Anderson will continue to be involved and committed to the cause and mission of ACEP and
36 emergency medicine; therefore be it
37

38 RESOLVED, That the American College of Emergency Physicians commends and thanks Stephen H.
39 Anderson, MD, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of
40 emergency medicine.



RESOLUTION: 2(20)
SUBMITTED BY: Ohio Chapter
SUBJECT: Commendation for James J. Augustine, MD, FACEP

1 WHEREAS, James J. Augustine, MD, FACEP, has been a steadfast member of the American College of
2 Emergency Physicians since 1983; and
3

4 WHEREAS, Dr. Augustine has extensive service in leadership roles for the Ohio Chapter and served on the
5 chapter's Board of Directors 1989-02 and as chapter president 1994-95; and
6

7 WHEREAS, Dr. Augustine served on the national ACEP Board of Directors 2013-19 and brought the breadth
8 and depth of his experience to his role on the Board of Directors; and
9

10 WHEREAS, Dr. Augustine has shown exemplary leadership and outstanding service with his dedication,
11 tireless efforts, and expertise by serving as a member and Board liaison to a variety of ACEP committees, task forces,
12 sections, and as a member of the *ACEP Now* Editorial Advisory Board; and
13

14 WHEREAS, ACEP's Clinical Emergency Data Registry was created in 2014 and Dr. Augustine has been
15 instrumental in guiding its development, expansion, and success as a critical resource for ACEP and emergency
16 medicine for quality measurement; and
17

18 WHEREAS, Dr. Augustine is a recognized pioneer and leader in the field of EMS and disaster medicine,
19 serving as the first chair of the Ohio EMS Board, and as chair of ACEP's EMS-Prehospital Care Section 1995-96; and
20

21 WHEREAS, Dr. Augustine is a national consultant, author, and speaker on emergency department operations
22 and design; and
23

24 WHEREAS, Dr. Augustine's commitment to emergency medicine advocacy and research initiatives is
25 exemplified by his contributions to the National Emergency Medicine Political Action Committee, the Emergency
26 Medicine Foundation, and through his participation in the Wiegenstein Legacy Society; and
27

28 WHEREAS, Dr. Augustine has had a profound, positive, and enduring impact on emergency medicine, a
29 mentor to many, and will continue to serve the College and the specialty of emergency medicine; therefore be it
30

31 RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and
32 gratitude and commends James J. Augustine, MD, FACEP, for his dedication as an emergency physician and his
33 outstanding service and leadership to the College and the specialty of emergency medicine.



RESOLUTION: 3(20)
SUBMITTED BY: Maryland Chapter
SUBJECT: Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP

1 WHEREAS, Jon Mark Hirshon, MD, MPH, PhD, FACEP, has served the American College of Emergency
2 Physicians with honor and dedication since becoming a member in 1991; and
3

4 WHEREAS, Dr. Hirshon has enjoyed a distinguished career in emergency medicine by continually striving
5 for excellence as a compassionate and skillful emergency physician and is dedicated to improving access to high
6 quality acute care in the United States and internationally; and
7

8 WHEREAS, Dr. Hirshon has a passion for learning as evidenced by his completion of residencies in
9 emergency medicine and preventive medicine, earning a master's degree in public health with special emphasis on
10 international health, and a doctor of philosophy degree in epidemiology; and
11

12 WHEREAS, Dr. Hirshon is a federally funded researcher and teacher and has been the principal investigator/
13 program director on more than \$8 million in federal research and training grants and contracts and has been co-
14 investigator on numerous other funded projects; and
15

16 WHEREAS, Dr. Hirshon is a recognized public health expert, served on ACEP's Public Health Committee
17 1996-06 and as chair 1998-99 and 2003-06, and served as ACEP's liaison representative to the American Public
18 Health Association 2001-10; and
19

20 WHEREAS, Dr. Hirshon was elected to the national ACEP Board of Directors in 2014, was re-elected in
21 2017, and was elected by his peers on the Board of Directors to serve as Vice President 2018-19 and as Chair of the
22 Board 2019-20; and
23

24 WHEREAS, Dr. Hirshon has served as a member, chair, and Board Liaison on numerous committees, task
25 forces, expert panels, and sections; and
26

27 WHEREAS, Dr. Hirshon was a vital member of ACEP's second National Report Card on the State of
28 Emergency Medicine, served as chair of the third task force, and participated in multiple media interviews regarding
29 the Report Card; and
30

31 WHEREAS, Dr. Hirshon demonstrated leadership through chapter involvement as a member of the Maryland
32 Chapter, serving on the Board of Directors 2000-09, as chapter president 2004-07, and maintaining an active presence
33 in the chapter during his tenure on the national ACEP Board of Directors; and
34

35 WHEREAS, Dr. Hirshon is a leader in international emergency medicine, is an active member of ACEP's
36 International Emergency Medicine Section, serves on the International Ambassador Program Committee, and is the
37 College's international ambassador to the emergency medicine communities in Egypt and Sudan; and
38

39 WHEREAS, Since 2015, Dr. Hirshon has served as chair of the Emergency Department Sickle Cell Care
40 Coalition, which is comprised of multiple stakeholder groups from emergency medicine, pediatrics, hematology, and
41 patient advocacy, and is focused on providing a national forum for the improvement of the ED care of patients with
42 Sickle Cell Disease in the United States; and

43 WHEREAS, Dr. Hirshon has contributed to the growth and maturation of emergency medicine and will
44 continue to serve the College and the specialty of emergency medicine in the future; therefore be it
45

46 RESOLVED, That the American College of Emergency Physicians commends Jon Mark Hirshon, MD, MPH,
47 PhD, FACEP, for his devotion as an emergency physician, educator, and leader in emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 4(20)
SUBMITTED BY: Alabama Chapter
SUBJECT: Commendation for Janyce M. Sanford, MD, MBA, FACEP

1 WHEREAS, Janyce M. Sanford, MD, MBA, FACEP, served with distinction and dedication as the Chair and
2 Chief of Service for the Department of Emergency Medicine at the University of Alabama at Birmingham for 12
3 years; and
4

5 WHEREAS, Dr. Sanford played a critical role in the evolution and current success of the Department of
6 Emergency Medicine at the University of Alabama at Birmingham across three missions of service, teaching, and
7 research; and
8

9 WHEREAS, Dr. Sanford provided critical leadership during a period of unprecedented growth, the number of
10 visits to the University Emergency Department has increased over 100%, additional clinical sites have been added,
11 and the faculty has doubled as well; and
12

13 WHEREAS, Dr. Sanford cultivated an emergency medicine residency program that has become one of the
14 most competitive and respected training programs in the Southeast and the research program of the department is
15 currently ranked #11 in the country in terms of National Institutes of Health funding; and
16

17 WHEREAS, Dr. Sanford has been a mentor for hundreds of emergency physicians, encouraging their
18 interests, helping them find their voice, and guiding their careers; therefore be it
19

20 RESOLVED, That the American College of Emergency Physicians commends Janyce M. Sanford, MD,
21 MBA, FACEP, for her service as Chair and Chief of Service for the Department of Emergency Medicine at the
22 University of Alabama at Birmingham.



RESOLUTION: 5(20)

SUBMITTED BY: Board of Directors
Council Officers

SUBJECT: Commendation for Dean Wilkerson, JD, MBA, CAE

1 WHEREAS, Dean Wilkerson, JD, MBA, CAE, has served the American College of Emergency Physicians
2 with honor and distinction as its Executive Director and Council Secretary from April 2004 to July 2020; and
3

4 WHEREAS, During Mr. Wilkerson’s tenure, ACEP achieved unprecedented growth as an organization from
5 23,000 members and a budget of \$18 million to more than 40,000 members and a budget of \$44 million; and
6

7 WHEREAS, As ACEP’s membership grew, the composition of the Council increased from 269 councillors
8 allocated in 2004 to 443 councillors allocated for the 2020 annual meeting; and
9

10 WHEREAS, ACEP’s annual meeting attendance increased from 4,492 registrants in 2004 to an all-time high
11 of 7,479 in 2018; and
12

13 WHEREAS, Mr. Wilkerson developed an outstanding professional staff and increased staffing to provide
14 additional services and value to members; and
15

16 WHEREAS, Mr. Wilkerson led ACEP to increase its presence and recognition within the media, embraced an
17 increased social media presence, expanded ACEP’s pursuit and procurement of grants, and magnified advocacy
18 initiatives at the state and federal levels; and
19

20 WHEREAS, Under Mr. Wilkerson’s direction, ACEP held its first rally on Capitol Hill on September 27,
21 2005, with more than 4,000 physicians, nurses, and other emergency health care professionals participating to
22 advocate for the “Access to Emergency Medical Services Act of 2005,” which generated significant media coverage
23 to highlight emergency medicine and access to care; and
24

25 WHEREAS, The “Access to Emergency Medical Services Act” was reintroduced multiple times and was
26 subsequently included in the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148); and
27

28 WHEREAS, Mr. Wilkerson championed providing additional services to chapters such as the state public
29 policy tracking service, development of chapter newsletters and chapter websites, supported chapter advocacy efforts
30 and established the State Public Policy Grant Program; and
31

32 WHEREAS, Mr. Wilkerson guided ACEP through several major overhauls of the ACEP website, creation of
33 the daily customized news briefing *EM Today*, the reengineering of *ACEP Now* into a premier publication for
34 emergency medicine, and the launch of ACEP’s open access journal *JACEP Open*; and
35

36 WHEREAS, Mr. Wilkerson directed ACEP to publish the first National Report Card on the State of
37 Emergency Medicine, published in 2005, with media coverage on network television, radio, and in major news
38 publications, and additional reports were published in 2009 and 2014 that helped drive ACEP’s advocacy agenda; and
39

40 WHEREAS, In 2009, Mr. Wilkerson was selected as #37 on the Top 100 Most Influential People in
41 Healthcare by *Modern Healthcare* magazine; and

42 WHEREAS, Through Mr. Wilkerson's leadership, The Future of Emergency Medicine paper was published
43 in 2010; and

44
45 WHEREAS, After adoption of the Affordable Care Act, the Emergency Medicine Action Fund (now known
46 as the Emergency Medicine Policy Institute), was created in 2011 and has funded many important projects including
47 the Value of Emergency Medicine Study conducted by the RAND Corporation and published in 2013; and

48
49 WHEREAS, Through Mr. Wilkerson's guidance, ACEP provided the initial funding for the Emergency
50 Medicine Foundation endowment fund in 2012; and

51
52 WHEREAS, The Clinical Emergency Data Registry was created in 2014 and is now a cornerstone asset of
53 ACEP and emergency medicine as quality measurement and improvement continues to be important to the specialty
54 and payers; and

55
56 WHEREAS, Mr. Wilkerson was responsible for numerous innovative projects within ACEP such as the
57 Geriatric Emergency Department Accreditation Program, the Pain and Addiction Care in the ED Accreditation
58 Program, the Emergency Medicine Practice Research Network, emergency medicine point-of-care tools for use at the
59 bedside, and multiple other clinical resources for emergency physicians; and

60
61 WHEREAS, Mr. Wilkerson was instrumental in the decision to build a new headquarters for national ACEP
62 that reflects the bold and progressive character of emergency medicine and the project was completed on time and
63 under budget in 2016; and

64
65 WHEREAS, Besides demonstrating his exemplary leadership qualities at ACEP, Mr. Wilkerson also served
66 in significant positions in the association community by serving on the Board of Directors of the Texas Society of
67 Association Executives (2010-13), the American Society of Association Executives (2011-14); the Foundation for
68 Advancing Alcohol Responsibility National Advisory Board (2017-present), the HeartGift Foundation (2017-present),
69 the Council of Medical Specialty Societies Nominating Committee (2018-22), the Visit Dallas Leadership Council
70 (2019-present) and served as chair of the Specialty Society CEO Coalition (S2C2 Group) (2010-12) and chair of the
71 Key Professional Associations Committee of the American Society of Association Executives (2012-13); and

72
73 WHEREAS, Mr. Wilkerson led ACEP skillfully during the COVID-19 pandemic of 2020; and

74
75 WHEREAS, Mr. Wilkerson provided strong and trusted counsel to the physician leadership of the College
76 and contributed to the growth and maturation of emergency medicine; and

77
78 WHEREAS, The patients seeking emergency care in the United States have benefited from his focus on our
79 College as a standard bearer for high quality emergency medicine; and

80
81 WHEREAS, The specialty of emergency medicine has benefited tremendously from Mr. Wilkerson's vision,
82 dedication, and leadership during the past sixteen years; therefore be it

83
84 RESOLVED, That the American College of Emergency Physicians commends Dean Wilkerson, JD, MBA,
85 CAE, for his outstanding contributions to ACEP and the specialty of emergency medicine.



RESOLUTION: 6(20)
SUBMITTED BY: Illinois College of Emergency Physicians
SUBJECT: In Memory of Walter J. Bradley, III, MD, MBA, FACEP

1 WHEREAS, The specialty of emergency medicine lost a beloved leader who provided over 25 years of
2 distinguished service to Emergency Medical Services and emergency preparedness when Walter J. Bradley, III, MD,
3 MDA, FACEP, passed away on February 9, 2020, at the age of 63; and
4

5 WHEREAS, Dr. Bradley chaired the Illinois College of Emergency Physicians (ICEP) EMS Committee and
6 Illinois EMS Forum for six years and was a member and officer of the ICEP Board of Directors from 2000-2007
7 when he stepped down to be appointed Senior Medical Administrator for the Illinois Department of Public Health
8 (IDPH); and
9

10 WHEREAS, After leaving IDPH, Dr. Bradley served as Director of the Illinois State Police Tactical
11 Response Team; he was as a leader in the tactical medicine community for more than 15 years including being a
12 contributor to the *Tactical Medicine Essentials* textbook endorsed by ACEP and published in 2011, and he remained
13 as Medical Director for the Illinois State Police until the time of his death; and
14

15 WHEREAS, Dr. Bradley also served as Chair of the Board of International Trauma Life Support (ITLS) for
16 four years and he traveled the world, including to Mexico, England and Poland to bring trauma care education to new
17 markets and under his leadership ITLS grew to be the leading pre-hospital trauma education program in the world;
18 and
19

20 WHEREAS, Dr. Bradley was recognized with numerous awards including as the inaugural recipient of the
21 National Association of Emergency Medical Technicians (NAEMT) Richard Ferneau EMS Medical Director of the
22 Year award, the IDPH Directors Award for Outstanding Services and Leadership in EMS, and the ICEP Downstate
23 Member of the Year Award; and
24

25 WHEREAS, Dr. Bradley was a mentor and member of 100 Black Men, a group dedicated to providing and
26 promoting educational opportunities for young Black men; and
27

28 WHEREAS, Despite his many medical struggles, Dr. Bradley always had a joke to share or a story to tell; he
29 was a lover of vintage cars, fine wine, and Harley Davidsons; he made regular trips to Sturgis, SD, for the famous
30 annual motorcycle rally, and "SwatDoc" was a charter member of the Renegade Pigs Motorcycle Club; therefore be it
31

32 RESOLVED, That the American College of Emergency Physicians (ACEP) cherishes the memory of Walter
33 J. Bradley, III, MD, MBA, FACEP, whose philosophy and approach to patient care was "Whatever the hour you may
34 come, you will find light, hope, and human kindness," and be it further
35

36 RESOLVED, That national ACEP and the Illinois Chapter extend to his wife Meme, son Ryan, and the
37 extended Bradley and Wood families gratitude for his tremendous service to emergency medicine and EMS.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 7(20)
SUBMITTED BY: New York Chapter
SUBJECT: In Memory of Lorna Breen, MD, FACEP

1 WHEREAS, The specialty of emergency medicine lost a dedicated, compassionate physician and colleague in
2 Lorna Breen, MD, FACEP, who passed away on April 26, 2020, at the age of 49; and
3

4 WHEREAS, Dr. Breen received her medical degree from the Medical College of Virginia and completed a
5 combined residency in emergency medicine and internal medicine at Hofstra Northwell Health Long Island Jewish
6 Medical Center in Queens, NY, where she served as Chief Resident in 2003, and currently was pursuing an Executive
7 MBA/MS in Healthcare Leadership at Cornell SC Johnson College of Business; and
8

9 WHEREAS, Dr. Breen served as the Site Director at the New York-Presbyterian – Allen Hospital Department
10 of Emergency Medicine and was a distinguished faculty member and an assistant professor of emergency medicine at
11 Columbia University Vagelos College of Physicians and Surgeons; and
12

13 WHEREAS, Dr. Breen served as a physician educator since 2004 to numerous residents, medical students,
14 advanced practice practitioners, nurses, staff of the Columbia University Department of Emergency Medicine; and
15

16 WHEREAS, Dr. Breen devoted herself as a staunch advocate of her patients and colleagues and made
17 enduring contributions to the operations and teaching programs at Columbia University Irving Medical Center; and
18

19 WHEREAS, Dr. Breen served as a member of the New York ACEP Board of Directors from 2007 to 2010,
20 was a member of the New York ACEP Practice Management Committee, was a contributor to the New York ACEP
21 *EPIC* newsletter, and served on the national ACEP Education and Emergency Medicine Practice Committees; and
22

23 WHEREAS, Dr. Breen’s spirit, dedication, and passion for her work was contagious and she made others
24 strive to be better, regardless of the role or discipline; and
25

26 WHEREAS, Dr. Breen was a loving and devoted daughter, sister, and friend who will be missed by family
27 and colleagues; therefore be it
28

29 RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and
30 colleagues of Lorna Breen MD, FACEP, our condolences and gratitude for her tremendous service to the specialty of
31 emergency medicine and to the patients and physicians of New York and the United States.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 8(20)
SUBMITTED BY: Government Services Chapter
SUBJECT: In Memory of Col (ret) Christopher Scharenbrock MD, CPE, FACEP

1 WHEREAS, The specialty of emergency medicine and the Government Services Chapter of the American
2 Emergency Physicians (GSACEP) lost a compassionate physician, military officer and leader, colleague, and friend in
3 Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, who passed away unexpectedly on November 4, 2019,
4 at the age of 53; and
5

6 WHEREAS, Colonel Scharenbrock was a distinguished graduate of the United States Air Force Academy and
7 Uniformed Services University of the Health Sciences School of Medicine starting as a General Medical Officer in
8 emergency medicine and subsequently completing his emergency medicine residency top of his class at the San
9 Antonio Uniformed Services Health Education Consortium; and
10

11 WHEREAS, Dr. Scharenbrock was respected for his sharp clinical acumen, platinum standard patient care,
12 calm under fire, selfless service, humility, and compassion to patients and colleagues always with his trademark
13 continuous smile and optimism; and
14

15 WHEREAS, Dr. Scharenbrock was equally as impressive as a leader, a certified physician executive, twice
16 Emergency Department Director, and ultimately Chief Medical Officer (CMO) at David Grant Medical Center leading
17 to the hospital being recognized as 2012 Best Air Force Hospital and Best Inpatient Safety Program; and
18

19 WHEREAS; Colonel Scharenbrock was a combat warrior, five times deploying in harm's way, first Air Force
20 physician to volunteer for Afghanistan Provincial Reconstruction Team with over 286 combat missions "outside the
21 wire" while training Afghan nationals to build a healthcare system, earning him the 2007 Lt Gen Paul Meyers Award;
22 and
23

24 WHEREAS; Dr. Scharenbrock was a renaissance man who loved travel, sharing wine with friends, gardening,
25 and could fix anything, he found his resilience through his greatest priority and joy in life – his beloved daughters and
26 wife; therefore be it
27

28 RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the
29 many contributions made by Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, as one of the leaders in
30 emergency medicine and military medicine; and be it further
31

32 RESOLVED; That the American College of Emergency Physicians extends to his wife Mary, his daughters
33 Emily and Anna, his extended family, colleagues, and friends our condolences and gratitude for his tremendous
34 service to the specialty of emergency medicine, military medicine, and to the countless patients and physicians across
35 the world whom he selflessly served.



2020 Council Meeting Reference Committee Members

Reference Committee A Governance & Membership Resolutions 9-23

Andrea L. Green, MD, FACEP (TX), Chair
Bradley Burmeister, MD (WI)
Angela P. Cornelius, MD, FACEP (TX)
Douglas M. Char, MD, FACEP (MO)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Michael Ruzek, DO, FACEP (NJ)

Leslie Moore, JD
Maude Surprenant Hancock
Shari Purpura

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Bylaws Amendment

RESOLUTION: 9(20)

SUBMITTED BY: Board of Directors
Bylaws Committee
Todd B. Taylor, MD, FACEP

SUBJECT: ACEP Committee Quorum Requirement – Housekeeping Amendment

PURPOSE: Amends the Bylaws to define the quorum requirement for all ACEP committees as a majority of the voting membership of the committee.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws and add the clarification to the Committee Manual.

1 WHEREAS, Parliamentary procedure is important in deliberations by all ACEP committees; and

2
3 WHEREAS, The quorum requirement for ACEP committees is not defined in the Bylaws; and

4
5 WHEREAS, This lack of definition has created some confusion, especially considering there are often both
6 voting and non-voting members of committees and committee chairs and staff may not always be fully cognizant of
7 the default quorum requirements within ACEP’s designated parliamentary authority; and

8
9 WHEREAS, This amendment is a simple, straightforward housekeeping amendment that will help to avoid
10 such confusion; therefore be it

11
12 RESOLVED, That the ACEP Bylaws Article XI – Committees, Section 1 – General Committees, be amended
13 to read:

14
15 The president shall annually appoint committees and task forces to address issues pertinent to the College as
16 deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the
17 chair of a committee be a member of the Board. A majority of the voting membership of a committee shall
18 constitute a quorum.

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

Background

This resolution amends the Bylaws to specify that the quorum requirement for all ACEP committees is a majority of the voting membership of the committee.

Committee quorum requirements are not currently defined in the Bylaws. The lack of definition has created some confusion because many of ACEP’s committees have voting and non-voting members. ACEP’s designated parliamentary authority, *The Standard Code of Parliamentary Procedure*, suggests that an organization’s Bylaws “should state the number or proportion of members that constitutes the quorum. In the absence of such a provision, parliamentary law fixes the quorum at a majority of the members.” A quorum is required for a committee to conduct official committee business. The proposed Bylaws amendment defines the quorum requirement for all ACEP committees as a majority of the voting membership of the committee. By clearly stating the quorum requirement in the Bylaws, the College will ensure that any committee recommendations to the Board of Directors are valid.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Bylaws and add the clarification to the Committee Manual

Prior Council Action

None specific to defining a quorum in the Bylaws for ACEP committees.

Prior Board Action

June 2020, approved cosponsoring the “ACEP Committee Quorum Requirement – Bylaws Housekeeping Amendment” with the Bylaws Committee for submission to the 2020 Council.

Background Information Prepared by: Leslie P. Moore, JD
General Counsel and Chief Legal Officer

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Council Standing Rules Amendment

RESOLUTION: 10(20)
SUBMITTED BY: Council Steering Committee
SUBJECT: Commendation and Memorial Resolutions

PURPOSE: Amends the Council Standing Rules to codify that commendation and memorial resolutions are not assigned to a Reference Committee for deliberation and recommendation to the Council.

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

1 WHEREAS, The Council Standing Rules specify that resolutions submitted by the deadline will be assigned
2 to a Reference Committee for deliberation and recommendation to the Council; and

3
4 WHEREAS, Traditionally, commendation and memorial resolutions, whether submitted by the deadline, or
5 submitted as a late or emergency resolution, are not assigned to a Reference Committee for discussion and
6 recommendation to the Council; and

7
8 WHEREAS, The Council Standing Rules should be amended to codify this practice; therefore be it

9
10 RESOLVED, That the Council Standing Rules, “Reference Committees” section, paragraph one, be amended
11 to read:

12
13 “Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the
14 speaker to a Reference Committee for deliberation and recommendation to the Council, **except for commendation**
15 **and memorial resolutions**. Reference Committee meetings are open to all members of the College, its committees,
16 and invited guests.”; and be it further

17
18 RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

19
20 “Resolutions” are considered formal motions that if adopted by a majority vote of the Council and ratified by
21 the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do
22 not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College
23 Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a
24 two-thirds vote of the Board of Directors.

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

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

32 Background information, including financial analysis, will be prepared by staff on all resolutions, **except for**
33 **commendation and memorial resolutions**, submitted on or before 90 days prior to the annual meeting.

34 • ***Regular Non-Bylaws Resolutions***

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

38 Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual
39 meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with
40 consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90
41 to 45 day window that appear to alter the original intent of a regular resolution or that would render the
42 background information meaningless will be considered as “Late Resolutions.”
43

44 • ***Bylaws Resolutions***

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

50 Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual
51 meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with
52 consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day
53 window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of
54 order under parliamentary authority, will not be permitted.
55

56 • ***Late Resolutions***

57 Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of
58 the annual meeting are known as “late resolutions.” These late resolutions are considered by the Steering
59 Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee
60 is empowered to decide whether a late submission is justified due to events that occurred after the filing
61 deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why
62 the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it
63 will be presented to the Council at its opening session and assigned to a Reference Committee, **except for**
64 **commendation and memorial resolutions**. If the Steering Committee votes unfavorably and rejects a late
65 resolution, the reason for such action shall be reported to the Council at its opening session. The Council does
66 not consider rejected late resolutions. The Steering Committee’s decision to reject a late resolution may be
67 appealed to the Council. When a rejected late resolution is appealed, the Speaker will state the reason(s) for
68 the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.
69

70 • ***Emergency Resolutions***

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

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

Background

This resolution amends the Council Standing Rules to codify that commendation and memorial resolutions are not assigned to a Reference Committee for deliberation and recommendation to the Council.

Traditionally, since 2004, commendation and memorial resolutions, whether submitted by the deadline, or as late or emergency resolutions, are not assigned to a Reference Committee for discussion. The Council Standing Rules (CSR) currently specify that resolutions submitted by the deadline, will have background information prepared, including a financial analysis, and will be assigned to a Reference Committee for deliberation and recommendation to the Council. Late and emergency resolutions, if accepted by the Council, do not have background information prepared, but are assigned to a Reference Committee.

Prior to 2004, commendation and memorial resolutions were assigned to a Reference Committee. The resolutions rarely, if ever, received any testimony and all were adopted by the Council. Background information was not prepared on commendation and memorial resolutions and has not been prepared on these resolutions since 2004. All memorial resolutions are adopted by the Council observing a moment of silence on the first day of the Council meeting; all commendation resolutions are adopted by acclamation during the Council Awards Luncheon on the second day of the Council meeting.

The Steering Committee discussed commendation and memorial resolutions at their meetings in January and April 2020 and determined that a CSR amendment should be submitted to the 2020 Council. ACEP's parliamentarian has not advised that any changes are needed in the CSR to reflect this traditional practice, however, he has not advised against it either. There have not been any questions or complaints from the Council since commendation and memorial resolutions were removed from Reference Committee deliberation beginning in 2004.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

None specific to commendation and memorial resolutions in the Council Standing Rules.

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Bylaws Amendment

RESOLUTION: 11(20)
SUBMITTED BY: Council Steering Committee
SUBJECT: Council Resolution Sponsors and Cosponsors

PURPOSE: Amends the Bylaws to specify that all resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to
2 the Council meeting; and

3
4 WHEREAS, For the past few years there have been an increasing number of requests to add cosponsors to
5 resolutions after the submission deadline; and

6
7 WHEREAS, Staff have accommodated all requests to add cosponsors after the submission deadline because
8 the Bylaws and the Council Standing Rules do not prohibit it; and

9
10 WHEREAS, The leniency in allowing additional cosponsors after the resolution deadline creates an
11 impression that the deadline can be extended to garner additional support for a resolution; therefore be it

12
13 RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 6 – Resolutions, paragraph one, be
14 amended to read:

15
16 Resolutions pertinent to the objectives of the College or in relation to any report by an officer or committee of
17 the College shall be submitted in writing at least 90 days in advance of the Council meeting at which they are to be
18 considered. Resolutions submitted within 90 days of the Council meeting shall be considered only as provided in the
19 Council Standing Rules. Each resolution must be signed by at least two members of the College. **All resolution**
20 **sponsors and cosponsors must be confirmed at the time the resolution is submitted.**

Background

This resolution amends the Bylaws to specify that all resolution sponsors and cosponsors (i.e., “submitters”) must be confirmed at the time the resolution is submitted. There is also a companion Council Standing Rules (CSR) resolution.

The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting, and must be submitted (sponsored) by at least two members of the College. For the past few years there has been an increasing number of requests to add names of cosponsors, whether individuals or component bodies, to resolutions after the submission deadline. Although only two members are required to submit a resolution, having multiple cosponsors for a resolution indicates that the resolution has significant support. Staff have accommodated all requests to add cosponsors after the submission deadline because the Bylaws and the Council Standing Rules (CSR) do not prohibit it. However, there is a potential for error if the resolution file has already been sent to staff to develop background information and multiple resolution files are in circulation. The leniency in allowing additional cosponsors after the deadline creates an impression that the deadline can be extended to garner additional support for

the resolution before the resolutions are released to the Council, which occurs not less than 30 days prior to the Council meeting.

The Steering Committee discussed resolution sponsors and cosponsors at their meetings in January and April 2020 and determined that a Bylaws amendment and companion CSR amendment should be submitted to the 2020 Council.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 14(11) Endorsements for Council Resolutions and Bylaws Amendments not adopted. This proposed Bylaws resolution sought to change the requirements for submission of all Council resolutions to include sponsorship from the president or chair representing a component body of the Council, the national Board of Directors, or a committee of the College and would have eliminated the ability of only two members submitting a resolution.

Resolution 3(79) amended the Constitution and Bylaws to require that resolutions must be submitted by at least two members of the College.

Prior Board Action

None

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Council Standing Rules Amendment

RESOLUTION: 12(20)
SUBMITTED BY: Council Steering Committee
SUBJECT: Council Resolution Sponsors and Cosponsors

PURPOSE: Amends the Council Standing Rules to specify that all resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.

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

1 WHEREAS, The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to
2 the Council meeting; and

3
4 WHEREAS, For the past few years there have been an increasing number of requests to add cosponsors to
5 resolutions after the submission deadline; and

6
7 WHEREAS, Staff have accommodated all requests to add cosponsors after the submission deadline because
8 the Council Standing Rules and the Bylaws do not prohibit it; and

9
10 WHEREAS, The leniency in allowing additional cosponsors after the resolution deadline creates an
11 impression that the deadline can be extended to garner additional support for a resolution; therefore be it

12
13 RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

14
15 “Resolutions” are considered formal motions that if adopted by a majority vote of the Council and ratified by
16 the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do
17 not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College
18 Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a
19 two-thirds vote of the Board of Directors.

20 Resolutions must be submitted in writing by at least two members or by component bodies, College
21 committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a
22 component body. **All resolution sponsors and cosponsors must be confirmed at the time the resolution is**
23 **submitted.**

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

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

Background

This resolution amends the Council Standing Rules to specify that all resolution sponsors and cosponsors (i.e., “submitters”) must be confirmed at the time the resolution is submitted. A companion Bylaws resolution has also been submitted.

The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting, and must be submitted (sponsored) by at least two members of the College. For the past few years there has been an increasing number of requests to add names of cosponsors, whether individuals or component bodies, to resolutions after the submission deadline. Although only two members are required to submit a resolution, having multiple cosponsors for a resolution indicates that the resolution has significant support. Staff have accommodated all requests to add cosponsors after the submission deadline because the Bylaws and the Council Standing Rules (CSR) do not prohibit it. However, there is a potential for error if the resolution file has already been sent to staff to develop background information and multiple resolution files are in circulation. The leniency in allowing additional cosponsors after the deadline creates an impression that the deadline can be extended to garner additional support for the resolution before the resolutions are released to the Council, which occurs not less than 30 days prior to the Council meeting.

The Steering Committee discussed resolution sponsors and cosponsors at their meetings in January and April 2020 and determined that a Bylaws amendment and companion CSR amendment should be submitted to the 2020 Council.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 14(11) Endorsements for Council Resolutions and Bylaws Amendments not adopted. This proposed Bylaws resolution sought to change the requirements for submission of all Council resolutions to include sponsorship from the president or chair representing a component body of the Council, the national Board of Directors, or a committee of the College and would have eliminated the ability of only two members submitting a resolution.

Resolution 3(79) amended the Constitution and Bylaws to require that resolutions must be submitted by at least two members of the College.

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Bylaws Amendment

RESOLUTION: 13(20)

SUBMITTED BY: Zachary Jarou, MD, MBA
Kurtis Mayz, JD, MBA, FACEP
Emergency Medicine Residents' Association
Young Physicians Section

SUBJECT: Counting Fellowship Training Time Toward FACEP

PURPOSE: Amends the Bylaws to permit candidate physician members in post-residency training programs immediately following an emergency medicine residency program who have opted to continue as candidate members have the time spent in the fellowship training program count toward the three years of continuous membership immediately prior to election to ACEP Fellow status.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws. Potential increased revenue for FACEP application fees.

1 WHEREAS, Upon the completion of residency, many emergency physicians complete fellowships in
2 subspecialty areas of emergency medicine; and
3

4 WHEREAS, Upon the completion of residency, fellows are eligible to continue their ACEP membership by
5 either becoming a “regular” member of ACEP or by continuing as a “candidate” member; and
6

7 WHEREAS, Most fellows are paid salaries according to institutional pay scales and receive compensation
8 similar to residents; and
9

10 WHEREAS, Candidate membership is more affordable for fellows; and
11

12 WHEREAS, Candidate membership includes EMRA membership, which allows fellows to continue to
13 receive the majority of benefits they received as residents; and
14

15 WHEREAS, Candidate members may make significant post-residency contributions to the College while
16 completing additional fellowship training; and
17

18 WHEREAS, Other emergency medicine organizations provide members with “fellow status” immediately
19 upon graduation from residency; and
20

21 WHEREAS, Attaining FACEP status may increase long-term membership retention and involvement with
22 ACEP; therefore be it
23

24 RESOLVED, That the ACEP Bylaws, Article V – ACEP Fellows, Section 1 - Eligibility, be amended to read:
25

26 ARTICLE V — ACEP FELLOWS
27 Section 1 — Eligibility
28

29 Fellows of the College shall meet the following criteria:
30

- 31 1. Be candidate physician, regular, or international members for three continuous years immediately prior to
32 election.

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

58
59 Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate, and
60 determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee.

Background

This resolution amends the Bylaws to permit candidate physician members in post-residency training programs immediately following an emergency medicine residency program who have opted to continue as candidate members have the time spent in the fellowship training program count toward the three years of continuous membership immediately prior to election to ACEP Fellow status.

ACEP candidate members who enter fellowship training programs directly after completion of an emergency medicine residency program have the option of transitioning to regular membership (pay regular dues) or remain as a candidate member (pay candidate dues) until completion of the fellowship training program. Members who remain in the candidate member category while completing the fellowship training program do not currently have that time count toward the three years of continuous membership to qualify for ACEP Fellow status. Since 3.A. stipulates “exclusive of residency training,” this proposed change in the ACEP Fellow requirements cannot be misinterpreted to include all candidate physician members.

There are currently 639 candidate members in a fellowship program based on ACEP membership statistics as of August 31, 2020.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement

Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources to update the Bylaws. Potential increased revenue for FACEP application fees.

Prior Council Action

The Council has discussed and adopted numerous resolutions regarding ACEP Fellows (FACEP) requirements, but none that are specific to allowing candidate physician members to qualify.

Amended Resolution 7(13) Candidate Members in Fellowship Training adopted. This Bylaws amendment clarified that residents entering a fellowship program directly upon completing an emergency medicine residency have the option to remain a candidate member or transition to active membership.

Prior Board Action

Amended Resolution 7(13) Candidate Members in Fellowship Training adopted.

February 2013, approved cosponsoring the resolution Candidate Members in Fellowship Training with the Bylaws Committee for submission to the 2013 Council.

June 2011, assigned an objective to the Bylaws Committee to propose Bylaws revisions to allow candidate members entering a fellowship, after completion of an emergency medicine residency, the option of active membership.

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

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



Bylaws Amendment

RESOLUTION: 14(20)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Ethics Procedures

PURPOSE: Amends the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due
2 process to ensure it is fair to both the complainant and respondent; and

3
4 WHEREAS, A review by legal counsel, the ACEP Board of Directors, and a subcommittee comprised of
5 members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee determined that a more
6 efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually;

7
8 WHEREAS, The ACEP Board of Directors has approved a revision to the *Procedures for Addressing*
9 *Charges of Ethical Violations and Other Misconduct*, which creates a subcommittee appointed to review ethics
10 complaints and make determinations regarding disciplinary action against members; and

11
12 WHEREAS, The current Bylaws state that only the ACEP Board of Directors has the power to impose
13 disciplinary action on a member, and as such, a revision to the Bylaws is required to reflect the Board's right to
14 appoint a designated body to make such determinations on its behalf; therefore be it

15
16 RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 3 – Agreement, and Section 4 –
17 Disciplinary Action, be amended to read:

Section 3 — Agreement

18
19
20
21 Acceptance of membership in the College shall constitute an agreement by the member to comply with the
22 ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member's right to be or to remain a
23 member, subject to **Article IV, Section 4 of these Bylaws and** the due process as described in the College Manual.

24
25 All right, title, and interest, both legal and equitable, of a member in and to the property of this organization
26 shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of the member's
27 name from the roll of members; c) the member's death or resignation.

Section 4 — Disciplinary Action

28
29
30
31 Members of the College may be subject to disciplinary action or their membership may be suspended or
32 terminated by the Board of Directors, **or a designated body appointed by the Board of Directors for such purpose,**
33 for good cause. Procedures for such disciplinary action shall be stated in the College Manual.

Background

This resolution amends the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual. A companion College Manual resolution has also been submitted.

The Board of Directors submitted a College Manual resolution to the 2019 Council to amend by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* for consideration. Upon review by the Bylaws Committee and prior to the 2019 Council meeting, concerns were raised that the revised Procedures may be in conflict with the Bylaws because the Bylaws currently state that only the Board of Directors has the power to impose disciplinary action on a member. The Bylaws Committee recommended adding a provision to the Bylaws allowing a “designated body appointed by the Board of Directors” to review ethics complaints and make determinations regarding disciplinary action against members. As such, the resolution was withdrawn from the 2019 Council meeting based on these recommendations. A subcommittee was then assigned, comprised of members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee to revise the Procedures and draft revisions to the Bylaws to address this issue. The College Manual amendment is submitted as Resolution 15(20) Procedures for Addressing Ethical Violations & Other Misconduct.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

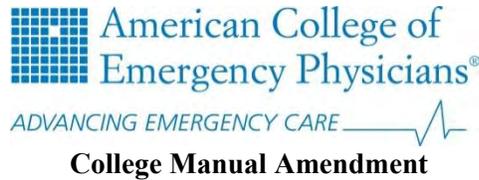
None that is specific to designating a body appointed by the Board of Directors to render a decision regarding disciplinary action.

Prior Board Action

June 2020, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting College Manual and Bylaws resolutions to the 2020 Council.

Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

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



College Manual Amendment

RESOLUTION: 15(20)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Procedures for Addressing Charges of Ethical Violations and Other Misconduct

PURPOSE: Amend by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues.

FISCAL IMPACT: Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

1 WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due
2 process to ensure it is fair to both the complainant and respondent; and
3

4 WHEREAS, A review by legal counsel, the ACEP Board of Directors, and a subcommittee comprised of
5 members of the Ethics Committee, Bylaws Committee and the Medical-Legal Committee determined that a more
6 efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually;
7 and
8

9 WHEREAS, The ACEP Board of Directors approved a revision to the *Procedures for Addressing Charges of*
10 *Ethical Violations and Other Misconduct* at its meeting in June 2020; and
11

12 WHEREAS, Approval by the ACEP Council is required to include the revised document in the College
13 Manual; therefore be it
14

15 RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges*
16 *of Ethical Violations and Other Misconduct* to read:
17

18 **Procedures for Addressing Charges of Ethical Violations and Other Misconduct**

19
20 Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in
21 accordance with College policy.
22

23 **A. Definitions**

- 24
25 **1. ACEP means the American College of Emergency Physicians.**
26 **2. Code of Ethics means the Code of Ethics for Emergency Physicians.**
27 **3. Procedures means the Procedures for Addressing Charges of Ethical Violations and Other**
28 **Misconduct.**
29 **4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two**
30 **(2) members of the Medical-Legal Committee – in matters requiring the expertise of a different**
31 **committee, the President may appoint two (2) members of the relevant committee to replace the**
32 **standing members of the Medical-Legal Committee.**
33 **5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.**
34 **6. Board Hearing Panel conducts all hearings and consists of the ACEP Vice-President, Chair of the**
35 **Board, and Board Liaison to the Ethics Committee.**

7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

A. B. Complaint Received

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

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of **an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ~~current~~ ACEP “Principles- Code of Ethics, for Emergency Physicians,” other ~~current~~ ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;**
3. Must allege a violation that occurred within ~~twelve (12)~~ **ten (10)** years prior to the submission of the complaint, **is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;**
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, ~~the Ethics Committee, the Bylaws Committee, the Board of Directors,~~ **any additional ACEP review body listed in these Procedures,** and ~~to~~ the respondent should the complaint be forwarded to the respondent; **and**
6. Must be submitted to the ACEP Executive Director.

B. C. Executive Director

1.
 - a. **If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.**
 - b. **If all elements of the complaint have been met, sends ~~1. Sends~~ a written acknowledgement to the complainant confirming ~~the~~ complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing and identifying the elements guidelines and timetables that ~~must will~~ be addressed followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the Procedures.**
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the ~~“Procedures for Addressing Charges of Ethical Violations and Other Misconduct” (“Procedures”)~~ **Procedures.**
3. Notifies the ACEP President and the ~~e~~Chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4.
 - a. Determines, in consultation with the ACEP President and the ~~e~~Chair of the Ethics ~~and/or~~ **Committee, the Bylaws Committee, or other committee designee,** that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the ~~Code of Ethics for Emergency Physicians or of~~ ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
 - b. Determines, in consultation with the **ACEP President and the Chair of the** Ethics Committee ~~chair,~~ **or other committee designee,** that the complaint alleges conduct that may constitute a violation of a policy or principle included in the ~~Code of Ethics for Emergency Physicians,~~ and if so, forwards the complaint and the response together, ~~as soon as~~ **after** both are received, to each member of the Ethics ~~Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose~~ **Complaint Review Panel,** or

- 91 c. Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee
92 ~~chair, or other committee designee,~~ that the complaint alleges conduct that may constitute a
93 violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and
94 forwards the complaint and response together, ~~as soon as~~ after both are received, to each member
95 of the Bylaws Committee, or at the discretion of the ~~e~~Chair of the Bylaws Committee, to members
96 of a subcommittee of the Bylaws Committee appointed for that purpose, or
97 d. Determines that the complaint is more appropriately addressed through judicial or administrative
98 avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP
99 should defer actions pursuant to such other avenues. If so, the Executive Director will refer the
100 matter to the ACEP President for review. If the President also determines that the complaint is more
101 appropriately addressed through judicial or administrative avenues, the complaint will not be
102 considered. The ~~Board of Directors~~ Ethics Complaint Review Panel or the Bylaws Committee
103 will review the President's action, ~~at the next regularly scheduled Board meeting.~~ The President's
104 action can be overturned by a majority vote of the ~~Board, or~~ applicable ACEP review body.
105 ~~e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care~~
106 ~~Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard~~
107 ~~of Care Review will be suspended pending the resolution of the complaint brought pursuant to these~~
108 ~~Procedures.~~
109 5. Within ten (10) business days after the determinations specified in Section ~~BC.4.b.~~ or Section ~~BC.4.c.~~
110 of these *Procedures*, forwards the complaint to the respondent by ~~certified U.S. mail~~ USPS Certified
111 Mail with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt
112 of the documents. The communication will indicate that ACEP is providing notice of the complaint, the
113 reasons for the review action, that no determination has yet been made on the complaint, and that the
114 respondent has the right to request a hearing if the ~~Board~~ applicable ACEP review body decides not to
115 dismiss the complaint. A copy of the complaint and all supporting documentation provided by the
116 complainant will be included in this communication. Such notice must also include a summary of the
117 respondent's rights in the hearing, and a list of the names of the members of the ~~ACEP Ethics~~
118 ~~Committee or the ACEP Bylaws Committee, as appropriate~~ applicable ACEP review body, including,
119 ~~and~~ the Board of Directors. The respondent will have the right to raise any issues of potential conflict or
120 reason that any individuals should recuse themselves from the review. Such recusal shall be at the
121 discretion of the ACEP President.
122 6. When a written response to a complaint is received, the Executive Director will forward that response
123 and any further related documentation to the complainant and the Ethics ~~Committee,~~ Complaint
124 Review Panel or the Bylaws Committee, ~~or the subcommittee~~ appointed to review the complaint, as
125 appropriate.
126

127 **D. Ethics ~~Committee~~ Complaint Review Process [within sixty (60) days of the forwarding of**
128 **the complaint/response specified in Section ~~BC.4.~~ eb. above]**
129

- 130 1. Reviews the written record of any complaint that alleges a violation of ~~current~~ the ACEP "Principles
131 Code of Ethics for Emergency Physicians" or other ~~current~~ ACEP ethics policies as they existed at the
132 time of the alleged violation and the accompanying response.
133 2. Discusses the complaint and response by telephone conference call;
134 3. Determines the need to solicit in writing additional information or documentation from the parties, third
135 parties, or experts regarding the complaint.
136 4. Considers whether:
137 a. ~~Current~~ Applicable version of the ACEP "Principles Code of Ethics for Emergency Physicians" or
138 other ~~current~~ ACEP ethics policies apply.
139 b. Alleged behavior constitutes a violation of ~~current~~ the applicable version of the ACEP
140 "Principles Code of Ethics for Emergency Physicians" or other ~~current~~ ACEP ethics policies.
141 c. Alleged conduct warrants censure, suspension, or expulsion.
142 ~~5. Proceeds to develop its recommendation based solely on the written record.~~
143 ~~6. Develops a report regarding the complaint and recommendation for action. Minority reports may also~~
144 ~~be presented.~~
145 ~~7.5. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In~~
146 ~~its report, the Ethics Committee shall recommend that the Board of Directors~~ Decides to:

- a. Dismiss the complaint; or
- b. ~~Take~~ **Ethics Complaint Review Panel renders a decision to impose** disciplinary action, ~~the specifics of which shall be included in the committee's report,~~ **based on the written record.**

~~8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:

- a. A hearing; or**
- b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.**

7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

~~C~~**E. Bylaws Committee Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section ~~BC~~.4.b.c. above]**

- 1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws **as it existed at the time of the alleged violation** and the accompanying response.
- 2. Discusses the complaint and response by telephone conference call.
- 3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
- 4. Considers whether:
 - a. ~~Current~~ **Applicable version of the** ACEP Bylaws apply.
 - b. Alleged behavior constitutes a violation of ~~current~~ **the applicable version of the** ACEP Bylaws.
 - c. Alleged conduct warrants censure, suspension, or expulsion.

~~5. Proceeds to develop its recommendation based solely on the written record.~~

~~6. Develops a report regarding the complaint and recommendation for action. A minority reports may also be presented.~~

~~7.5. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors~~

Decides to:

- a. Dismiss the complaint; or
- b. ~~Take~~ **Bylaws Committee renders a decision to impose** disciplinary action, ~~the specifics of which shall be included in the committee's report~~ **based solely on the written record.**

~~8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:

- a. A hearing; or**
- b. The imposition of the Bylaws Committee's decision based solely on the written record.**

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

- ~~1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.~~
- ~~2. May request further information in writing from the complainant and/or respondent.~~
- ~~3. Decides to:
 - ~~a. Dismiss the complaint; or~~
 - ~~b. Render a decision to impose disciplinary action based on the written record.~~~~
- ~~4. If the Board determines to impose disciplinary action pursuant to Section E.3.b., the respondent will be provided with notification of the Board's determination and the option of:
 - ~~a. A hearing; or~~
 - ~~b. The imposition of the Board decision based solely on the written record.~~~~
- ~~5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.~~
- ~~6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.~~

~~F. Ad Hoc Committee~~

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

258 **G.F. Right of Respondent to Request a Hearing**
259

260 If the ~~Board~~ **Ethics Complaint Review Panel or Bylaws Committee** chooses **to impose disciplinary**
261 **action**, the ~~option described in Section E.3.b., or an Ad Hoc Committee chooses the option described in~~
262 ~~Section F.3.cii., the~~ Executive Director will send to the respondent a written notice by ~~certified U.S. mail~~
263 **USPS Certified Mail** of the right to request a hearing, ~~or to have the Board or the Ad Hoc Committee~~
264 ~~impose its decision based solely on the written complaint.~~ This notice will list the respondent's hearing
265 rights as set forth in Section ~~H.G.~~ below. The respondent's request for a hearing must be submitted in
266 writing to the Executive Director within thirty (30) ~~business~~ days of receipt of the notice of right to a
267 hearing. In the event of no response, the ~~ACEP President may determine the manner of proceeding~~
268 **applicable ACEP review body will implement its final decision.**

269
270 **H. G. Hearing Procedures**
271

- 272 1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by
273 ~~certified U.S. mail~~ **USPS Certified Mail** by the Executive Director within ten (10) business days of
274 such request. Such notice will include a list of witnesses, if any, that the Board, ~~its subcommittee~~
275 ~~pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F.,~~ **Hearing Panel**
276 intends to call in the hearing.
- 277 2. The Executive Director will send a notification **by USPS Certified Mail** of the date, time, and place of
278 the hearing and will provide the parties with information regarding the hearing process and the conduct
279 of the hearing, ~~by certified U.S. mail.~~
- 280 3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after
281 the date on which notice of hearing was received by the respondent.
- 282 4. The complainant and respondent each may be represented by counsel or any other person of their
283 choice. Each party will bear the expense of his or her own counsel.
- 284 5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or
285 videotape at the expense of the requesting party.
- 286 6. The hearing ~~may be conducted by the entire Board, by a subcommittee of three to five members of the~~
287 ~~Board of Directors, at the discretion of and as appointed by the chair of the Board of Directors or, if~~
288 ~~required pursuant to Section F., by an Ad Hoc Committee described in Section F. If the hearing is~~
289 ~~conducted by a subcommittee or by an Ad Hoc Committee that includes one or more Board members as~~
290 ~~described in Section F., the presiding officer of the hearing will be a Board member designated by the~~
291 ~~chair of the Board. The chair of the Board of Directors will act as the presiding officer throughout the~~
292 ~~hearing conducted by the full Board unless the chair is unable to serve or is disqualified from serving,~~
293 ~~in which case the ACEP President will designate a member of the Board of Directors to chair the~~
294 ~~hearing. If all Board members have recused themselves, the Ad Hoc Committee members shall choose~~
295 ~~an individual from among themselves to chair the hearing. If a subcommittee of the Board or an Ad~~
296 ~~Hoc Committee conducts the hearing, such hearing must take place with all of the parties and all the~~
297 ~~members of the subcommittee or ad hoc committee present in person. If the full Board conducts the~~
298 ~~hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take~~
299 ~~place by telephone conference call~~ **will take place before the Board Hearing Panel. All members of**
300 **the Board Hearing Panel must be present in person, except in circumstances in which it is**
301 **impossible or commercially impracticable for the parties and the Board Hearing Panel to hold an**
302 **in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.**
- 303 7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present
304 evidence that is determined to be relevant by the presiding officer, even if the evidence would not be
305 admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All
306 witness expenses will be borne by the party who calls the witness.
- 307 8. The Board, ~~its appointed subcommittee, or an Ad Hoc Committee~~ **Hearing Panel** will, after having
308 given the complainant and the respondent an opportunity to be heard, including oral arguments and the
309 filing of any written briefs, conclude the hearing.
- 310 ~~9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee,~~
311 ~~such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing~~
312 ~~concludes, submit the written record of the hearing, along with the subcommittee's recommendation or~~

~~the Ad Hoc Committee's decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.~~

~~10.9.~~ The decision of the Board ~~or Ad Hoc Committee~~ Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the ~~Board's or Ad Hoc Committee~~ Board Hearing Panel's decision will be sent by ~~certified U.S. mail~~ USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the ~~Board's or Ad Hoc Committee's~~ Board Hearing Panel's decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the applicable ACEP review body in its review of the complaint. The Board shall review the Procedures used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these Procedures were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action: ~~Censure, Suspension, or Expulsion~~ and Disclosure to ACEP Members

1. Nature of Disciplinary Action

a. Censure

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

~~b.~~ ii. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section ~~A.B.2.~~ above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action.

~~2.~~ b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the ~~Board of Directors~~ ACEP President. At the end of the twelve- (12) month period of suspension, the suspended member ~~shall be offered~~ may request reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to

the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

3. c. Expulsion from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. The expulsion

J.—Disclosure

1.—Nature of Disciplinary Action

- a.—~~Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued~~ announced in an appropriate ACEP publication. The published announcement shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed, also state which ACEP policy or Bylaws provision was violated by
- b.—~~Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.~~
- c.—~~Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which~~ and shall inform ACEP members that they may result in a report of such request further information about the disciplinary action, to the National Practitioner Data Bank.
- d.—~~Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition.~~ ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure

- a. Disclosure to ACEP members ~~Members:~~ Any ACEP member may transmit ~~to the Executive Director~~ a request for information to the Executive Director regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section ~~J~~ I.1.
- b. Public Disclosure to Non-Members: ~~If a non-member~~ The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ~~If any person~~ makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided.

K.J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the ~~Board of Directors or an Ad Hoc Committee pursuant to Section F.~~ applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section ~~J~~ I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics ~~Committee~~ Complaint Review Panel, the Bylaws Committee, or the ~~Board of Directors,~~ their appointed subcommittees, as appropriate, or an Ad Hoc Committee Hearing Panel, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the ~~committee's, Board's, subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board~~

- 424 ~~beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee,~~
425 ~~subcommittee, or Ad Hoc Committee.~~ ACEP review body's overall time to complete its task.
- 426 4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative
427 and committee costs.
- 428 5. If a participant in this process (such as a member of the Ethics ~~Committee~~ Complaint Review Panel,
429 the Bylaws Committee, or ~~the Board of Directors~~ Hearing Panel) is a party to the complaint, has a
430 material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic
431 competition with the respondent, that person shall recuse himself or herself from the process except as a
432 complaining party or respondent. ~~Any committee member who recuses himself or herself shall report~~
433 ~~this recusal promptly to the committee chair, and any Board member who recuses himself or herself~~
434 ~~shall report this recusal promptly to the chair of the Board.~~ at which time the ACEP President will
435 appoint a replacement.
- 436 6. Once the ~~Board~~ Ethics Complaint Review Panel or the Bylaws Committee has made a decision ~~or~~
437 ~~implemented a decision of an Ad Hoc Committee pursuant to Section F.~~ on a complaint, it will not
438 consider additional allegations against the same respondent based on the same or similar facts.
- 439 7. The ~~Board's~~ Ethics Complaint Review Panel or the Bylaws Committee's decision ~~or the decision of~~
440 ~~an Ad Hoc Committee pursuant to Section F.~~ to impose an adverse action must be based on a
441 reasonable belief that the action is warranted by the facts presented or discovered in the course of the
442 disciplinary process.
- 443 8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a
444 request for information, the ~~Board or an Ad Hoc~~ Ethics Complaint Review Panel, the Bylaws
445 Committee, ~~pursuant to Section F.~~ or the Board Hearing Panel may make a decision on the
446 complaint solely on the basis of the information it has received.
- 447 ~~9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the~~
448 ~~Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to~~
449 ~~these Procedures.~~
- 450 ~~10.9.~~ 9. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a
451 complaint against that respondent, that request for resignation will not be accepted by ACEP until the
452 complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues
453 will be interpreted as a request for resignation.

Background

This resolution amends by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues. A companion Bylaws resolution has also been submitted.

In 1997, ACEP established procedures by which its members may initiate complaints against fellow members for violations of ACEP's *Code of Ethics for Emergency Physicians* ("Code of Ethics"). These procedures have been revised several times, most recently in 2013. In accordance with the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* (the "Procedures"), the current structure for review of ethics complaints is:

1. ACEP's President, Chair of the Ethics Committee, and its Executive Director conduct an initial review of a filed complaint, with input from the General Counsel. This review is limited to providing a determination as to whether the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in ACEP's *Code of Ethics* or Bylaws or if it should move forward for additional review by ACEP's Ethics Committee or subcommittee.¹
2. Should the case proceed to a formal review, a subcommittee of the Ethics Committee examines the complaint and response of the accused. It then provides the Board of Directors with a written recommendation to either dismiss the complaint or take disciplinary action.

¹ The *Procedures* also provide an opportunity for members to file complaints regarding violations of ACEP's Bylaws; however, no complaint of this nature has ever been filed. As such, a discussion regarding complaints alleging violations of ACEP's Bylaws have been omitted from this memo.

3. The Board of Directors reviews the complaint, response, and any additional information it deemed relevant. At its next meeting, the Board deliberates the ethics case and renders a determination to dismiss the complaint or impose disciplinary action.
4. If the respondent requests a hearing after receipt of notice regarding disciplinary action taken against him or her, an in-person hearing is held before the Board of Directors or a subcommittee of the Board.

Following establishment of the *Procedures*, 20 cases have been decided by the Board of Directors, 4 of which have resulted in hearings. The frequency of complaints varies annually; however, on average 1-2 cases are reviewed per year. During the 2017-18 fiscal year, the Board reviewed 3 cases, one of which required a hearing.

A 2017 survey of Ethics Committee members who have served on the complaint subcommittee revealed that each member spends an average of 8-12 hours reviewing case documents, as well as participating in a 90-120-minute conference call to deliberate the facts of the case and vote on a recommendation to the Board of Directors. This does not include additional hours required of the Chair of the subcommittee to collaborate with staff in drafting the recommendation, as well as participate in the Board deliberations and possible hearing.

The Board of Directors also spends a commensurate amount of time reviewing documents and preparing for ethics complaint deliberations. Should the respondent request a hearing in the case, a Board member will likely spend several hours refamiliarizing him/herself with the facts of the case. At Board meetings, deliberations and hearings can take up to 3 hours.

Because of the burden these responsibilities place on the Board and Ethics Committee, the committee was requested to develop an alternative process by which ethics complaints could be adjudicated in a manner that still provides adequate due process to the parties as required under the Health Care Quality and Improvement Act. After studying review processes used by other medical societies, researching ACEP's legal responsibilities, and discussing the needs of the College, the following revised process is proposed:

Step 1. A broad review of the complaint by the ACEP President, Chair of the Ethics Committee, Chair of the Bylaws Committee, or other committee designee and ACEP's Executive Director, with input from the General Counsel, to determine if the complaint alleges conduct that constitutes a violation of the *Code of Ethics* or other ACEP ethics policies, or of the ACEP Bylaws.

Step 2. The Ethics Complaint Review Panel or the Bylaws Committee will review the complaint and response from the parties and make its determination, which will be forwarded to the parties.

Step 3. Should a hearing be requested, a Board Hearing Panel consisting of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee will conduct the hearing and render its decision.

Step 4. At the next Board meeting following a final determination from the applicable ACEP review body, the Board will review the case for procedural matters only. It will not review the facts or merits of the case.

It is important that the Board maintain oversight of the process; however, this streamlined version should substantially reduce the amount of time and preparation required of the Board, as its role will be limited solely to ensuring the reviewing body acted in compliance with the *Procedures*. Several medical specialty societies, such as the American Academy of Otolaryngology and the Society of Thoracic Surgeons, engage in similarly structured reviews.

The Board of Directors submitted a similar resolution to the 2019 Council for consideration. Upon review by the Bylaws Committee and prior to the 2019 Council meeting, concerns were raised that the revised *Procedures* may be in conflict with the Bylaws because the Bylaws currently state that only the Board of Directors has the power to impose disciplinary action on a member. The Bylaws Committee recommended adding a provision to the Bylaws allowing a "designated body appointed by the Board of Directors" to review ethics complaints and make determinations regarding disciplinary action against members. As such, the resolution was withdrawn.

from the 2019 Council meeting based on these recommendations. A subcommittee was then assigned, comprised of members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee to revise the *Procedures* and draft revisions to the Bylaws to address this issue. The Bylaws amendment is submitted as Resolution 14(20) Ethics Procedures.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement

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

Fiscal Impact

Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

Prior Council Action

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the ethics procedures in the College Manual. The changes addressed the timeliness of filing allegations, clarifications of aspects of the process, ensuring that deadlines are reasonable in light of process and review requirements, a respondent's membership status during the pendency of an ethics complaint, and clarifications of the scope and disclosure of disciplinary actions.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to deadlines and provided mechanisms in the event that the number of Board recusals impacts the Board's ability to act on ethics complaints.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to due process and the hearing procedures.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes related to the categories of sanctions and clarifying when disclosure of such sanctions may be appropriate or necessary.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes included enhancements related to communications, responsibilities, timelines, and voting.

Resolution 5(99) College Manual adopted that included the "Procedures for Addressing Ethics and Other Disciplinary Charges." The resolution established the College Manual and defined the method for amending it.

Prior Board Action

June 2020, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting College Manual and Bylaws resolutions to the 2020 Council.

June 2019, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2019 Council.

December 2018, discussed revising the Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to create a more efficient review process.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2013, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting a College Manual resolution to the 2013 Council.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

April 2010, reviewed the proposed changes to the “Procedures for Addressing Ethics and Other Disciplinary Charges” and approved submitting a College Manual resolution to the 2010 Council.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2007, reviewed the proposed changes to the “Procedures for Addressing Ethics and Other Disciplinary Charges” and requested additional changes to be reviewed and approved by the Board. Approved submitting a College Manual resolution to the 2007 Council.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Resolution 5(99) College Manual adopted.

August 1998 Procedures for Addressing Ethics Charges adopted.

Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Bylaws Amendment

RESOLUTION: 16(20)
SUBMITTED BY: Board of Directors
SUBJECT: Special Board of Directors Meetings

PURPOSE: Amends the Bylaws to allow special meetings of the Board to be called by the chair of the Board in addition to the president with not less than 48 hours notice.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, Currently, only the president or one-third of the current members of the Board may call for a
2 special meeting of the Board of Directors; and
3

4 WHEREAS, There are times when a special meeting of the Board needs to occur with less than 10 days
5 notice; and
6

7 WHEREAS, If a special meeting of the Board of Directors is necessary with less than 10 days notice, Board
8 members must agree to waive the 10-day notice requirement; therefore be it
9

10 RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 3 – Meetings be amended to
11 read:

12
13 Section 3 — Meetings
14

15 The Board of Directors shall meet at least three times annually. One of these meetings shall take place not
16 later than 30 days following the annual meeting of the College. The other meetings shall take place at such other times
17 and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A majority
18 of the Board shall constitute a quorum.
19

20 Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors,
21 members of the Board of Directors may participate in and hold additional meetings of such Board by means of
22 conference telephone or similar communications equipment by means of which all persons participating in the
23 meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person
24 at such meeting, except where a director participates in such meeting for the express purpose of objecting to the
25 transaction of any business on the ground that the meeting is not lawfully called or convened.
26

27 Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a
28 meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board
29 of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the
30 members of the Board of Directors at a meeting of the Board of Directors.
31

32 Special meetings of the Board of Directors may be called by the president **or the chair of the Board** with not
33 less than **48 hours** ~~nor more than 50 days~~ notice to each director, either personally or by other appropriate means
34 of communication. Special meetings also may be called by one-third of the current members of the Board in like
35 manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be
36 transacted at, and the purpose of, such special meeting.

Background

This resolution amends the Bylaws to allow special meetings of the Board to be called by the chair of the Board in addition to the president with not less than 48 hours notice.

The current Bylaws stipulate that only the president or one-third of the current members of the Board may call for a special meeting of the Board of Directors. Since the chair of the Board is responsible for presiding at Board meetings, the chair should also have the ability to call a special meeting. The current requirement of “not less than 10 days” notice for a special Board meeting is not conducive for the Board to be able to act quickly on an emergent issue in today’s fast paced environment. The provision of “nor than 50 days notice” is unnecessary since email communications, notices on the ACEP website, and through ACEP’s all member engagED platform can quickly disseminate information about special Board of Directors meetings to members of the Board and the general membership.

Amended Resolution 3(89) Board of Directors Special Meetings, which was adopted by the Council and the Board of Directors, added the current language in the Bylaws regarding special meetings. This language was developed on the advice of an attorney based on a discussion of Resolution 17(88) Meetings of the Board of Directors (and other resolutions regarding meetings of the Board of Directors) that was referred to the Constitution & Bylaws Committee. At that time, the Texas Non-Profit Corporation Act required that notice be given with respect to special meetings and ACEP’s Bylaws did not contain a such a provision. ACEP’s Bylaws also contained a provision, and still does in Article III – College Meetings, stipulating that all meetings of the Board of Directors of the College are open to all members of the College except for closed sessions that may be called. In 1989, notification of special meetings was conducted by mail, telegram, fax, or notice in printed ACEP publications and a longer time period for notification was required.

ACEP’s parliamentary authority, *The Standard Code of Parliamentary Procedure*, provides additional guidance regarding special meetings of the Board of Directors by clarifying that any Board member that participates in a special meeting, and does not protest the lack of appropriate notice, waives notice by the fact of their attendance and participation. Any Board member who is unable to participate in the special meeting and does not object to the special meeting being held must provide a written waiver of notice prior to the special meeting. Quorum requirements for the special meeting still must be met.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Amended Resolution 3(89) Board of Directors Special Meetings adopted. The resolution amended the Bylaws to include the current language “with not less than 10 nor more than 50 days notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.”

Resolution 17(88) Meetings of the Board of Directors referred to the Constitution & Bylaws Committee.

Resolution 12(79) Meetings of the Board of Directors not adopted. The resolution sought to amend the Bylaws to allow special meetings to be called at the request of one-third of the members of the Board or by the president.

Prior Board Action

Amended Resolution 3(89) Board of Directors Special Meetings adopted.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



Council Standing Rules Amendment

RESOLUTION: 17(20)
SUBMITTED BY: Council Steering Committee
SUBJECT: Unanimous Consent Agenda

PURPOSE: Amends the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, including recommendations for amendment or substitution of the resolution. Contains a proviso that changes are effective after the 2020 Council meeting.

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

1 WHEREAS, Use of the Unanimous Consent Agenda increases the efficiency of the Council; and
2
3 WHEREAS, Use of the Unanimous Consent Agenda for Reference Committee recommendations has
4 increased over the past few years; and
5
6 WHEREAS, Many councillors have suggested that the Unanimous Consent Agenda be used for all
7 resolutions, except for Bylaws resolutions, which require a two-thirds affirmative vote for adoption; and
8
9 WHEREAS, A request for extraction of any resolution from the Unanimous Consent Agenda by any
10 credentialed councillor is in order at the beginning of the Reference Committee report; therefore be it
11
12 RESOLVED, That the Council Standing Rules, “Unanimous Consent Agenda” section, be amended to read as
13 follows with the proviso that the changes will become effective after the 2020 Council meeting:
14
15 **Unanimous Consent Agenda**
16 A “Unanimous Consent Agenda” is a list of resolutions with a waiver of debate ~~and may include items that meet~~
17 ~~one of the following criteria as determined by the Reference Committee:~~
18 1. ~~Non-controversial in nature~~
19 2. ~~Generated little or no debate during the Reference Committee~~
20 3. ~~Clear consensus of opinion (either pro or con) was expressed at Reference Committee~~
21 All resolutions assigned to a Reference Committee, except for Bylaws resolutions, ~~and resolutions that require~~
22 ~~substantive amendments~~ shall ~~not~~ be placed on a Unanimous Consent Agenda.
23 A The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with
24 the committee’s recommendation for adoption, referral, amendment, substitution, or ~~defeat~~ not for adoption for
25 each resolution listed. A request for extraction of any resolution from a the Unanimous Consent Agenda by any
26 credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining
27 items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference
28 Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate
29 time during that report.

Background

The resolution amends the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codifies that recommendations for amendment or substitution of the

resolution will be included on the Unanimous Consent Agenda, although amended and substitute resolutions have been included on the Unanimous Consent agenda in previous years.

Currently, the Unanimous Consent Agenda is used for resolutions that are non-controversial, or generated little/no debate, or had a clear consensus of opinion in favor, opposed, or for referral. If one person objects, then it is not unanimous, the item is removed from the Unanimous Consent Agenda, and the item is then debated and voted on by the Council. Use of the Unanimous Consent Agenda for Reference Committee recommendations has increased over the past few years with tremendous success in streamlining the Council meeting agenda. Many councillors have suggested that the Reference Committees place all resolutions on the Unanimous Consent Agenda, except for Bylaws resolutions since they require a 2/3 vote for adoption. There are multiple opportunities to provide feedback to the Reference Committee about a resolution whether through comments on the Council engagED platform, written testimony submitted in advance of the Council meeting, or in person testimony during the Reference Committee hearing.

The Steering Committee discussed use of the Unanimous Consent Agenda at their meetings in January and April 2020 and determined that a Council Standing Rules amendment should be submitted to the 2020 Council.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 14(17) Unanimous Consent not adopted. This resolution intended to amend the Council Standing Rules by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda with the Reference Committee's recommendation for adoption, not adoption, or referral for each resolution and requiring a second for extraction.

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

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

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

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 18(20)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Emergency Medicine Residents' Association
District of Columbia Chapter
Puerto Rico Chapter

SUBJECT: ACEP Membership and Leadership

PURPOSE: 1) Set benchmarks for improving racial/ethnic and gender diversity of its members, committee members, councillors, Council Officers, and Board of Directors; and 2) encourage community and academic emergency medicine groups to collect and publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity amongst its members.

FISCAL IMPACT: Budgeted resources for developing reports and encouraging other emergency medicine groups to collect and publish demographic data. Potential unbudgeted costs for obtaining demographic data from other sources for use in comparing ACEP's data to assist with setting benchmarks.

1 WHEREAS, Diverse organizations have been shown to be more productive and satisfying to its membersⁱ;
2 and

3
4 WHEREAS, A diverse ACEP membership and leadership will provide the collective perspective and diverse
5 set of experiences to adequately address the disparities in health care and health outcomes; and

6
7 WHEREAS, ACEP is committed to increasing diversity and inclusion, including multigenerational diversity
8 within the organizationⁱⁱ; and

9
10 WHEREAS, ACEP collection of member demographic data was found to be inadequate and incomplete by
11 the ACEP Diversity and Inclusion Task Force in 2017; and

12
13 WHEREAS, ACEP does not routinely publish granular member demographic data; and

14
15 WHEREAS, ACEP does not set benchmarks for improving the diversity of its membership and leadership;
16 and

17
18 WHEREAS, ACEP does not encourage community or academic emergency medicine groups to collect or
19 publish demographic data about its members, or set benchmarks for improving their diversity; and

20
21 WHEREAS, The Leadership Diversity Task Force (LDTF) was assigned by the ACEP Board to fulfill the
22 following objectives: 1. Review the national ACEP Board of Directors nominating process(es), both formal and
23 informal, and recommend best practices. 2. Survey current pipeline programs within Council component bodies (i.e.
24 chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best
25 practices to improve diversity within ACEP leadership. 3. Identify barriers to becoming a councillor, Council leader,
26 and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations
27 such as age, gender, race, religion, LGBTQ, and practice type; and

28
29 WHEREAS, In June 2018, the Board of Directors approved the LDTF's recommendations: 1. Collection of
30 demographic data, including the proportion of underrepresented populations within ACEP's overall membership and
31 leadership (including the Board of Directors, Council, sections, and committees) and including, but not limited to,
32 domains such as gender, race, ethnicity, sexual orientation, and age. 2. Reviewing diversity data every three years and

33 presenting the findings to the ACEP Council to determine whether efforts have been effective in promoting increased
34 diversity within ACEP leadership and to inform future initiatives to increase diversity; and

35

36 WHEREAS, Two years after the adoption of these recommendations, ACEP has yet to effectively
37 operationalize these measures as requested by the ACEP Council; and

38

39 WHEREAS, ACEP sets the philosophical and ethical standard for our specialty and must hold itself
40 accountable for evaluating and addressing its lack of diversity; and

41

42 WHEREAS, Only with structure and transparency will these ongoing barriers to inclusion be torn down;
43 therefore be it

44

45 RESOLVED, That ACEP set benchmarks for improving racial/ethnic and gender diversity of its members,
46 committee members, councillors, Council Officers, and Board of Directors; and be it further

47

48 RESOLVED, That ACEP encourage community and academic emergency medicine groups to collect and
49 publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity
50 among its members.

ⁱ Paul Gompers and Silpa Kovvali, “The Other Diversity Dividend”, Harvard Business Review, July-August 2018, pp 72-77

ⁱⁱ Rebecca Parker et al, “Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians’ Future Success,” Annals of Emergency Medicine, Jan. 27, 2017, Vol 69, Issue 6, P 714-717

Background

This resolution requests ACEP to: 1) set benchmarks for improving racial/ethnic and gender diversity of its members, committee members, councillors, Council Officers, and Board of Directors; and 2) encourage community and academic emergency medicine groups to collect and publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity among its members.

A comprehensive report of ACEP’s membership is available in the Council meeting materials as directed by Amended Resolution 12(19) ACEP Composition Annual Report. The report includes demographics of councillors and alternate councillors by chapter, ACEP’s committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. The data is limited to the extent that members provide this information in their membership profile. Many members choose not to answer certain profile questions, which can account for a higher number of “not specified” or “unknown.” This report will serve as the foundation for comparison of the data in future years.

An infographic of the [demographics of ACEP’s Board of Directors](#) is posted on the ACEP Website.

As mentioned in the Whereas statement, ACEP has not established benchmarks for improving diversity of members and leaders in the College. Such benchmarks would need to be set by the Board of Directors.

ACEP is committed to increasing the diversity of members in all leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. It is important for residents, young physicians, and others who represent a minority of members of the College, to become active in their chapters and sections, seek appointment or election as a councillor or alternate councillor within their chapter (approximately half of the ACEP chapters elect councillors and alternate councillors and half appoint them) or section, and to apply for and be selected to serve on national ACEP committees. It should be noted that committee members are selected from the applications submitted by members who are interested in serving. Committee members are appointed based on their qualifications and subject matter expertise.

The Nominating Committee's role is limited to vetting candidates submitted by component bodies or self-nominations for leadership positions elected by the Council, which include the Board of Directors, President-Elect, Speaker, and Vice Speaker. No candidates have ever been excluded from nomination because of gender, ethnicity, political or religious beliefs, or sexual orientation.

Amended Resolution 14(18) Diversity of ACEP Councillors directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members. A notice was sent to chapters on March 27, 2019, reminding them of the adopted resolution. A follow up message was sent to chapters on February 17, 2020.

Resolution 12(18) Nominating Committee Revision to Promote Diversity amended the Council Standing Rules to provide further guidance to the Nominating Committee regarding candidate qualifications to increase leadership diversity.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership directed the ACEP Board of Directors to work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation. The resolution was addressed through the work of the Diversity & Inclusion Task Force, the Leadership Development Advisory Group (now formalized as the Leadership Development Advisory Committee), the Leadership Diversity Task Force (LDTF), and the National/Chapter Relations Committee. The Board of Directors accepted the final report from the Diversity & Inclusion Task Force in September 2018 and the final report of the Leadership Diversity Task Force in January 2019. The Diversity, Inclusion, & Health Equity Section continues to work on the strategies developed by the Diversity & Inclusion Task Force.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted resources for developing reports and encouraging other emergency medicine groups to collect and publish demographic data. Potential unbudgeted costs for obtaining demographic data from other sources for use in comparing ACEP's data to assist with setting benchmarks.

Prior Council Action

Amended Resolution 12(19) ACEP Composition Annual Report adopted. Directed that ACEP provide the Council with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 12(18) Nominating Committee Revision to Promote Diversity adopted. This Council Standing Rules amendment added further guidance regarding candidate qualifications to increase leadership diversity.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership.

Prior Board Action

Amended Resolution 12(19) ACEP Composition Annual Report adopted.
January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.

May 2018, approved the Leadership Diversity Task Force recommendations to collect demographic data, including the proportion of underrepresented populations within ACEP's overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council.

April 2017, approved the Diversity & Inclusion Task Force's recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges to the membership.

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

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 19(20)

SUBMITTED BY: California Chapter
Maryland Chapter
Massachusetts College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians
Pennsylvania College of Emergency Physicians
New York Chapter
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
Emergency Medicine Residents' Association

SUBJECT: Framework to Assess the Work of the College Through the Lens of Health Equity

PURPOSE: Develop a framework to assess the work of the College through an equity lens and provide to members biannually (every six months) an assessment of the work of the College through the lens of health equity.

FISCAL IMPACT: Budgeted staff resources. Potential unbudgeted additional resources needed to create the framework. Actual costs will be determined based on the scope of the framework created and whether honorarium or additional fees will be necessary to complete the development of the framework and production of the biannual report.

1 WHEREAS, A health disparity is defined as “a higher burden of illness, injury, disability, or mortality
2 experienced by one group relative to another” (KFF); and
3

4 WHEREAS, Prior to the COVID-19 pandemic, significant disparities in emergency care already existed, as
5 are described in the 2017 ACEP Information Paper, “[Disparities in Emergency Care](#)”; and
6

7 WHEREAS, The groups affected by healthcare disparities include (but are not limited to) racial and ethnic
8 minority populations, the LGBTQ community, people with intellectual and physical disabilities, persons living with a
9 mental health diagnosis; and
10

11 WHEREAS, The COVID-19 pandemic has highlighted and exacerbated health disparities affecting racial and
12 ethnic minority groups, for example, the death rate of COVID-19 in some predominantly black counties is six-fold
13 higher than in predominantly white counties; and
14

15 WHEREAS, Racial and ethnic minority groups in the U.S. disproportionately live in at-risk communities
16 placing them at a greater risk for disease and have disproportionately more barriers to accessing care; and
17

18 WHEREAS, Addressing health equity and working to eliminate health disparities will require a multifaceted
19 approach with an understanding that decisions in healthcare – from direct clinical care to how care is delivered, what
20 care is delivered, and how care is paid for – have an impact on disparities; therefore be it
21

22 RESOLVED, That ACEP create or select a framework to assess the work of the College (position statements,
23 adopted resolutions, task forces) through the lens of health equity; and be it further
24

25 RESOLVED, That ACEP provide to members a biannual assessment of the work of the College as it pertains
26 to health equity.

Resources:

- Coronavirus Disease 2019 (COVID-19) Racial & Ethnic Minority Groups. 2020; <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>. Accessed May 29th, 2020, 2020.
- Yancy CW. COVID-19 and African Americans. *JAMA*. 2020;323(19):1891–1892. doi:10.1001/jama.2020.6548
- Ubri P, Artiga S. Disparities in health and health care: Five key questions and answers. Kaiser Family

Background

This resolution calls for the College to develop a framework to assess the work of the College through an equity lens, (including position statements, adopted resolutions, task forces) and provide to members a biannual (every six months) assessment of the work of the College through the lens of health equity.

The [Equitable Evaluation Initiative](#) developed a framework in which organizations can evaluate assets and services to ensure they conceptualize and implement using an equitable lens. The framework is utilized by organizations to address the cultural appropriateness and validity of their methods. The framework is based on three principles:

1. Evaluation and evaluative work should be in service of equity.
2. Evaluative work can and should answer critical questions about the history and structure that contribute to the issues being addressed, effect of a strategy on different populations, and how cultural context is addressed.
3. Evaluative work should be designed and implemented commensurate with the values underlying equity work.

The information paper “[Disparities in Emergency Care](#)” compiled and distributed information on health care disparities and strategies to address disparities. The areas addressed were:

1. Disparities in Practice
2. Disparities in Pre- Hospital Care
3. Disparities in Utilization
4. Disparities in Outcomes

Health disparities specifically related to COVID-19 are referenced in the [ACEP COVID-19 Field Guide](#). The chapter on Racial and Ethnic Minority Groups explains the special considerations that need to be taken by physicians when screening and treating these patients.

ACEP is committed to increasing the diversity of members in leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. It is important for members of underrepresented groups of the College to become active in their chapters and sections, seek appointment or election as a councillor or alternate councillor, and to apply and be elected to serve on national ACEP committees.

Demonstrating the ongoing importance of this issue, 14 of ACEP’s committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted staff resources. Potential unbudgeted additional resources needed to create the framework. Actual costs will be determined based on the scope of the framework created and whether honorarium or additional fees will be necessary to complete the development of the framework and production of the biannual report.

Prior Council Action

None that is specific to assessing the work of the College through the lens of health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members. The policy statement is in development. The Diversity, Inclusion, & Health Equity Section continues to promote the [Unconscious Bias in Clinical Practice](#) course.

Amended Resolution 12(19) ACEP Composition Annual Report adopted. The resolution directed ACEP to provide an annual report to the Council on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. A report has been prepared for the 2020 Council.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members. There was unanimous support for the intent of the resolution to increase diversity within the Council. The majority of those testifying believed that the language was not appropriate for the ACEP Bylaws. Testimony on behalf of state chapters emphasized the importance of chapter independence and that this would create roadblocks for small chapters because of the limited number of councillors allotted to them and it would force them to substitute a more knowledgeable councillor for those with less experience.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership. The Diversity & Inclusion Task Force and the Leadership Diversity Task Force were appointed in response to this resolution.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

April 2020, approved the revised policy statement "[Cultural Awareness and Emergency Care](#);" reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

Amended Resolution 12(19) ACEP Composition Annual Report adopted

January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.

June 2018, approved the revised policy statement "[Non-Discrimination and Harassment](#);" revised and approved with the current title April 2012; originally approved October 2005 with the title "Non-Discrimination."

May 2018, approved the Leadership Diversity Task Force recommendations to collect demographic data, including the proportion of underrepresented populations within ACEP's overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council. This action has been superseded by Amended Resolution 12(19) ACEP Composition Annual Report.

November 2017, approved the revised policy statement "[Workforce Diversity in Health Care Settings](#);" reaffirmed June 2013 and October 2007; originally approved October 2001.

October 2017, reviewed the information paper "[Disparities in Emergency Care](#)."

April 2017, reviewed the information paper “Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management.”

April 2017, approved the Diversity & Inclusion Task Force’s recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges to the membership.

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

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA
Senior Manager, Development & Special Projects

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 20(20)

SUBMITTED BY: John Bibb, MD, FACEP
Fred Dennis, MD, MBA, FACEP
Emergency Medicine Residents' Association
Florida College of Emergency Physicians
Pain Management & Addiction Medicine Section

SUBJECT: Kayce Anderson Award for Excellence in Innovations in the ED Care of Patients with Substance Use & Behavioral Health Issues

PURPOSE: Create an annual award to honor emergency physicians named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

FISCAL IMPACT: Budgeted staff resources for development and administration of the award. Approximately \$500 for a master plaque at ACEP headquarters with the names of each year's recipient(s). Potential \$2,300 additional costs to include in the annual budget for cost of the award and travel expenses and waived registration fee to attend *Scientific Assembly* the year the award is received.

1 WHEREAS, The U.S. death toll from substance use and suicide exceeds 160,000 people annually causing the
2 average life span to decline; and
3

4 WHEREAS, These afflictions are often chronic and relapsing and it is difficult to substantially alter the
5 course in one ED visit; and
6

7 WHEREAS, Effective treatment and referral are necessary for long-term beneficial outcomes; and
8

9 WHEREAS, Successful innovations have been initiated by ED physicians in recent years, for example, the
10 provision of ED social workers, effective referrals to outpatient care, and the initiation of buprenorphine in
11 appropriate patients; and
12

13 WHEREAS, These advances in ED care have significantly improved the lives of many patients; and
14

15 WHEREAS, The joy of the practice of emergency medicine has been augmented by being able to offer these
16 patients better care; and
17

18 WHEREAS, There is still a very substantial unmet need in the care of these patients; and
19

20 WHEREAS, These innovations should be publicized to further improve care; and
21

22 WHEREAS, An award for emergency physicians who have made innovations in the care of these patients
23 may be used by the College to promote public relations; and
24

25 WHEREAS, Kayce Anderson, daughter of Stephen Anderson, MD, FACEP, and Kathy Anderson died of an
26 opioid overdose, and her loss is symbolic of the profound effect mental health disorders and substance use disorders
27 have on our patients, our own families, and each of us personally; therefore be it
28

29 RESOLVED, That ACEP honor emergency physicians with an annual award named in memory of Kayce
30 Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

Background

This resolution seeks to create an annual award to honor emergency physicians named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

ACEP has a robust awards program that recognizes leadership and excellence and provides an opportunity to recognize members for significant professional contributions as well as service to the College. Ten awards are administered by the Awards Committee, five awards by the Academic Affairs Committee, one award by the Disaster Preparedness & Response Committee, two awards by the Emergency Medicine Practice Committee, one award by the National/Chapter Relations Committee, two awards by the Public Relations Committee, one award by the Well-Being Committee, and 5 awards by the Council Awards Committee.

It is not known whether eligibility for this proposed award is intended to be limited to ACEP members or if non-members would also be eligible for nomination. The actual award criteria, eligibility, and benefits associated with receiving the award would need to be determined by the Board of Directors.

ACEP has several awards named in honor of prominent individuals who have had a significant impact on the College and emergency medicine:

- The John G. Wiegenstein Leadership Award is named after one of ACEP's eight founding members and first president. It is ACEP's highest award.
- The James D. Mills Outstanding Contribution to Emergency Medicine Award is named after ACEP's second president and the designer of the "Alexandria Plan" for staffing emergency facilities with full-time practitioners of emergency medicine.
- The John A. Rupke Legacy Award is named after one of ACEP's eight founding members and is given for outstanding lifetime contributions to the College.
- The Pamela P. Bensen Trailblazer Award is named after the first woman resident in emergency medicine who was also the first woman elected to the national ACEP Board of Directors.
- The Judith E. Tintinalli Award for Outstanding Contribution in Education is named after the author of one of the premier emergency medicine textbooks.
- The Colin C. Rorrie, Jr, PhD Award for Excellence in Health Policy is named after ACEP's second executive director who was instrumental in the development of ACEP's Washington office and in elevating the stature of emergency medicine's advocacy efforts.
- The Diane K. Bollman Chapter Advocate Award is named after the former executive director of the Michigan College of Emergency Physicians who served in that role for 25 years.

ACEP sections also have the ability to create and administer awards. Another option for administration of this award is through the Pain Management & Addiction Medicine Section.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective F – Provide and enhance leadership development and recognition and strengthen liaison relationships with other emergency medicine organizations.

Fiscal Impact

Budgeted staff resources for development and administration of the award. Approximately \$500 for a master plaque at ACEP headquarters with the names of each year's recipient(s). Potential \$2,300 additional costs to include in the annual budget for cost of the award and travel expenses and waived registration fee to attend *Scientific Assembly* the year the award is received.

Prior Council Action

None that is specific to recognizing innovations in the ED care of patients with substance use and behavioral health issues.

Prior Board Action

The Board has approved the creation of many awards but none that is specific to recognizing innovations in the ED care of patients with substance use and behavioral health issues.

The Board approves ACEP award recipients each year.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 21(20)

SUBMITTED BY: Marc Futernick, MD, FACEP
Katelyn Moretti, MD, MS
Nikhil Ranadive, MD, MS
Caitlin Rublee, MD, MPH
Joshua Weil, MD
California Chapter
Wisconsin Chapter

SUBJECT: Medical Society Consortium on Climate & Health

PURPOSE: Requests that ACEP become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

FISCAL IMPACT: Approximately \$1,000 for travel costs to attend the annual meeting and unknown cost for the registration fee. Potential membership fee to join as a member society.

1 WHEREAS, According to the World Health Organization, climate change is “the greatest threat to global
2 health in the 21st century”²; and
3

4 WHEREAS, In the United States, adverse public health impacts resulting from climate change include, but
5 are not limited to: 1) the increasing exposure of an aging population to increasingly severe and frequent heatwaves; 2)
6 decreasing worker productivity due to extreme heat; and 3) substantial premature mortality attributable to fine
7 particulate air pollution³; and
8

9 WHEREAS, According to the Intergovernmental Panel on Climate Change, climate-related risks to human
10 health are projected to increase, and we are currently not meeting national and global emission targets to adequately
11 mitigate the harmful health effects of climate change⁴; and
12

13 WHEREAS, Given the role of emergency medicine in pre-hospital and acute care, emergency departments
14 will bear a large burden of the adverse influences of climate change, particularly due to the increasing frequency and
15 severity of climate hazards (extreme heat, extreme weather events, and ecological changes) and the increasing
16 incidence and prevalence of climate-sensitive diseases (acute heat illness, respiratory disease, cardiovascular disease,
17 waterborne communicable diseases, vector-borne diseases, trauma)⁵; and
18

19 WHEREAS, Given the de facto role of emergency medicine as a “safety-net” specialty, emergency physicians
20 care for the communities and populations most vulnerable to climate change including the elderly, individuals of low
21 socioeconomic status, and patients with multiple comorbidities⁵; and
22

23 WHEREAS, ACEP has previously committed to advocating “for policies and practices to mitigate and
24 address the effects of climate change on human health, health care systems, and public health infrastructure”⁶; and
25

26 WHEREAS, ACEP has previously committed to advocating “for initiatives to reduce the carbon footprint of
27 emergency departments and their affiliated institutions through energy conservation and health care waste reduction
28 and/or recycling”⁶; and
29

30 WHEREAS, ACEP could make a powerful contribution to national climate change adaptation and mitigation
31 efforts by joining the Medical Society Consortium on Climate & Health – a network of medical societies
32 encompassing over 600,000 clinicians that has, since its founding, logged 1,091 environmental health-related

33 activities across 39 states and these have included 338 policy activities, 38 research publications, 293 media articles
34 and interviews, and 422 presentations¹; and

35

36 WHEREAS, Twenty-nine other medical societies have already joined the Medical Society Consortium on
37 Climate & Health, including the California Chapter of the American College of Emergency Physicians, the American
38 Medical Association, the American Academy of Dermatology, the American Academy of Family Physicians, the
39 American Academy of Ophthalmology, the American Academy of Pediatrics, the American College of Obstetricians
40 and Gynecologists, the American Psychiatric Association, the Infectious Diseases Society of America, and the Society
41 of General Internal Medicine⁷; and

42

43 WHEREAS, The requirement for membership is: “The Consortium will be governed by a Steering
44 Committee composed of one representative from each participating medical society, and one representative of George
45 Mason University’s Program on Climate & Health. Each participating Medical Society will designate a member of
46 their Society to serve on the Steering Committee for a term of two years (renewable), and a second member to act as
47 an alternate, when necessary. The Steering Committee will convene quarterly via conference call and have one in
48 person meeting at the Consortium annual meeting. The annual meeting will be held each spring in Washington, DC.”
49 (*Roles and Responsibilities, Medical Society Consortium on Climate & Health.*); and

50

51 WHEREAS, This furthers ACEP’s mission to “be a leading advocate for emergency physicians, their
52 patients, and the public” amplifying our voices on a multidisciplinary national level; therefore be it

53

54 RESOLVED, That ACEP become an official member of the Medical Society Consortium on Climate &
55 Health; and be it further

56

57 RESOLVED, That ACEP support one ACEP member representative by paying registration and travel
58 expenses to attend the Medical Society Consortium on Climate & Health annual meeting starting in 2021.

References:

1. About The Medical Society Consortium on Climate and Health (MSCCH). The Medical Society Consortium on Climate and Health (MSCCH). <https://medsocietiesforclimatehealth.org/about/>. Accessed July 11, 2020.
2. WHO | WHO calls for urgent action to protect health from climate change – Sign the call. April 2016. <https://www.who.int/globalchange/global-campaign/cop21/en/>. Accessed July 11, 2020.
3. Salas RN, Knappenberger P, Hess JJ. Lancet Countdown, 2019: 2019 Lancet Countdown on Health and Climate Change Policy Brief for the United States of America. In: *Lancet Countdown U.S. Policy Brief*. London, United Kingdom.
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Background

This resolution requests that ACEP become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Climate change can be a controversial topic. However, both domestic and global organizations are addressing the effect of climate change on public health, disaster response, disease prevalence, and clinical implications. This involves research and response to the direct and indirect medical impact related to climate change.

ACEP and several other prominent medical organizations, including, but not limited to, the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American Lung Association, and the American Public Health Association, the World Association for Disaster and Emergency Medicine, and the World Health Organization have policy statements regarding the impacts of climate change on human health

The [Medical Society Consortium on Climate & Health](#) was launched in 2016 and membership currently includes 29 national medical societies and 55 partner organizations. Their mission “is to organize, empower and amplify the voice of America’s doctors to convey how climate change is harming our health and how climate solutions will improve it.” According to their Website:

“To facilitate the medical community’s awareness-raising efforts, the Medical Society Consortium on Climate and Health (Consortium) brings together associations representing over 600,000 clinical practitioners to carry three simple messages:

- Climate change is harming Americans today and these harms will increase unless we act;
- The way to slow or stop these harms is to decrease the use of fossil fuels and increase energy efficiency and use of clean energy sources; and
- These changes in energy choices will improve the quality of our air and water and bring immediate health benefits.

This is especially important to vulnerable Americans and communities who are experiencing a disproportionate impact today from climate change.”

ACEP has liaison relationships with many medical organizations but none that are associated with climate change.

ACEP Strategic Plan Reference

None

Fiscal Impact

Approximately \$1,000 for travel costs to attend the annual meeting and unknown cost for the registration fee. Potential membership fee to join as a member society.

Prior Council Action

None that are specific to joining the Medical Society Consortium on Climate & Health.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors.

Prior Board Action

The Board approves all formal liaison relationships with other organizations but has not previously considered a liaison with the Medical Society Consortium on Climate & Health.

June 2018, adopted the policy statement “[Impact of Climate Change on Public Health and Implications for Emergency Medicine.](#)”

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 22(20)

SUBMITTED BY: Illinois College of Emergency Physicians
Massachusetts College of Emergency Physicians
Minnesota Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: State Media Training for Emergency Physicians

PURPOSE: Develop and promote media training for members with a focus on social media for ACEP chapters and sections and provide such training in conjunction with *Scientific Assembly* or other ACEP meetings..

FISCAL IMPACT: Approximately \$3,500 – \$5,000 for each hybrid training session for up to 100 participants that includes traditional media and social media would cost. Adding a training session to another meeting beyond *Scientific Assembly* will double the annual cost to \$7,000 – \$10,000.

1 WHEREAS, Emergency physicians are on the frontlines of the healthcare system; and

2
3 WHEREAS, Emergency physicians frequently receive requests by media to educate the public on healthcare
4 related issues, including, but not limited to, public health and policy issues; and

5
6 WHEREAS, Social media platforms have become a common place for the public to seek information related
7 to healthcare related issues; and

8
9 WHEREAS, During pandemics, emergency physicians on the frontlines treat most of the patients affected by
10 pandemics; and

11
12 WHEREAS, During pandemics, the public and the media frequently look to and trust emergency physicians
13 to report on their experiences in treating patients affected by pandemic diseases in an objective, unbiased manner; and

14
15 WHEREAS, Many emergency physicians are asked by media at the state and local level to perform
16 interviews on television or radio, or on social media; and

17
18 WHEREAS, ACEP has a national media training platform (“how to become a spokesperson”) mostly focused
19 on television and radio mediums; and

20
21 WHEREAS, The ACEP national training platform does not explicitly market training in effective social
22 media messaging; and

23
24 WHEREAS, Certain public health or policy issues are most impactful or important at the state or local level;
25 and

26
27 WHEREAS, ACEP does not have dedicated media training for emergency physicians at the state or local
28 level, and

29
30 WHEREAS, ACEP constituent chapters and sections may not have the financial resources to develop media
31 training individually; therefore be it

32
33 RESOLVED, That ACEP develop a dedicated media training course for emergency physicians to respond to

34 requests from state or local media outlets via ACEP constituent chapters and sections with an emphasis on specific
35 talking points pertinent to the key issues affecting those physicians at that level; and be it further

36

37 RESOLVED, That ACEP develop a media training course specifically focused on effective, unbiased, fact-
38 based social media delivery; and be it further

39

40 RESOLVED, That ACEP partner with state chapters and sections to effectively market a media training
41 course for chapter and section leaders and encourage that chapter and section officers are offered the opportunity to
42 enroll in such training in conjunction with ACEP *Scientific Assembly* or other ACEP meetings.

Background

This resolution calls for the College to develop and promote media training for members with a focus on social media for ACEP chapters and sections and provide such training in conjunction with *Scientific Assembly* or other ACEP meetings.

Given the influx of media attention on emergency physicians because of the COVID-19 pandemic, there are new and influential opportunities for ACEP members and chapters to continue to elevate themselves, the College, and the specialty as thought leaders in public health crises and pandemic preparedness. While much of the conversations about the pandemic and general health care issues occur in mainstream news outlets, there are growing communications happening between the emergency medicine community, press, policymakers, and the public on social media platforms such as Facebook, Twitter, and LinkedIn. While ACEP does traditionally offer in-person media training during *Scientific Assembly**, that training has not previously included social media. Historically, the in-person training at *Scientific Assembly* meeting has been 90-120 minutes (the same training is offered twice to enable maximum participation) and includes the essentials of how to prepare and successfully conduct traditional media interviews. ACEP has not charged for members to participate in this training.

Moving forward, ACEP, could revamp the media training to decrease the focus on traditional media interviews and include social media strategy and best practices that would result in a higher level overview of both topics, or include an additional training (at additional cost) that would enable participants to do a deeper dive into traditional media and social media.

**Note: Funds for media training in the 2019-20 budget were eliminated because of budget constraints and media training was not provided at ACEP19. Funds for media training were restored in the 2020-21 and a virtual course will be held during ACEP20. It is not known at this time whether funds will be included in the FY 2021-22 budget.*

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.

Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Approximately \$3,500 – \$5,000 for each hybrid training session for up to 100 participants that includes traditional media and social media would cost. Adding a training session to another meeting beyond *Scientific Assembly* will

double the annual cost to \$7,000 – \$10,000.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Maggie McGillick
Public Relations Director

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



RESOLUTION: 23(20)

SUBMITTED BY: Tracy Legros, MD, PhD, FACEP
J. Richard Walker, III, MD, MS, FACEP
Undersea & Hyperbaric Medicine Section

SUBJECT: Subspecialty Faculty for ACEP Educational Programs

PURPOSE: Develop a process to collaborate with sections to identify individuals to serve as faculty in subspecialty content areas for in-person and virtual education and serve as authors of educational publications with priority given to subject matter experts that are board certified emergency physicians who are recognized as national or international leaders in the subspecialty field of the topic presented or authored with preference to those subspecialty trained or endorsed by the section.

FISCAL IMPACT: Unbudgeted staff and technology resources. Additional FTE to research and verify credentials of all subspecialty subject matter experts, including verification of publications and lectures, and review of prior course and speaker evaluations outside of ACEP to ensure the quality of presentations. Additional technology resources to collect and maintain this information. Additional costs for increased faculty at ACEP meetings.

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

4
5 WHEREAS, Emergency medicine now has a number of nationally recognized subspecialties for which board
6 certification is available; and

7
8 WHEREAS, Board certification by the American Board of Emergency Medicine is one mechanism that is
9 generally recognized to establish subject matter expertise in a field; and

10
11 WHEREAS, The need for academic integrity and accuracy of content is paramount in the American College
12 of Emergency Physicians' *Scientific Assembly* lecture series; and

13
14 WHEREAS, There is fellowship specialty training for many additional subspecialties that are not currently
15 board certifiable specialties, but may be one day, and currently do provide additional training, skills, and experience;
16 and

17
18 WHEREAS, There are board certified emergency physician researchers who have, through their peer-
19 reviewed publications and long standing dedication to the field, established a national or international reputation as a
20 subject matter expert in certain areas; and

21
22 WHEREAS, The expectation of patients who utilize emergency departments for their emergency medical care
23 is that there is seamless, high quality medical care provided by physicians who have maintained currency through
24 high quality continuing medical education; therefore be it

25
26 RESOLVED, That ACEP develop a process to collaborate with ACEP sections to identify and retain
27 subspecialty content expert lecturers based on training, extensive experience, and subspecialty-certification (when
28 applicable) for in-person and virtual education as well as publications; and be it further

29
30 RESOLVED, That priority be given to subject matter experts when selecting faculty lecturers at the *Scientific*
31 *Assembly* to include in the following order:

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1. Board certified emergency physicians who are recognized as national or international leaders in the subspecialty field, typically by their scientific contributions and unique experiences, and/or those who have received the formal endorsement of the ACEP section of greatest interest; or
 2. Fellowship trained board diplomates in the subspecialty subject matter area with authorship of subject matter peer reviewed publications; or
 3. Fellowship trained board diplomates in the subspecialty subject matter area; or
 4. Fellowship trained board certified or board eligible diplomates in the subspecialty subject matter area; or
 5. Board certified emergency physicians who can demonstrate subject matter expertise in the area in question, such as a regional or national reputation, extensive experience and/or with authorship of subject matter peer-reviewed publications.

Background

This resolution first calls for the College to develop a process to collaborate with ACEP sections to identify and retain individuals to serve as faculty in subspecialty content areas for in-person and virtual education and serve as authors of educational publications. The resolution also specifies prioritization criteria to use when selecting faculty lecturers for *Scientific Assembly*. This background information will first comment on the current processes for soliciting subject matter experts and course proposals and contents and will then address the specific issue of the prioritization concept.

ACEP operates under several processes when soliciting course proposals and faculty from sections, committees, and individual members along with their faculty recommendations.

- The Education Committee and each of its subcommittees strives to serve the dynamic education needs of ACEP members. Feedback and evaluation data from members is reviewed and incorporated into the content and speaker selection process. Members drive the educational offerings and are instrumental in efforts to increase diversity in presenters and content. This is demonstrated by ongoing membership engagement through consistent growth in the number of paid registrants to ACEP educational meetings.
- The Educational Meetings Subcommittee's current and long-standing practice is to select speakers based on subject matter expertise, section recommendations and input, and reputation as a national-caliber speaker and/or recognized expert on the subject matter in the identification of faculty. Faculty and courses are evaluated thoroughly with course and faculty evaluations for each course presented at ACEP meetings and by a member of the subcommittee who monitors audits each course to assess the presentations. The average score of *Scientific Assembly* faculty is a 98% rating with demonstrated subject matter expertise, excellent teaching skills, achieving the stated learning objectives, PowerPoints enhanced learning experience, and free of commercial bias, based on conference evaluations of each speaker and course
- There are processes in place for members of the Educational Meetings Subcommittee, Online Education Subcommittee, Publications Subcommittee, and Continuous Competency and Certification Subcommittee to collaborate with sections and committees as necessary to identify faculty and authors who are subject matter experts and national caliber speakers and authors. The Education Committee has an ongoing objective and strategy to ensure diversity among speakers at ACEP meetings as one of many factors that are considered when selecting speakers.
- Specific to sections, the Education Committee has been assigned an additional objective for the FY 2020-21 committee year to "develop and implement a process to collaborate with ACEP sections in the development of subspecialty education content and selection of faculty." Currently, there are section liaisons assigned to the Education Steering Committee. These processes could be enhanced if each section and committee developed a list of potential speakers and authors that includes subspecialty qualifications of subject matter experts with expertise as national-caliber speakers and identifying specific topics each can present to form a speakers' list and provided annual updates to that list.

Implementing the Proposed Faculty Prioritization Criteria

Based on the above processes and data year over year, it is unclear that implementation of this resolution would improve these already high faculty scores. Instead, the process suggested could inadvertently place limitations on the work of the Education Committees, its subcommittees, and staff and add significant additional time and expense to implement.

Limitations of programming could emerge when planning novel educational delivery formats for meetings. For example, the subcommittee often plans debates and controversies as a presentation format. Often, controversies are presented by at least one member who is not subspecialty trained but these are exceptional learning experiences for the membership. Likewise, some of emergency medicine's most respected experts and speakers are not subspecialty trained and would not be considered to speak on current topics for which they are so successful. For example, a well-known and respected speaker is not trained in critical care but is one of the College's most revered and prolific speakers and authors and is more than qualified as a subject matter expert in this area. *Scientific Assembly* is also a superb opportunity for junior faculty to compete in the Drop the Mic competition of new speakers and be vetted by the subcommittee and given speaking opportunities at future annual meetings.

Limitations may also occur beyond the scope of the Educational Meetings Subcommittee. For example, recently the Online Education Subcommittee has focused on recruiting promising junior faculty as determined by section leadership to contribute to online courses and webinars. This has allowed for the development of new, high-quality content for membership as well as professional development opportunities for junior faculty. Such professional development opportunities can be critical to an individual's career. Opportunities to contribute can also be educational. Consider PEER, through a rigorous editing system each question undergoes several iterations. Many times these questions are written by residents or junior faculty. As their questions move through the editing process to more advanced editors, they receive feedback on the medical content, overall question quality, and even writing style. These are all skills that are undoubtedly beneficial to their development as young physicians. It is also likely other areas of the College would face the same challenge as Educational Meetings – limited expertise and time. *Critical Decisions in Emergency Medicine*, is a monthly publication that relies on the contributions of several authors each month. By further limiting the pool of qualified authors it may become difficult to identify enough contributors to meet the needs of the publication each month.

Education expertise must also be considered. Ability to synthesize and communicate/educate the audience effectively is paramount. There are operational and research leaders that are expert educators in some formats, but this is not assured of all subspecialty experts. They must be effective speakers, comfortable teaching to large audiences, and excel at educational knowledge transfer. Content expertise must also be considered. Emergency Medicine is a vast field with new advancements made each day. These advancements do not always emerge quickly in Emergency Medicine. Limiting selection of non-emergency medicine faculty for education could have a negative impact on the infusion of cutting-edge information from all fields necessary for the improvement of emergency medicine patient care and practice.

Requiring or prioritizing subspecialty training to the many factors already considered when selecting these subject matter experts as speakers and/or authors may further reduce the cadre of members who are qualified and willing to volunteer their time for educational meetings and products and may, therefore, have the unintended consequence of diminishing important diversity of thought at ACEP meetings.

The research of speakers' credentials once courses are identified would delay the completion of planning by the Educational Meetings Subcommittee and staff to plan the program and identify speakers for each course within the necessary timeline for speaker invitations and early marketing of the meeting.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings, including novel delivery methods.

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

Fiscal Impact

Unbudgeted staff and technology resources. An additional FTE would be needed to research and verify the credentials of all subspecialty subject matter experts, including verification of publications and lectures, and review of prior course and speaker evaluations outside of ACEP to ensure the quality of presentations. This level of review would be essential to ensure the high quality of presentations currently experienced at *Scientific Assembly* and other meetings and products. Additional technology resources would be required to collect and maintain this information. These expenses could not be accommodated in the current fiscal year budget.

There would also be additional costs to increase the number of faculty presenters at *Scientific Assembly* and other educational meetings to meet the requirement of this resolution. Currently, many faculty present on multiple topics. Additional faculty would be required to meet the subspecialty requirements in this resolution, i.e., more speakers with narrowly-focused speaking abilities and knowledge would require more speakers to present on other topics.

Prior Council Action

None

Prior Board Action

None

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

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



2020 Council Meeting Reference Committee Members

Reference Committee B Advocacy & Public Policy Resolutions 24-39

Ashley Booth-Norse, MD, FACEP (FL), Chair
Sara A. Brown, MD, FACEP (IN)
John M. Gallagher, MD, FACEP (KS)
William D. Falco, MD, FACEP (WI)
Heidi C. Knowles, MD, FACEP (TX)
Jay Mullen, MD, FACEP (ME)

Ryan McBride, MPP
Jeff Davis
Brad Gruehn

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RESOLUTION: 24(20)

SUBMITTED BY: Adam Ash, DO, FACEP Jay Rao MD, FACEP
Alexander Chiu, MD, MBA, FACEP EMS-Prehospital Care Section
Joo Yup Shaun Chun MD, FACEP Louisiana Chapter
Gaston Costa, MD, FACEP Maryland Chapter
William Holubek, MD, FACEP Puerto Rico Chapter
Nizar Kifaieh, MD, MBA, CPE, FACEP Vermont Chapter
Mark Kindschuh, MD Wyoming Chapter

SUBJECT: 911 Awareness and Policy

PURPOSE: 1) Promote awareness that healthcare providers are calling 911 on behalf of patients who cannot or will not call themselves; and 2) Promote awareness that medical directors of Public Safety Access Points and EMS may need to develop policies to address patients' medical information and patients' medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

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

- 1 WHEREAS, ACEP represents emergency physicians practicing in all emergency care environments; and
- 2
- 3 WHEREAS, ACEP represents emergency physicians who support and endorse good policies in emergency
- 4 medical systems and 911 Public Safety Access Points (PSAPs) through its lobbying and public awareness; and
- 5
- 6 WHEREAS, There are roughly 6,100 PSAPs in the U.S. that have different office, regional, state, and federal
- 7 guidelines and policies; and
- 8
- 9 WHEREAS, Medical professionals often treat patients who are in different locations in an emergency and there
- 10 are known methods for calls to be routed to correct PSAPs pertaining to the patient location; and
- 11
- 12 WHEREAS, Patients are at times reluctant or unable to call or activate 911 themselves and communication is
- 13 shown to be better when between a treating medical professional and 911 dispatchers; and
- 14
- 15 WHEREAS, The COVID-19 pandemic has increased the cases where doctors are treating patients remotely and
- 16 are directly activating 911 on behalf of patients and in such cases treating doctors are often still communicating with
- 17 patients when EMS arrives, are able to communicate with EMS, expedite emergency response, and convey valuable
- 18 medical information and recommendations to improve care; and
- 19
- 20 WHEREAS, 911 EMS National and State Guide cards, International Academies of Emergency Dispatch
- 21 protocols, were reviewed and none of them had much guidance or training on healthcare professionals calling 911 on
- 22 behalf of patients in different areas; and
- 23
- 24 WHEREAS, Guide cards contain standard emergency medical questions for patients such as chest pain with
- 25 algorithms on determining if ALS or BLS units were needed but lacked guide cards and protocols for doctors calling on
- 26 behalf of patients in different locations; and
- 27
- 28 WHEREAS, Twenty-two emergency 911 call audio recordings were reviewed by ACEP members for 911 calls
- 29 placed by providers calling on behalf of patient addresses located in New Jersey, New York, Texas, Connecticut, Florida,
- 30 and Pennsylvania and common cases included suicidal ideation, altered mental status, and shortness of breath; 911 PSAP
- 31 dispatchers activated ambulances however there were delays due to not having protocols in place; example responses

32 included “how are you calling me,” “can I talk to the patient,” and “let me see what the procedure is” and one such case
33 had a patient in SVT diagnosed over Mobile Cardiac Telemetry (MCT) where the treating provider activated 911 and
34 needed an ALS response yet there was no dispatcher guide card or procedure in place for the scenario of a doctor calling
35 them; and

36
37 WHEREAS, ACEP’s EMS section has 1,143 members including 40 international EMS doctors from the five
38 continents (Argentina, Australia, South Africa, Bahrain, United Arab Emirates, Saudi Arabia, Canada, Ireland, Germany,
39 Brazil, Lebanon, Belgium, Taiwan, Panama, Israel, Austria, New Zealand, Trinidad and Tobago, Chile , India, and
40 Philippines) and lack of awareness and protocols for doctor initiated 911 activations on behalf of patients is a global
41 problem; therefore be it

42
43 RESOLVED, That ACEP promote awareness that healthcare providers are calling 911 on behalf of patients who
44 cannot call 911 themselves, will not call 911 themselves, or have inadequate communication when speaking to 911
45 dispatchers themselves; and be it further

46
47 RESOLVED, That ACEP promote awareness that medical directors of Public Safety Access Points and EMS
48 may need to build policies to take into strong consideration the patients’ medical information and patients’ medical needs
49 provided by the treating doctor who activates the 911 emergency on behalf of a patient.

Background

This resolution calls on ACEP to promote awareness that healthcare providers are calling 911 on behalf of patients who cannot or will not call themselves. Additionally, the resolution requests that ACEP promote awareness that medical directors of Public Safety Access Points and EMS may need to develop policies to address the patients’ medical information and patients’ medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

Many members of ACEP’s EMS-Prehospital Care Section are EMS medical directors who oversee Public Safety Answering Points (PSAP)/911 and Emergency Medical Dispatch (EMD) centers or work closely with other physicians that oversee them. Most PSAP/EMD systems address handling 911 calls from third parties but how these procedures are implemented locally are not uniform across the county. In some areas 911/PSAP’s are under the control of the fire department or law enforcement and the EMS EMD personnel may not be able to speak directly with the caller on every call received. The EMS medical director also may not have control or oversight on some of these systems.

ACEP can work with other EMS organizations to promote awareness of the issue and identify appropriate actions to collaborate with other organizations to address it going forward.

ACEP Strategic Plan Reference

Goal 1 –Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 27(17) 9-1-1 Number Access and Prearrival Instructions adopted. Directed ACEP to advocate and promote efforts that support achieving 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point (PSAP) or EMS dispatch center provides appropriate medical pre-arrival

instructions with EMS physician oversight. Also directed the College to work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that incorporates EMS physician involvement.

Resolution 24 (91) Universal Access to 911 adopted. Directed ACEP to promote the availability of basic 911 access for all communities and encourage the establishment of enhanced levels of 911 in all communities where feasible.

Prior Board Action

June 2018, approved the policy statement “[Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training](#),” which replaced the rescinded policy statement “Public Training in Cardiopulmonary Resuscitation” and “Public Access Defibrillation.”

October 2017, approved the policy statement “[The Role of the Physician Medical Director in Emergency Medical Services Leadership](#)” replacing five policy statements that were rescinded or sunsetted.

Resolution 27(17) 9-1-1 Number Access and Prearrival Instructions adopted.

Resolution 24 (91) Universal Access to 911 adopted.

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

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



RESOLUTION: 25(20)

SUBMITTED BY: Arizona College of Emergency Physicians Pennsylvania College of Emergency Physicians
Florida College of Emergency Physicians Texas College of Emergency Physicians
Illinois College of Emergency Physicians Virginia College of Emergency Physicians
Indiana Chapter Wisconsin Chapter
Ohio Chapter Air Medical Transport Section

SUBJECT: Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage

PURPOSE: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

FISCAL IMPACT: Budgeted task force and staff resources. Additional unbudgeted costs of \$10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated \$50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

1 WHEREAS, The deliberate consolidation of healthcare insurers has reduced competition in the healthcare
2 insurance marketplace and has reduced healthcare insurance options for our patients; and
3

4 WHEREAS, Healthcare insurers have reduced the actual healthcare insurance coverage of illness and injury
5 with high-deductible plans, increased patient cost-sharing and increased out-of-pocket expenses; and
6

7 WHEREAS, Healthcare insurers have implemented many strategies to reduce physician reimbursement
8 including:

- 9 • termination or non-renewal of contracts to preemptively reduce compensation and decrease median in-
10 and out-of-network rates
- 11 • automatically down-coding or denying payment by using exempted diagnosis lists
- 12 • retrospectively denying higher-acuity emergency physician service payment by failing to acknowledge
13 the increased acuity of conditions presenting to the emergency department over the past decade
- 14 • bundling services (e.g., electrocardiogram interpretation) to avoid payment for cognitive services
- 15 • consistent cost shifting by The Employee Retirement Income Security Act (ERISA) plan administrators to
16 increase the costs to employers and employees
- 17 • disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on
18 discharge diagnosis; and
19

20 WHEREAS, Health insurers are required to cover emergency services but have insufficient in-network
21 emergency physicians to provide these services and no requirement to contract with emergency physicians or to
22 negotiate in good faith to pay for EMTALA mandated care; and

23 WHEREAS, Healthcare insurers are reporting record profits including profit of \$18.4 billion for Centene, \$14
24 billion for United Health Group, \$5.1 billion for CIGNA, \$4.8 billion for Anthem and \$1 billion for CVS in 2019; and
25

26 WHEREAS, During the COVID-19 pandemic when emergency physicians were focused on caring for
27 emergency patients, insurers were reporting record profits due to reduced payment for suspended elective non-
28 emergent procedures, while they continued to promote inequitable surprise billing legislation; and
29

30 WHEREAS, The Affordable Care Act (ACA) requires health insurers to pay annual premium rebates when
31 the Medical Loss Ratio (MLR) for groups or health insurance policies issued in a state is below 85% for large
32 employer group policies and 80% for small employer group policies and individual policies; by failing to meet this
33 threshold, it is estimated the healthcare insurers will be required to rebate approximately \$2.7 billion in 2020 due to
34 failure to meet the MLR requirement; and
35

36 WHEREAS, Health insurers have established large employer third-party administrators (TPAs), acquired
37 Pharmacy Benefit Management companies (PBMs) and medical practices, and that these entities accounted for more
38 profit than the core insurance business lines; and
39

40 WHEREAS, Insurance companies by owning or influencing both medical practices, TPA's and PBM's they
41 are potentially "price-setting" and "self-referring" and these are not subject to MLR therefore they may be unilaterally
42 and arbitrarily increasing the costs of medical care with potentially little to negative effects on quality; therefore be it
43

44 RESOLVED, That ACEP create a task force and commission an independent study on the extraordinary
45 financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and
46 withholding appropriate reimbursement against emergency physicians; and be it further
47

48 RESOLVED, That ACEP engage an independent healthcare economist to analyze the reimbursement
49 challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of
50 commercial health insurance and reimbursement policies on emergency care; and be it further
51

52 RESOLVED, That ACEP advocate for higher standards and additional scrutiny of health insurer spending,
53 including the Medical Loss Ratio (MLR) standards, to ensure more resources are dedicated to the patient health
54 services and not diverted for other business pursuits without clear benefit to their patient population; and be it further
55

56 RESOLVED, That ACEP work with other similarly affected professional organizations, consumer advocacy
57 groups, and the American Medical Association (AMA) to further understand the contribution of health insurers on the
58 increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Background

This resolution directs ACEP to: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Recent Advocacy Efforts to Combat Unfair Insurer Practices

ACEP has continued to push back against burdensome and illegal insurer financial influence on reimbursement for emergency medicine as part of the strategic plan. These efforts included an ACEP-EDPMA Joint Task Force, formed in 2015, in part to combat unfair insurer practices against the specialty. While the task force is now defunct, ACEP and EDMPA have included a representative on each other's respective reimbursement and state and regulatory

committees to continue to push back against new and existing issues. ACEP and EDPMA have sent joint letters to Optum, United Health Care, Centene, and various Medicaid plans conveying concerns about their payment policies. Many ACEP chapters have sent letters to CMS and individual states regarding insurance denials and other specific reimbursement issues.

The continued termination or non-renewal of contracts, down-coding, or denial of payment via diagnosis lists, retrospective denial of higher-acuity emergency physician service payment, bundling services to avoid payment, consistent cost shifting by ERISA plans, and disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on discharge diagnosis will continue to be issues that ACEPs State Legislative and Regulatory Affairs, Public Affairs, and Reimbursement Departments budget time and staff resources for advocacy efforts.

ACEP also advocates for higher standards and scrutiny of insurer policies and spending through its representation at the American Medical Association (AMA), and along with other similarly affected specialties, advocates for policies that seek to restrict and/or prevent damaging insurer policies.

This resolution would take these efforts a step further by contracting with a respected healthcare economist to conduct an independent study to analyze challenges and adverse financial impacts to reimbursement from insurer policies.

Recent Advocacy Efforts to Uphold Legal Rights Established by EMTALA and Prudent Layperson (PLP)

Despite the longstanding legal precedence of protecting patients and physicians from unwarranted third-party payer denials established by EMTALA and PLP, significant numbers of denials continue to persist.

ACEP has continued to fight for the inclusion of the EMTALA provision in third-party payer policies, especially those from managed care plans, which have significantly increased their market share since EMTALA was mandated by law. Although PLP laws have largely eliminated the issue of prior authorization denials for emergency services, many third-party payers have continued to make after-the-fact decisions to deny payment for services resulting in loss of revenue for physicians and an unnecessary financial burden on patients.

ACEP also has continued tracking third-party payer denials and has successfully lobbied on behalf of members in states where policies were announced that would have led to a process of automatic denials. Letters have been sent to third-party payers that make up a large percentage of total market share in the U.S. with varying degrees of success. A lawsuit against BCBS in GA has been pending since 2018 and letters sent to UHC (multiple states) and Anthem BCBS (23 states) in the past year successfully defeating automatic denials and unfair down coding policies.

The College has continued to monitor and influence both the legislative and regulatory process related to EMTALA and PLP. We have successfully lobbied both Congress and the Centers for Medicare and Medicaid Services (CMS) on several issues of importance to emergency medicine, including removing criminal penalties against physicians, adding on-call requirements to the law, instituting whistleblower protections, and PRO review requirements. ACEP regulatory affairs staff have submitted formal comments to CMS and met with them on numerous occasions over the years to discuss the law, the regulations, and enforcement issues.

ACEP developed a toolkit in 2018 to reach out to third-party stakeholders to track and collect payment denials by Anthem Blue Cross Blue Shield in 23 states where the policy had taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the prudent layperson standard.

Pursuing Strategies for Ensuring Fair Payment and Practice Sustainability

The current tactics for ensuring fair payment for services include:

- Engaging ACEP chapters, CMS, and the National Association of State Medicaid Officials in initiating and supporting efforts to minimize the impact of state Medicaid cuts on access to emergency care and to protect the prudent layperson standard.
- Collaborating with the AMA, state medical societies, and other medical organizations on payment and practice sustainability issues, including interaction with entities such as FAIR Health, NCOIL, NAIL, and PAI, as appropriate.

- Identifying payers that do not pay fairly and consider compliance disputes and legal actions through the most strategic available mechanisms, via the ACEP Coding & Nomenclature Advisory Committee, Reimbursement Committee, State Legislative/Regulatory Committee, and ACEP staff time devoted to advocacy efforts.

The proposed additional tactics of creating a task force and engaging a healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine as well as the effect of commercial health insurance and reimbursement policies on emergency care are new tactics that could fit into the current ACEP Strategic Plan, although some of the associated expenses are unbudgeted.

ACEP Strategic Plan Reference

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

Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted task force and staff resources. Additional unbudgeted costs of \$10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated \$50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

Prior Council Action

Amended Resolution 38(19) Standards for Insurance Denials adopted. Directed ACEP to work with legislators to enact legislation that makes it illegal for a payor to engage in automatic denials; and that to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and that patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by payors; and that ACEP work towards getting an affirmation in writing from payors that they will adopt this as policy.

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.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted. Directed ACEP to convene a work group of subject matter experts to identify the impact that high deductible insurance plans have on patients seeking emergency care, emergency physicians, and emergency departments, and create a paper to inform stakeholders about such impact.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, a payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate EMTALA recommendations to CMS' regulatory advisory committee including physician on-call responsibilities, greater consistency of enforcement, and more effective involvement of peer review organizations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Reaffirmed that EDs are an essential part of the health care safety net for all populations, including foreign nationals, and in advocacy efforts ACEP recognizes uncompensated care for foreign nationals as one example of the many factors that threaten the health care safety net.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed ACEP to champion the principle that emergency care is an essential public service.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and provide a report at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. Directed ACEP develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed that 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 providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products; and support legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity that mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Prior Board Action

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.”

January 2020, ACEP and EDPMA sent a letter to Optum conveying concerns about Optum's payment policies.

Amended Resolution 38(19) Standards for Insurance Denials adopted.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

February 2018, reaffirmed the policy statement “[Assignment of Benefits](#);” reaffirmed April 2012; originally approved April 2006.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

April 2017, approved the revised policy statement “[Fair Coverage When Services Are Mandated](#);” reaffirmed April 2011 and September 2005 with the title “Compensation When Services are Mandated;” originally approved September 1992.

April 2017, approved the revised policy statement “[Prior Authorization](#);” revised and approved October 1998; originally approved November 1987.

May 2016, ACEP [filed suit against the federal government](#). Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are “out of network” because of a medical emergency.

April 2016, approved the revised policy statement “[Fair Payment for Emergency Department Services](#);” originally approved April 2009.

April 2016, approved the revised policy statement “[Balance Billing](#);” revised and approved 2009 with the current title; reaffirmed October 2008; originally approved October 2002 titled “Prohibition of Balance Billing.”

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted.

April 2014, revised and approved the policy statement “[Third-Party Payers and Emergency Medical Care](#);” revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title “Managed Health Care Plans and Emergency Care;” originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Substitute Resolution 29(01) Funding of Emergency Care for Foreign Nationals adopted.

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

Amended Substitute Resolution 15(00) EMTALA adopted. A report was distributed at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. ACEP’s Task Force on Health Care and the Uninsured developed six principles to be used as a framework for expanding health care coverage to all. In 2000, ACEP hosted the National Congress on Preserving America’s Health Care Safety Net in Washington, DC. This initiative called for a national debate on the issue and for building a national consensus among leaders in business, consumer and advocacy groups, public policy, health care, and medicine to make incremental changes to expand health care access. ACEP also joined six other medical specialties in calling on Members of Congress and presidential candidates to begin a serious debate over the health care funding crisis confronting the nation. Coverage of the uninsured will reduce the financial pressures on EDs of EMTALA compliance.

June 1999 approved the revised policy statement, "Compensation When Services are Mandated."

Amended Resolution 11(92) Payment for Mandated Services adopted.

Background Information Prepared by: Adam Krushinski, MPA
Reimbursement Manager

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



RESOLUTION: 26(20)
SUBMITTED BY: District of Columbia Chapter
SUBJECT: Addressing Systemic Racism as a Public Health Crisis

PURPOSE: Requests ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism, continue to explore models of health care that would make equitable health care accessible to all, and continue to support ACEP members who seek to dismantle systems of discrimination and advocate for policies promoting social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

FISCAL IMPACT: Budgeted committee and staff and resources.

1 WHEREAS, ACEP advocates for tolerance and respect for the dignity of each individual and opposes all
2 forms of discrimination against and harassment of patients;¹ and
3

4 WHEREAS, Minorities in America disproportionately suffer from income inequality, debt, barriers to
5 housing and home-ownership, discrimination from financial institutions, decreased access to education, barriers to
6 employment, workplace discrimination, barriers to accessing health care, disparities in the quality of health care, over-
7 policing, and many other forms of injustice due to historical and ongoing structural racism; and
8

9 WHEREAS, ACEP acknowledges the causal link between these persistent disadvantages (collectively known
10 as the social determinants of health) and poor health outcomes; and
11

12 WHEREAS, ACEP’s mission includes the promotion of health equity within the communities we serve;² and
13 therefore be it
14

15 RESOLVED, That ACEP reaffirm the importance of recognizing and addressing the social determinants of
16 health, including systemic racism; and be it further
17

18 RESOLVED, That ACEP continue to explore models of health care that would make equitable health care
19 accessible to all; and be it further
20

21 RESOLVED, That ACEP continue to use its voice as an organization and support its members who seek to
22 dismantle systems of discrimination and advocate for polices promoting the social determinants of health within
23 historically disenfranchised communities at an institutional, local, state, and national level.

Background

The resolution requests ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism, continue to explore models of health care that would make equitable health care accessible to all, and continue to support ACEP members who seek to dismantle systems of discrimination and advocate for policies promoting social determinants of health within historically disenfranchised communities at an

¹ <https://www.emergencyphysicians.org/press-releases/2020/5-30-20-acep-statement-on-structural-racism-and-public-health>

² <https://www.emergencyphysicians.org/press-releases/2020/5-30-20-acep-statement-on-structural-racism-and-public-health>

institutional, local, state, and national level.

Over the last several years, health researchers and medical professionals have focused greater attention on social determinants of health and health disparities that exist for minority communities in the United States, with increasing awareness of the impact of systemic or institutional racism as a social determinant in particular. Recent events, including nationwide protests that occurred in the wake of the deaths of George Floyd and Breonna Taylor, have also brought the issue of structural racism further into the collective American public consciousness.

Systemic or “structural” racism refers to the systems, structures, or institutions that disadvantage minority populations. Though much of the recent attention has centered around structural racism within law enforcement, it also manifests in housing policies, employment and economic opportunities, educational systems, politics, health care, geography, and numerous other factors.

Discrimination also occurs in institutional health care experiences, e.g., disparities that result from a lack of access to the same or comparable high-quality health care options and facilities as those available to white Americans, implicit (or explicit) biases on the part of providers, or provider ignorance of culturally- or racially-sensitive health care needs.

Racism also has a causal link to health outcomes. The American Psychological Association (APA) notes that chronic stress resulting from “...factors such as poverty, family dysfunction, feelings of helplessness and/or traumatic early childhood experience” can disrupt nearly all the body’s physical processes.³ Chronic stress is linked to greater risk for numerous diseases, such as heart disease, obesity, diabetes, and immune disorders, as well as premature aging that can accelerate or exacerbate many of these diseases. The APA further notes that “[s]tudies examining the role of social and biological stress on health suggests a link between socioeconomic status and ethnic disparities in stress and health (Warnecke et al, 2008). Some ethnic/racial groups are more economically disadvantaged and may be more susceptible to SES-related stress.”

Additionally, there are a number of chronic health issues that disproportionately affect certain racial or ethnic groups, and care and treatment for these populations may be affected. Sickle cell disease (SCD), for example, is the most common genetic blood disorder affecting about 100,000 Americans, predominantly occurring in those of Black or African-American (1 in 365) or Hispanic (1 in 16,300) descent. Patients with SCD often present in the emergency department with severe pain, and due to limited SCD treatment options, opioid treatment is frequently the only effective option (though new evidence-based clinical guidelines have been developed). However, in the wake of the nation’s response to the opioid epidemic and a push to reduce or avoid opioid treatments, patients with SCD have experienced new challenges in treating the pain so often associated with this disease. These difficulties have been aggravated by unintentional outcomes of federal guidelines like the Centers for Disease Control and Prevention (CDC) *Guideline for Prescribing Opioids for Chronic Pain*. Despite clarifications that the guideline is not intended to deny clinically-appropriate opioid therapy to patients with conditions such as SCD or cancer, emergency physicians have continued to receive reports that patients with SCD are unable to access these appropriate medications.⁴

In March 2018, ACEP, as a recommendation of the Diversity and Inclusion Task Force, ACEP launched the [Unconscious Bias in Clinical Practice](#) one-hour, accredited CME course. This course focuses on:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

ACEP’s policy statement “ [Non-Discrimination and Harassment](#)” advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual’s race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin,

³ <https://www.apa.org/topics/health-disparities/fact-sheet-stress>

⁴ https://www.acep.org/globalassets/uploads/uploaded-files/acep/by-medical-focus/hematology---edsc3/5---ash-acep-scd-aa-letter-re-pain-management-in-scd_june-2019.pdf

language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender, identity or expression, sexual orientation, or any other classification protected by local, state, or federal law. ACEP's goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Discrimination and bias can serve as major drivers of influence on the quality of care provided in the emergency department toward individuals of underrepresented populations.

ACEP's policy statement "[Cultural Awareness and Emergency Care](#)" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. Implicit Bias is recognized by the individual and mitigated through education recalling stereotypical thought processes.

As referenced, ACEP issued a [statement on structural racism and public health](#) on May 30, 2020.

ACEP's Social Emergency Medicine has as one of its objectives "to propose, evaluate, and critique health policies that affect the social determinants of health of our communities, especially as they pertain to marginalized and vulnerable populations that frequently present to EDs for their care."

Demonstrating the ongoing importance of this issue, 14 of ACEP's committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff and resources.

Prior Council Action

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

April 2020, approved the revised policy statement "[Cultural Awareness and Emergency Care](#);" reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

June 2018, approved the revised policy statement "[Non-Discrimination and Harassment](#);" revised and approved April

2012 with the current title; originally approved October 2005.

November 2017, approved the revised policy statement “[Workforce Diversity in Health Care Settings](#),” reaffirmed June 2013 and October 2007; originally approved 2001.

October 2017, reviewed the information paper “[Disparities in Emergency Care](#).”

April 2017, reviewed the information paper “Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management.”

Substitute Resolution 41(05) Non-Discrimination adopted.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 27(20)
SUBMITTED BY: Emergency Medicine Residents' Association
SUBJECT: Attributing the Unqualified Term "Resident" to Physicians

PURPOSE: 1) Advocate for the use of the unqualified terms "resident" and "residency" and "fellow" and "fellowship" when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program. 2) Recognize the gold standard for emergency medicine training is, and must remain, the completion of an ABEM or AOBEM accredited physician residency program.

FISCAL IMPACT: Budgeted resources to convey ACEP's position to federal Executive and Legislative branch officials.

1 WHEREAS, The term "resident" or "residency" in reference to physician training and accreditation was first
2 introduced over 125 years ago¹; and
3

4 WHEREAS, The Centers for Medicare & Medicaid Services (CMS) defines the term resident as "an intern,
5 resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program
6 including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty
7 board"²; and
8

9 WHEREAS, "EMRA believes that the only pathway to the independent practice of emergency medicine in
10 the 21st century is completion of an Accreditation Council for Graduate Medical Education/American Osteopathic
11 Association (ACGME/AOA) accredited emergency medicine residency training program and board certification by
12 ABEM/AOBEM"³; and
13

14 WHEREAS, The Society for Emergency Medicine Physician Assistants (SEMPA) guidelines on Emergency
15 Medicine Physician Assistant Postgraduate Training discourages the use of "residencies" to describe postgraduate
16 emergency medicine training programs for physician assistants⁴; and
17

18 WHEREAS, A consensus on terminology for emergency medicine physician assistant postgraduate training
19 has not been reached, as evidenced by a cursory search engine inquiry which results both "fellowship" and
20 "residency" in the top ten auto-complete suggestions; and
21

22 WHEREAS, Half of patients surveyed by the American Medical Association for the campaign "Truth in
23 Advertising" believed it was difficult to identify who is a physician by reading their title⁵; and
24

25 WHEREAS, The same campaign suggested nearly 90% of patients believe "only a medical doctor or doctor
26 of osteopathic medicine should be able to use the title 'physician'⁵; and
27

28 WHEREAS, The SEMPA standard for postgraduate physician assistant training in emergency medicine is "a
29 minimum of 3,000 hours or 18 months of direct-patient care in an emergency department, preceptored by an
30 experienced emergency physician"⁴; and
31

32 WHEREAS, The average board certified emergency physician will complete an average of 14,272 to 18,772
33 hours of postgraduate training prior to sitting for ABEM/AOBEM board certification exams⁶; and
34

35 WHEREAS, There is widely held belief that the terms "resident" and "fellow" connote "physician"; and

36 WHEREAS, A reasonable patient may be led to draw a conclusion about the clinical experience of their
37 provider that may misrepresent the provider’s clinical expertise based on the use of the terms “resident” or “fellow,”
38 potentially to the patient’s detriment; therefore be it
39

40 RESOLVED, That ACEP advocate for the use of the unqualified terms “resident” and “residency” and
41 “fellow” and “fellowship” when used in the emergency medicine clinical setting to connote a physician with
42 acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or
43 fellowship) program; and be it further
44

45 RESOLVED, That ACEP recognizes the gold standard for emergency medicine training is, and must remain,
46 the completion of an American Board of Emergency Medicine or American Osteopathic Board of Emergency
47 Medicine accredited physician residency program.

References:

1. <https://www.ama-assn.org/education/improve-gme/history-residency-and-what-lies-ahead>
2. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>
3. <https://www.emra.org/globalassets/emra/about-emra/governing-docs/policycompendium.pdf>
4. https://www.sempa.org/Static/360/uploadedFiles/SEMPA/PostGraduate_Programs/NS%20-%20SEMPA%20Training%20and%20EMPA%20Practice%20Guidelines%20-%20FINAL%20No%20Letterhead.pdf
5. <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>
6. Emergency PA/NP Utilization Task Force Final Report

Background

This resolution requests ACEP to: 1) Advocate for the use of the unqualified terms “resident” and “residency” and “fellow” and “fellowship” when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program; and 2) Recognize the gold standard for emergency medicine training is, and must remain, the completion of an ABEM or AOBEM accredited physician residency program

For several years, ACEP has worked with the AMA to promote federal legislation that would require appropriate representation about a clinician’s license and training. The current bill, the “Truth in Healthcare Marketing Act” ([H.R. 6663](#)), would make it unlawful for any person to make a deceptive or misleading statement, or engage in a deceptive or misleading act, that misrepresents whether they hold a state health care license or misrepresents their education, training, degree, license, or clinical expertise. It further requires that any person who is advertising health care services disclose the applicable license under which they are authorized to provide those services.

As part of the AMA’s [Truth in Advertising campaign](#), we have also sought a requirement that all health care professionals wear, during patient encounters, a name tag that clearly identifies the type of license they hold. The overall objective of the campaign is to ensure health care providers clearly and honestly state their level of training, education, and licensing. As the materials state: “Patients are confused about the qualifications of different health care professionals. Many non-physicians earn advanced degrees, and many of those degree programs now confer the title ‘doctor.’ As a result, patients often mistakenly believe they are meeting with physicians (medical doctors or doctors of osteopathic medicine) when they are not.” A 2014 [study](#) by the AMA found that 35% of the general public believed that NPs with their doctorate of nursing practice were physicians.

According to [Physicians for Patient Protection](#), nurse practitioners (NPs) and physician assistants (PAs) have recently developed programs that training institutions are referring to as “residencies” and “fellowships.” These programs are normally one year and contain multiple “administrative half days.” These programs are not necessarily standardized or accredited and many of these programs claim equivalence with physician training, although they are 1/3 or less of the residency training time for physicians.

ACEP’s policy statement “[Use of the Title ‘Doctor’ in the Clinical Setting](#)” states “ACEP strongly opposes the use of the term ‘doctor’ by other professionals in the clinical setting...”

ACEP’s policy statement “[The Role of the Legacy Emergency Physician in the 21st Century](#)” emphasizes that “physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by ABEM or AOBEM.”

ACEP’s policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles](#)” specifies that it is the “role and responsibility of ABEM and AOBEM to set and approve the training standards” for emergency physicians.

Given the standard use of the term “resident” and “fellow” to denote physicians, mid-level providers who introduce themselves as a resident or fellow may be confusing to patients. As noted in the previously referenced study, patients are often perplexed about who is taking care of them, even without the use of confusing terminology.

Some medical organizations have already developed statements in opposition to NP and PA advanced training programs using the terms “residency” and “internship.” In May 2019, the American Academy of Dermatology (AAD) approved the following [statement](#): “Education of physicians and non-physician clinicians is entirely different. Physicians undergo rigorous training programs that have been accredited by various agencies. Historically the terms ‘residency training’ and ‘fellowship training’ have been used to indicate physician training. This lexicon has become standard across the medical profession . . . It is the position of the AAD that the term ‘residency’ in reference to training in dermatology apply only to allopathic and osteopathic physicians (MD’s and DO’s) trained in Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training programs and that the term ‘fellowship’ in reference to clinical or research training in dermatology apply only to MD’s and DO’s so trained.”

In February 2020, the American Academy of Emergency Medicine (AAEM) and AAEM/RSA approved a position [statement](#) that additional training programs for PAs and NPs: “Should be clear to the public by avoiding the use of the following terms: doctor, intern, internship, resident, residency program, fellow, fellowship . . . Should be structured, intended or advertised as to prepare its participants to practice only as members of a physician-led team.”

ACEP and eight other emergency medicine organizations released a [Joint Statement Regarding Post-Graduate Training of Nurse Practitioners and Physician Assistants](#) on September 3. The statement conveyed unified support of physician-led patient care and training and that the terms “resident,” “residency,” “fellow,” and “fellowship” in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within ACGME accredited training programs.

The American Board of Emergency Medicine released a [Statement on Advanced Practice Providers](#) on September 10 affirming that “use of the terms ‘residency’ or ‘fellowship’ in conjunction with an advanced practice provider training program should be avoided as they are not equivalent to the training undertaken in an ACGME-accredited emergency medicine program.”

ACEP’s policy statement “[Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department](#)” states “the gold standard for care in an ED is that performed or supervised by a board-certified/board eligible emergency physician.”

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted resources to convey ACEP’s position to federal Executive and Legislative branch officials.

Prior Council Action

Substitute Resoluituion 30(13) Use of the Title “Doctor” in the Clinical Setting adopted. Directed ACEP to affirm that a physician is an individual who has received a “Doctor of Medicine” or “Doctor of Osteopathic Medicine” degree or equivalent degree and that anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Prior Board Action

June 2020, approved the revised policy statement “[Guidelines Regarding the Role of Physician Asistants and Nurse Practitioners in the Emergency Department](#)” 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” replacing “Guidelines on the Role of Physician Assistants in Emergency Departments” (2002) and “Guidelines on the Role of Nurse Practitioners in the Emergency Department (2000).

February 2020, approved the revised policy statement “[Use of the Title ‘Doctor’ in the Clinical Setting;](#)” originally approved April 2014.

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.

February 2018, reaffirmed the policy statement “[The Role of the Legacy Emergency Physician in the 21st Century;](#)” reaffirmed April 2012; originally approved June 2006.

Substitute Resoluituion 30(13) Use of the Title “Doctor” in the Clinical Setting adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

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



RESOLUTION: 28(20)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Young Physicians Section
Florida College of Emergency Physicians

SUBJECT: Banning of Choke Holds

PURPOSE: Endorse a national ban on the use of choke holds, educate members and relevant stakeholders about the hazard of choke holds and the availability of non-lethal alternatives, and promote these alternatives when appropriate.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Choke holds or neck holds that compress the upper airway (trachea, larynx or laryngopharynx)
2 therefore interfering with breathing and leading to asphyxia can lead to death are dangerous and less safe than blood
3 chokes (carotid restraints)^{1,2}; and
4

5 WHEREAS, Not all choke holds result in death, however, an analysis of 56 episodes of transient cerebral
6 hypoxia on people who completely lost consciousness showed muscle jerks in 90% of patient generally consisting of
7 multifocal arrhythmic jerks in both proximal and distal muscles, superposition of generalized myoclonus, righting
8 movements (if the patient had slumped in one direction while falling asleep they woke up and immediately corrected),
9 oral automatisms, head turns, visual and auditory hallucinations;³ and
10

11 WHEREAS, Use of choke holds by law enforcement leading to inadvertent upper airway compression can have
12 deadly outcomes especially when performed on a combative person and even when the initial intent is to apply a neck
13 hold the danger exists that the officer's pressure will slip or move to the front of the neck, constricting the windpipe and
14 thereby stemming the flow of oxygen to the lungs and the brain⁴; and
15

16 WHEREAS, In a 2013 Justice Department survey, police departments serving more than one million people,
17 43% allow a neck restraint of some kind including choke holds⁵; and
18

19 WHEREAS, Almost half of the people who lost consciousness were injured according to Minneapolis police data
20 in which neck restraints were used at least 237 times since 2015 and of these, 16% lost consciousness⁶; and
21

22 WHEREAS, Recognizing the deadly consequences of the choke hold, most large police departments do not
23 allow it including the New York Police Department, Metropolitan Police Department of Washington, DC, the Los
24 Angeles Police Department. and the Chicago Police Department⁷; and

¹ Ready DT, Eisele JW. Death from law enforcement neck holds. *Am J Forensic Med Pathol.* 1982 Sep;3(3):253-8.

² GM Vilke. Neck Holds. In *Sudden deaths in Custody.* Springer. 2006

³ Lempert T, Bauer M, Schmidt D. Syncope: a videometric analysis of 56 episodes of transient cerebral hypoxia. *Ann Neurol* 1994;36:233-237

⁴ Ready DT, Eisele JW. Death from law enforcement neck holds. *Am J Forensic Med Pathol.* 1982 Sep;3(3):253-8.

⁵ Reaves, B. A. (2015). *Local police departments, 2013: Equipment and technology.* Washington, DC: Bureau of Justice Statistics (BJS), U.S. Department of Justice, Office of Justice Programs.

⁶ <https://www.nbcnews.com/news/us-news/minneapolis-police-rendered-44-people-unconscious-neck-restraints-five-years-n1220416>

⁷ <https://www.thestate.com/news/nation-world/national/article243230871>.

25 WHEREAS, A federal appeals court, the Ninth US Circuit Court of Appeals, banned the use of the maneuver
26 when someone is not resisting arrest citing it violates the constitutional ban on unreasonable search and seizure⁸;
27 therefore be it
28

29 RESOLVED, That the American College of Emergency Physicians endorse a national ban on the use of choke
30 holds; and be it further
31

32 RESOLVED, That ACEP educate its members and relevant stakeholders about the hazard of choke holds and the
33 availability of non-lethal alternatives and promote these alternatives when appropriate.

Background

This resolution proposes that ACEP endorse a national ban on the use of choke holds, that ACEP educate its members and relevant stakeholders about the hazards of choke holds and the availability of non-lethal alternatives, and promote these alternatives when appropriate.

A choke hold is a form of restraint intended to control an individual who may be uncooperative or violent by compressing the upper airway to interfere with breathing or cause asphyxiation. A choke hold is distinguished from another type of neck restraint, a “stranglehold” (also referred to as a blood choke or carotid restraint), that is a form of strangulation restricting the flow of blood to the brain. Both are capable of inflicting significant injuries and death.

The use of choke holds and other uses of force by law enforcement has come under greater scrutiny in recent years, especially after high-profile incidents like the death of Eric Garner, who was killed in 2014 by a police officer who put him in a prohibited choke hold, and more recently, the killing of George Floyd, who was killed by police during an arrest after an officer knelt on his neck for eight minutes with no medical attention rendered. The nationwide protests that began in the wake of George Floyd’s death have brought more widespread attention to the issue of what constitutes appropriate use of force by law enforcement and renewed calls for training that prioritizes de-escalation tactics. Others, like some in law enforcement, maintain that through proper training, choke holds are an important method to control an individual to reduce the potential for greater injury or violence. ACEP issued statement on [Structural Racism and Public Health](#) on May 30, 2020 denouncing racism and all senseless acts of violence.

As the resolution notes, several law enforcement agencies already discourage or prohibit the use of choke holds, but some doubt the effectiveness of these policies. In the Eric Garner killing, the New York Police Department (NYPD) had already banned the use of choke holds. In New York City, the Civilian Complaint Review Board found that the use of choke holds [appeared to increase](#) though the restraint was prohibited. On June 12, 2020, New York Governor Andrew Cuomo signed into law the “Eric Garner Anti-Chokehold Act,” which allows for any police officer who injures or kills someone by using a choke hold (or similar use of force) to be charged with a class C felony that is punishable by up to 15 years in prison.

On June 16, 2020, President Donald Trump signed an executive order (EO), “[Executive Order on Safe Policing for Safe Communities](#),” which among other provisions, bans the use of most choke holds by making receipt of federal grants by law enforcement agencies contingent on banning the use of choke holds, “except in those situations where the use of deadly force is allowed by law.” The EO also encourages law enforcement agencies to improve training procedures to emphasize de-escalation tactics and to better interact with individuals with mental health needs, substance use disorders, or suffering from homelessness. However, some police reform advocates have suggested this EO does not go far enough to address the issue.

Congress has also recently attempted to address the issue of law enforcement reform, including policies surrounding the use of choke holds. A recent legislative proposal offered by the Democratic Majority in the House of Representatives proposed a complete nationwide ban on the use of choke holds, while a proposal put forward by the Senate Republican Majority would encourage police departments to ban choke holds but would not legally ban their use outright.

⁸ <https://www.usnews.com/news/best-states/california/articles/2019-12-24/man-choked-unconscious-can-sue-police-court-rules>

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 34(18) Violence is a Health Issue adopted. Directed ACEP to recognize violence as a health issue addressable through medical and public health interventions, and to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

Resolution 14(15) Body-Worn Cameras for Police not adopted. Directed ACEP to create a policy statement endorsing laws requiring police officers to wear body-worn cameras.

Resolution 22(10) Police Pursuits not adopted. Directed ACEP to strongly encourage use of safer alternatives to police pursuits, support enactment of laws requiring law enforcement agencies to accept responsibility for their actions regarding police pursuits and support mandatory tracking of pursuit-related injury data by NHTSA.

Amended Resolution 21(08) Excited Delirium adopted. Directed ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

April 2020, approved the revised policy statement “[Cultural Awareness and Emergency Care;](#)” reaffirmed April 2014; originally approved April 2008 with the current title, replacing “Cultural Competence and Emergency Care” that was approved October 2001.

April 2019, revised and approved the policy statement “[Violence-Free Society;](#)” reaffirmed June 2013; revised and approved January 2007; reaffirmed 2000; originally approved January 1996.

October 2009, approved the “[White Paper Report on the Excited Delirium Syndrome](#)” and authorized its distribution to the Council. A workgroup was appointed in August 2020 to update the paper.

Amended Resolution 34(18) Violence is a Health Issue adopted.

Amended Resolution 21(08) Excited Delirium adopted

Resolution 28(20) Banning of Choke Holds

Page 4

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

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

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



RESOLUTION: 29(20)

SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP

SUBJECT: Billing and Collections Transparency in Emergency Medicine

PURPOSE: 1) Amend two current ACEP policy statement to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. 2) Adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. 3) Petition state or federal legislative and regulatory to require revenue cycle management entities to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. 4) Adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy efforts. Potentially significant reduction in outside funding support.

1 WHEREAS, It is common knowledge that many ACEP members are denied access to what is billed and
2 collected in their name; and
3

4 WHEREAS, A lack of transparency regarding what is billed and collected in a physician's name breeds
5 distrust and can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing the
6 difficult specialty of emergency medicine; and
7

8 WHEREAS, Without transparency regarding what is billed and collected in a physician's name the efforts to
9 end gender disparity in physician pay will be lacking due to insufficient information; and
10

11 WHEREAS, The physician is supposed to see this information to ensure honest billings and can be held
12 individually liable for up coding and fraud; and
13

14 WHEREAS, Without this information the physician risks being a party to fee-splitting whereby a physician
15 gives up a portion of their professional fee above fair market value in return for the right to see patients (receive
16 referrals) in the ED; and
17

18 WHEREAS, The original Bylaws of ACEP opposed fee-splitting stating that "In the practice of medicine, a
19 physician shall limit the source of his income to medical services actually rendered by him to his patients. He should
20 neither pay nor receive a commission for referral of patients."; and
21

22 WHEREAS, Participation in prohibited fee splitting has long been recognized as a risk to the emergency
23 physician by ACEP as demonstrated in the 1996 book published by ACEP written by Kalifon and Sullivan titled
24 "Before you sign. Contract basics for the emergency physician" and this book states "Medicare, Medicaid and some
25 states' laws prohibit kickbacks and fee-splitting. The Group and the Contractor (the physician) might violate these
26 laws if the Group retains or, phrased differently, the Contractor pays more than fair market value for the services the
27 Group provides to the Contractor."; and
28

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

32 WHEREAS, AMA policy H – 190.971 states that “all physicians are entitled to receive detailed itemized
33 billing and remittance information for medical services they provide, and that our AMA develop strategies to assist
34 physicians who are denied such information” (reaffirmed 2017); and
35

36 WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response
37 to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are
38 detrimental to its members or the public”; and
39

40 WHEREAS, Denial of this information can be detrimental to ACEP members in regard to unwitting
41 participation in fee-splitting and upcoding as well as to the public if they are subject to excessive charges; and
42

43 WHEREAS, The billing entity is supposed to be answerable to the individual physician; and
44

45 WHEREAS, The reputation of an emergency physician can be affected if inflated bills for services are sent to
46 the patient; therefore be it
47

48 RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Contractual
49 Relationships” through deletion and substitution as follows: “The emergency physician ~~should~~ **shall receive detailed**
50 **itemized reports on** ~~have the right to review~~ what is billed and collected for his or her service **on at least a monthly**
51 **basis** regardless of whether or not billing and collection is assigned to another entity within the limits of state and
52 federal law. **The emergency physician shall not be asked to waive access to this information.**”; and be it further
53

54 RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and
55 Responsibilities” through deletion and substitution as follows: “5. Emergency physicians ~~should~~ **shall** be provided
56 ~~periodic~~ **detailed itemized** reports of billings and collections in their name **on at least a monthly basis** and have the
57 right to audit such billings, without retribution. **The emergency physician shall not be asked to waive access to this**
58 **information.**”; and be it further
59

60 RESOLVED, That ACEP adopt as policy that: “No member of ACEP will, directly or indirectly, deny
61 another emergency physician the ability to receive detailed itemized billing and remittance information for medical
62 services they provide.”; and be it further
63

64 RESOLVED, That ACEP petition the appropriate state or federal legislative and regulatory bodies to
65 establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly
66 provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances
67 for medical services they provide on at least a monthly basis; and be it further
68

69 RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at
70 its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021,
71 provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed
72 information on what has been billed and collected in the physician’s name. This information must be provided without
73 the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities
74 affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing
75 companies.”

Background

This resolution directs ACEP to amend two current policy statements, “Emergency Physicians Contractual Relationships” and “Emergency Physician Rights and Responsibilities,” to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. The resolution further directs ACEP to adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. Additionally, the resolution directs ACEP to petition state and federal regulatory bodies to require revenue cycle management entities, regardless of their

ownership structure, to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. Finally, the resolution directs ACEP to adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP and that these reports should be provided automatically to every member without a requirement to request such reports.

The intent of this resolution is similar to Resolution 30(20) Protection and Transparency, therefore the background for both resolutions is also similar. The scope of Resolution 30(20) is not as comprehensive.

The requested new policy stating that “no member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide” would presumably be enforced through ACEP’s ethics procedures. Non-member entities would not be subject to this process for member violations.

ACEP’s policy statement “[Emergency Physician Contractual Relationships](#)” and the associated [Policy Resource and Education Paper](#) (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name. Further, the PREP states that “the contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is party and to relate to one another in an ethical manner.”

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

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.”

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

ACEP’s “[Antitrust](#)” policy statement states: “The College is not organized to and may not play any role in the competitive decisions of its member or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.” The policy further specifies:

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

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

Adoption of a policy that prohibits members from denying other emergency physicians the right to detailed reports of billing and collections for their services would presumably mean that members could face sanctions, including possible expulsion from membership, for failing to abide by the policy. ACEP would be required to report any suspension or expulsion to the National Practitioners Data Bank. Enforcement of self-regulation codes, even if the enforcement is not anti-competitive, must be carried out in a manner that affords the alleged offender due process, which includes proper notice and a fair hearing. The ACEP Bylaws state that “Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.” The College Manual currently describes the process for addressing all disciplinary actions and is the process currently used to adjudicate ethics charges.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide adequate due process to the accused member(s). The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to revoke a member’s membership or deny an entity’s ability to exhibit, sponsor, or advertise with ACEP may create additional potential liability risk for ACEP. Affected members could bring legal action against the College with claims of defamation, limiting professional opportunities, or denial of due process on the part of ACEP. Excluding an entity from being able to sponsor any ACEP activity could subject the College to a claim of restraint of trade. Such challenges can be mitigated by developing and adhering to strict processes.

Currently, approximately 24% of all corporate support in FY 2019-20 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed \$1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective E: Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources for policy development and advocacy efforts. The financial impact would depend on how many entities would not agree to provide monthly detailed itemized reports to all contracted emergency physicians. Physician groups, staffing companies, and hospitals/clinics contributed \$1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities in FY 2019-20. Additionally, ACEP’s prescribed procedures for adjudicating accusations of member misconduct is time intensive for the Ethics Committee, Board of Directors, and staff involved in investigation and rendering decisions on ethics complaints.

Prior Council Action

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement “Promotion of College Policies on Contracting and Compensation” and potentially realign it with other ACEP policies or rescind it and report back to the 2003 Council.

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to

disclose their level of compliance with College policies on compensation and contractual relationships.

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

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

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

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that “the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment,” and its accompanying objective that “fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered.”

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

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians’ rights to fair and equitable treatment.

Prior Board Action

January 2019, reaffirmed the policy statement “[Antitrust](#),” reaffirmed June 2013 and October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title that was approved in April 1994.

July 2018, reviewed the Policy Resource & Education Paper (PREP) “[Emergency Physician Contractual Relationships](#)” as an adjunct to the policy statement “Emergency Physician Contractual Relationships.”

June 2018, approved the revised policy statement “[Emergency Physician Contractual Relationships](#),” revised and approved 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.”

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.”

October 2015, approved the revised policy statement “[Emergency Physician Rights and Responsibilities;](#)” revised and approved April 2008 and July 2001; originally approved September 2000.

April 2015, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians;](#)” revised and approved April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

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

Substitute Resolution 10(01) Commercial Sponsorships adopted.

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

June 1997 reviewed the information paper “Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships.”

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted.

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

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

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



RESOLUTION: 30(20)
SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section
SUBJECT: Protection and Transparency

PURPOSE: Establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information monthly to the emergency physician for all charges billed and all collections made under the physician’s name, license number, or other identifying information without the physician having to request it. Additionally calls for new policy that would requires these same entities to automatically provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or CMG as a result of the physician providing his or her services.

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

1 WHEREAS, Many emergency physicians work for or are contracted by others to provide their services; and

2
3 WHEREAS, The majority of emergency department staffing contracts are owned, controlled, or influenced by
4 contract management groups and not the physicians working in the emergency department; and

5
6 WHEREAS, Most of the billing done for the services provided by emergency physicians are not billed by or
7 under the control of the physicians who provided, or are responsible for, the services; and

8
9 WHEREAS, The physician remains responsible and liable for any fraud or false claims that might occur in
10 the billing for services provided by them or that they may be responsible for in a supervisory role, regardless of who
11 performs the billing services; and

12
13 WHEREAS, The False Claims Act (FCA) provides that any person who knowingly submits false claims to
14 the government is liable for treble the government’s damages plus a penalty (\$5,000-\$10,000)ⁱ that is linked to
15 inflation for each false claim”ⁱⁱ; and

16
17 WHEREAS, “The False Claims Act makes it a crime for any person or organization to knowingly make a
18 false record”ⁱⁱⁱ and “knowingly includes having actual knowledge that a claim is false or acting with ‘reckless
19 disregard’ as to whether a claim is false”^{iv}; and

20
21 WHEREAS, 31 U.S.C. § 3729 (False Claims Act) states that while “the False Claims Act imposes liability
22 only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual
23 knowledge that the claim is false”^{vi}; and

24
25 WHEREAS, The physician may be viewed as “acting with reckless disregard” if he or she is not aware of
26 what is being billed under their name or license number; and

27
28 WHEREAS, By providing detailed information to the physician for all charges that are billed and collected
29 under his or her name and allow the physician to review the information would remove this reckless disregard
30 argument and protect the physician; and

31
32 WHEREAS, Allowing physicians who have charges billed under their identifying information would serve as
33 an additional tool to protect physicians, help screen for, identify, and possibly prevent healthcare fraud; and

34 WHEREAS, Contract management groups (CMGs) or employers may not want to share the physician's
35 billing or collection data with the physician for various reasons; and

36
37 WHEREAS, CMGs often receive benefits because of the services the emergency physicians provide that may
38 be separate from traditional billing and collections; and

39
40 WHEREAS, CMGs or employers may discourage physicians from requesting their own billing or collection
41 information and may penalize conspicuously or inconspicuously; and

42
43 WHEREAS, If this information is only provided when a physician asks for it, physicians who request such
44 information would stand out and could become targets for discriminatory treatment by their employer or CMG; and

45
46 WHEREAS, Many emergency physicians do not know exactly how much is being billed to patients and third
47 parties for the services they provided or were the attending physician supervising a non-physician provider who
48 provided the service; and

49
50 WHEREAS, Many emergency physicians are unaware how much is taken out of the money they generate for
51 medical malpractice insurance, billing services, management fees, or other expenses; and

52
53 WHEREAS, Many emergency physicians are unaware of their true market value as emergency physicians
54 because they are unaware of the exact amount of collections that are generated under their identifying information;
55 therefore be it

56
57 RESOLVED, That ACEP establish policy that requires all employers, persons, or entities who contract for
58 emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection
59 information on a monthly basis to the emergency physician for all charges billed and all collections made under the
60 physician's name, license number, or other identifying information without the physician having to request it; and be
61 it further

62
63 RESOLVED, That ACEP establish policy that requires all employers, persons or entities who contract for
64 emergency physician services to provide information on a monthly basis to physicians for any and all compensation
65 or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result
66 of the physician providing his or her services without any requirement of the physician requesting it.

ⁱⁱ United States Department of Justice. July 15, 2020. <<https://www.justice.gov/civil/false-claims-act>>

ⁱⁱⁱ Total Health Care. July 15, 2020. <[^{iv} Total Health Care. July 15, 2020. <\[^v United States House of Representatives. July 15, 2020.\]\(https://themi.com/false-claims-act/#:~:text=The%20False%20Claim%20Act%20is%20a%20federal%20law,United%20States%20Government%20or%20any%20Ostate%20healthcare%20system.></p></div><div data-bbox=\)](https://themi.com/false-claims-act/#:~:text=The%20False%20Claim%20Act%20is%20a%20federal%20law,United%20States%20Government%20or%20any%20Ostate%20healthcare%20system.></p></div><div data-bbox=)

<[https://uscode.house.gov/view.xhtml?req=\(title:31%20section:3729%20edition:prelim\)%20OR%20\(granuleid:USC-prelim-title31-section3729\)&f=treesort&edition=prelim&num=0&jumpTo=true](https://uscode.house.gov/view.xhtml?req=(title:31%20section:3729%20edition:prelim)%20OR%20(granuleid:USC-prelim-title31-section3729)&f=treesort&edition=prelim&num=0&jumpTo=true)>

^{vii} Capital District Physicians' Health Plan. July 15, 2020. <https://www.cdphp.com/-/media/files/home/false_claims_act_relevant_statutes.pdf?la=en>

Background

This resolution directs the College to establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information on a monthly basis to the emergency physician for all charges billed and all collections made under the

physician's name, license number, or other identifying information without the physician having to request it. The resolution additionally calls for new policy that would require these same entities to automatically provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services.

The intent of this resolution is similar to Resolution 29(20) Billing and Collections Transparency in Emergency Medicine, therefore the background for both resolutions is also similar. The scope of resolution 29(20) is more comprehensive.

ACEP's policy statement "[Emergency Physician Contractual Relationships](#)" and the associated [Policy Resource and Education Paper](#) (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name:

Billing Rights:

- **The emergency physician should have the right to review what is billed and collected for his or her service regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law.**

Further, the PREP states that "the contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is party and to relate to one another in an ethical manner."

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

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

ACEP's policy statement "[Compensation Arrangements for Emergency Physicians](#)," mentions recognition of various compensation methods and that exploitation of emergency physicians is improper. It further strongly urges members to carefully evaluate any health care delivery system or arrangement that might unfairly profit from the professional services of the emergency physician.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide adequate due process to the accused member(s). ACEP would not have any standing to investigate CMG's for non-compliance since ACEP's "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" apply only to members. It is also possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective E: Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources for policy development.

Prior Council Action

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement “Promotion of College Policies on Contracting and Compensation” and potentially realign it with other ACEP policies or rescind it and report back to the 2003 Council.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted. Directed ACEP to endorse the principles outlined in the Emergency Physician Rights and Responsibilities" information paper as a priority for the College.

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

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that “the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment,” and its accompanying objective that “fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered.” Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians' rights to fair and equitable treatment.

Prior Board Action

June 2018, approved the revised policy statement “[Emergency Physician Contractual Relationships](#),” revised and approved October 4 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled “Contractual Relationships between Emergency Physicians and Hospitals.”

July 2018, reviewed the PREP “[Emergency Physician Contractual Relationships](#)” as an adjunct to the policy statement “Emergency Physician Contractual Relationships.”

January 2017 approved the revised policy statement “[Code of Ethics for Emergency Physicians](#),” revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled “Ethics Manual.”

October 2015, approved the revised policy statement “[Emergency Physician Rights and Responsibilities](#),” revised and approved April 2008 and July 2001; originally approved September 2000

April 2015, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians](#),” revised and approved April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

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

June 1997 reviewed the information paper “Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships.”

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted.

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

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

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



RESOLUTION: 31(20)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Insurer Accountability/Policy Weakness Disclosure

PURPOSE: Establish policy that advocates for legislation requiring Policy Weakness Disclosures (PWDs) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy and support legislation imposing penalties on insurers who do not provide PWDs to policyholders as required.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement and convey ACEP’s position to federal Executive and Legislative branch officials.

1 WHEREAS, Many insurance companies sell many different forms of health insurance policies; and

2
3 WHEREAS, People often choose policies based on the costsⁱ, and

4
5 WHEREAS, Many people do not understand the policies that they are being sold or what their financial
6 responsibilities will be should they need medical attention or incur medical costsⁱⁱ and

7
8 WHEREAS, In many cases the physician, hospital, staffing company and/or their staff are the ones that often
9 must explain the insurance policy to patients and not the insurance company that sold the policy; and

10
11 WHEREAS, Many insured have complained about “surprise bills” (balance billing) and ACEP and EDPMA
12 representatives have stated that often turns out to be a “surprise coverage problem”ⁱⁱⁱ; and

13
14 WHEREAS, There has been a lot of national attention regarding surprise billing and will likely result in
15 legislation that could significantly impact reimbursement and patient care that ACEP has been addressing through
16 conversations with legislators, i.e., meetings, Day on the Hill, lobbying efforts, etc.; and

17
18 WHEREAS, Because the average or typical family has about \$400-\$700 in emergency funds, insurance
19 companies are shifting more of the financial responsibility to patients, and after one applies in or out of network
20 status, deductibles, and co-pays, the financial responsibility of the patient often outstrips the emergency funds of the
21 family^{iv}; and

22
23 WHEREAS, Approximately one in five people in the United States have medical debt in collections^v and
24 according to the Commonwealth Fund, two in five working Americans (72 million) are paying off medical debt or
25 have medical bill problems^{vi}; and

26
27 WHEREAS, Physicians explain risks and benefits of procedures to patients and often are required to obtain
28 written informed consent before they proceed with procedures to document the patient’s understanding of the risks
29 and benefits, including the unlikely but most serious risks such as loss of limb, brain damage, permanent disability,
30 vegetative state, or death, etc., it is reasonable that insurers also be required to explain to patients (their customers)
31 what they are selling them; and

32
33 WHEREAS, In an ACEP Fair Coverage Fact Sheet, it was stated “9 out of 10 emergency physicians polled
34 say health insurance companies mislead patients...”^{vii}; therefore be it

35 RESOLVED, ACEP establish policy that advocates for legislation requiring Policy Weakness Disclosures
36 *(PWD) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy
37 that specifically explains the policy that they are selling with specific examples of “worse case scenarios” (including
38 hypothetical emergency department visits resulting in \$10,000 outpatient visit and \$200,000 hospitalization with out-
39 of-network emergency physicians, anesthesiologists, radiologists, telehealth physician and non-physician providers,
40 excluded services, co-pays, deductibles, etc., to help the public understand the potential risks of buying a particular
41 insurance policy that actually can and do occur; and be it further
42

43 RESOLVED, That ACEP support legislation imposing penalties on insurers who do not provide Policy
44 Weakness Disclosures to policyholders as required, i.e., before they purchase the policy that include requiring the
45 insurer to cover 100% of all charges without deductible, co-pay, exclusions, etc.
46

47 *PWD-Policy Weakness Disclosure. A written disclosure that insurance companies would be required to provide to customers
48 before they could receive any benefit (sell) that explains the policy and lists numerous examples of the short fall or worse case
49 scenarios where customers would be financially responsible (insurance would not cover) for large amounts of money based on
50 what actually occurs, i.e., emergency department visits (testing, imaging, out-of-network emergency physicians, radiologists,
51 anesthesiologists, pathologists, etc.).

ⁱ Shaheen, Etch. (2020). *How the healthcare system keeps you... IN THE DARK*. Knowledge is Power Publishing.

ⁱⁱ Venkat, Arvind. February 2017. Pennsylvania ACEP Testimony on Fair Payment and Balanced Billing.

ⁱⁱⁱ Hammerstedt, MD, MPH, Heather, Parker, MD, FACEP, Rebecca, Seay, MD, FACEP, Timothy. (November 3, 2016). ACEP and EDPMA letter: “Draft of Potential Legislation, An Act Relating to Network Adequacy.”

^{iv} Shaheen, Etch. (2020). *How the healthcare system keeps you... IN THE DARK*. Knowledge is Power Publishing.

^v Christensen-Garcia, Laura. August 27, 2019. <https://thefinancialclinic.org/medical-debt-collection-know-your-rights/>

^{vi} Weyl, Ben. August 27, 2019. <https://www.commonwealthfund.org/publications/newsletter-article/americans-facing-increasing-problems-medical-debts>

^{vii} ACEP Fair Coverage Fact Sheet. February 2017.

Background

This resolution directs ACEP to establish policy that advocates for legislation requiring Policy Weakness Disclosures (PWDs) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy and support legislation imposing penalties on insurers who do not provide PWDs to policyholders as required.

A 2016 [survey](#) conducted by PolicyGenius in partnership with Radius Global Research of 2,000 American health insurance consumers found that 96% of Americans overestimate their understanding of four key health insurance concepts – deductible, co-insurance, co-pay, and out-of-pocket maximum. There was a significant difference between the respondents’ confidence (68%) that they “definitely understood” these terms and their overall comprehension (42%) of these terms. Only 4% could actually define all four terms.

In 2019, PolicyGenius used Google Consumer Surveys to poll a nationally representative sample of 1,500 people and [found](#) more than one in four people said uncertainty over their coverage led them to avoid treatment. It also found few people understand what health insurance plans must cover by law. They have also conducted surveys about health insurance literacy for the past three years and found people are increasingly confused about the Affordable Care Act (ACA) and what coverage is required. In 2018 and 2019, the surveys asked about the same six (of 10) essential health benefits (EHBs). While 28% thought health insurance plans were not required to cover any of the six EHBs in 2018, 44% held this incorrect belief in 2019.

With the reinstatement in 2017 of short-term (up to one year) health insurance plans by the Trump Administration, there is further confusion amongst consumers about their health insurance coverage. A 2019 [report](#) from Kleimann Communication Group, which was commissioned by a group of consumer representatives to the National Association of Insurance Commissioners (NAIC), found most consumers struggled to understand the marketing materials for a popular short-term plan and many misunderstood the basic concept of that type of insurance plan because they expect

their health insurance to reflect the Affordable Care Act's consumer protections.

Kleimann also asked about the federally mandated disclosure and whether consumers thought it adequately conveyed the limitations of the policy. The federally mandated disclosure requires short-term plans to state, on application materials and the contract, that the plan does not have to comply with the ACA and may have coverage limitations and annual or lifetime dollar limits. However, the disclosure went largely unnoticed and was ineffective at reducing consumer confusion. Few participants looked at the disclosure language included on the cover page of the short-term plan brochure. Participants in the study did not notice the disclosure because it was de-emphasized through its placement on the cover in very small font. When the disclaimer was pointed out to them, participants thought it was important, but few noticed it on their own and it did not eliminate or reduce the confusion about coverage and cost-implications.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement and convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

Substitute Resolution 10(03) Changing Payer Market adopted. It directed ACEP to: 1) study the effect of changes in the private payer market (caused by health care insurers' changes in coverage and payment policies) to access to emergency medical services, including increases in premiums, co-payments, and deductibles incurred by insured individuals, as well as discounted fees to health care providers; and 2) develop a strategy targeting the business community and insurers to address adverse effects of changes in the private payer market. A report was developed and distributed to the 2004 Council. The report focuses on the lack of evidence supporting a relationship between payer policies and ED access.

Prior Board Action

None

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 32(20)

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

SUBJECT: Loss of Health Insurance Due to COVID-19

PURPOSE: Support adoption of Medicare-for-All as an alternative to employment-based insurance (with conditions) and explore opportunities to partner with other like-minded organizations favoring a Medicare-for-All approach.

FISCAL IMPACT: Budgeted staff and committee time and resources.

1 WHEREAS, The COVID-19 pandemic has caused almost 27 million Americans to lose health care coverage
2 as a result of becoming involuntarily unemployed¹; and
3

4 WHEREAS, Tying insurance to employment creates an undue burden on both employees and businesses
5 alike; and
6

7 WHEREAS, The 2010 Affordable Care Act (ACA) created a complex and inefficient bureaucracy that works
8 through private insurers with high administrative overhead, and even prior to COVID-19 left 28 million Americans
9 uninsured and another 44 million underinsured, causing them to receive care at an advanced stage of disease or to
10 forego care altogether²; and
11

12 WHEREAS, Medicare-for-All is an alternative to employment-based insurance, with financing streamlined
13 through a single-payer system; adds simplicity to billing and medical care administration resulting in lower overhead;
14 and has the potential to help American businesses compete globally by reducing their financial obligations for their
15 employees' health care; and
16

17 WHEREAS, Recent polls demonstrate majority support for Medicare-for-All or single-payer by the general
18 public^{3,4,5} and among clinicians⁶; and
19

20 WHEREAS, There is no truth to the memes that Medicare-for-All is "socialized medicine"; that it is
21 "government-controlled health care"; that it represents a massive pay cut for physicians; or that it will block health
22 care competition, diminish quality, forestall medical innovation, or inhibit patient choice of provider; and
23

24 WHEREAS, In 1999, the ACEP Council adopted Resolution 15(99) Promotion of Health Care Insurance
25 stipulating that ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage
26 for the uninsured and underinsured, a stipulation that has yet to be consummated; and
27

28 WHEREAS, ACEP's Health Care Financing Task Force, created in 2017 to study alternative financing
29 models that foster competition and preserve patient choice, did not provide any actionable conclusions; and
30

31 WHEREAS, ACEP's Acute Unscheduled Care Model (AUCM), created by the Alternative Payment Model

32 Task Force, focused on physician reimbursement rather than overall health care financing; therefore, be it

33

34 RESOLVED, That ACEP support adoption of Medicare-for-All as an alternative to employment-based
35 insurance – but only if such a program provides universal access, fosters competition, preserves patient choice of
36 provider and physician autonomy, and recognizes the essential value of emergency medicine; and be it further

37

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

¹ Garfield R, Claxton G, Damico A, Levitt L. Eligibility for ACA health coverage following job loss – data note. Kaiser Family Foundation. Published May 13, 2020, at: www.kff.org/8b2d153/

² Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, February 2019), at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

³ KFF Health Tracking Poll. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage (slide file; published May 27, 2020), at: http://files.kff.org/attachment/SP_5.21.20

⁴ Poll: 69 percent of voters support Medicare for All. *The Hill*. Published April 24, 2020, at: <https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all>

⁵ Murad Y. As coronavirus surges, ‘Medicare for All’ support hits 9-month high. *Morning Consult/Politico* poll (February 21-23, 2020 and March 27-29, 2020; published April 1, 2020), at: <https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/>

⁶ Serafini M. Why clinicians support single-payer – and who will win and lose. *NEJM Catalyst*. Published on January 17, 2018, at: <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0278>

Background

The resolution calls for ACEP to support the adoption of Medicare-for-all as an alternative to employment-based insurance, but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine. Additionally, it calls for ACEP to explore opportunities to partner with other like-minded organizations that favor the Medicare-for-all approach to providing universal health care to all Americans.

The resolution notes the economic impact of the COVID-19 pandemic that resulted in dramatic job losses in the U.S., especially during the first several months of the response. While some of these losses were temporary and the economy has recovered a large portion of the initial drop, as of mid-August, weekly unemployment claims numbered nearly one million. Since President Trump declared a state of emergency on March 14, 2020, [more than 56 million Americans have applied for unemployment benefits](#) in a 21-week period. The resolution further notes that because of the predominance of the employer-sponsored model of health insurance in the U.S., unemployment is directly linked to a loss of insurance, which in turn affects individual and public health in addition to its financial impacts on the health care system.

The resolution references the Health Care Financing Task Force (HCFTF) established in response to Amended Resolution 19(16) to study alternative health care financing models, including single payer. The task force submitted its report to the Board of Directors in fall 2018 and the report served as the foundation for the 2018 Council Town Hall Meeting. The report notes:

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

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system –

could be espoused over another. The HCFTF concluded “ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer.”

It is important to recognize that single-payer is not equivalent to universal health care. Universal health care refers to a system in which all citizens have access to health care services, although payment for these services could derive from either a single source or multiple sources. Single-payer, on the other hand, is a health care financing system where all reimbursements derive from one entity.

Further, while the resolution states “Single-payer health insurance, often known as ‘Medicare-for-All’...”, it should be noted that “single-payer” and “Medicare-for-All” are also considered distinct proposals, even by many proponents. For example, a [2016 poll conducted by Kaiser Family Foundation \(KFF\)](#) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a [2019 Morning Consult poll](#), a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, “there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a “Medicare for all” program could be single-payer but does not necessarily have to be.”

Recently, there appears to be growing public support for Medicare-for-All proposals, driven by the COVID-19 pandemic. The resolution cites an April 2020 Morning Consult/Politico survey of registered voters showing an approximately 40 percent increase in support for both the Affordable Care Act and for universal health care proposals. It is unclear if this trend has continued in the ensuing weeks. It also found that support for Medicare-for-All was supported by 55 percent of registered voters, a one percent increase since June 2019.

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP or military health care (TRICARE or VA/CHAMPVA). For those who are privately insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs and in the private marketplace. Government programs insured 95 million Americans while private insurance covered 196 million of those who had health insurance in 2010,.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources. For example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the Journal of the American Medical Association in 2003), all residents of the U.S. would be enrolled and all medically necessary care would be covered. Obviously, the question of what is considered medically necessary could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums. Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than \$294

billion annually on administrative costs, which represents 31% of health expenditures in this country. However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification. Furthermore, these savings would only be generated one time.

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

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

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

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

Prior Council Action

Resolution 37(19) Single-Payer Health Insurance not adopted.

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

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

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

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

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

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

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

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

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Resolution 11(00) Funding the Mandate referred to the Board.

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

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

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

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

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

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.

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

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

Prior Board Action

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



RESOLUTION: 33(20)

SUBMITTED BY: Aimee Moulin, MD, FACEP
John Rogers, MD, FACEP

SUBJECT: Metrics, Measures, and Pay-for-Performance Programs

PURPOSE: Seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay for performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of up to 15 ACEP staff.

- 1 WHEREAS, Scientific management by metrics, first described by Frederick Taylor, has been widely adopted
- 2 and implemented in emergency medicine; and
- 3
- 4 WHEREAS, Metrics are often the basis for reimbursement through pay-for-performance programs; and
- 5
- 6 WHEREAS, Metrics often become goals, therefore violating Goodhart’s law and no longer serve as useful
- 7 measures; and
- 8
- 9 WHEREAS, Pay-for-performance programs often lead to perverse behaviors and gaming; and
- 10
- 11 WHEREAS, Don Berwick, a previous CMS Director, and others, have called for the end of pay-for-
- 12 performance programs; and
- 13
- 14 WHEREAS, Many measures, such as the sepsis quality measures, are often at odds with current science; and
- 15
- 16 WHEREAS, The American Medical Informatics Association has called for the discontinuation of using
- 17 clinical documentation for billing and administrative purposes; and
- 18
- 19 WHEREAS, Many emergency physicians cite these programs and expectations as oppressive and rob them of
- 20 the joy of practicing emergency medicine; therefore be it
- 21
- 22 RESOLVED, That the College seek the decoupling of clinical documentation from billing, regulatory, and
- 23 administrative compliance requirements; and be it further
- 24
- 25 RESOLVED, That the College seek the end of pay-for-performance programs in emergency medicine; and be
- 26 it further
- 27
- 28 RESOLVED, That the College encourage the Emergency Medicine Foundation Board of Trustees to offer
- 29 funding for research into the effects of scientific management and pay-for-performance programs on patient care and
- 30 emergency physicians.

Background

This resolution requests ACEP to seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians. The intent of the resolution is to address programs that have become too complex, burdensome, potentially detrimental, and unjustly used to punish physicians and expresses concern that the metrics have become the goals and thereby are no longer useful measures.

The American Medical Informatics Association (AMIA)¹ proposes to substitute clinical documentation by creating an authoritative body from professional and specialty societies to: (1) assess clinical documentation requirements; (2) evaluate technological capabilities available today to extract then report data; and (3) define a financial mechanism to remunerate clinicians, hospitals, and healthcare systems for their work.

Decoupling clinical documentation from the functions of billing, regulatory, and compliance functions is a revolutionary idea. There is long precedent that the medical record is the best source of data to determine the level of service provided, support that service using diagnosis and management options considered, and justify the medical necessity of those choices to the payer community for payment and review under audit. A viable alternative would need to be provided in place of the medical record for this to occur. The clinical medical record is currently the most reliable vehicle for the physician themselves to document what care was provided and why to inform the selection of codes reported for payment, to provide a record of the medical care for future interactions and to justify the services provided under audit for internal review, productivity based compensations, and external payer compliance audits.

Such a move could hurt ACEP's advocacy efforts in the American Medical Association CPT Editorial Panel to define clinical services and the Relative Value Update Committee (AMA RUC) process to accurately value ED-related services.

Eliminating pay for performance programs for emergency medicine would require a change to the 2015 MACRA law that was passed with high bi-partisan support. The resolution invokes former CMS Director Don Berwick and the book *The Tyranny of Metrics* describing how pay-for-performance programs have been detrimental to other industries. Additionally, the resolution warns that although quality measures as a basis for improving performance is admirable, using them for payment purposes may be misguided.

A large percentage of ACEP's Clinical Emergency Data Registry (CEDR) participant groups have scored very well in their Merit-based Incentive Payment System (MIPS) scores to qualify for the "exceptional" bonus. In 2018, 40% of CEDR participants received the exceptional bonus. In 2019, the percentage is likely to be much higher. Exceptional bonus provides a significant return on investment for CEDR participation and a good pay-for-performance bonus on Medicare Part-B reimbursement. For a perfect score of 100 the bonus is 1.79 percent on all Medicare payments for the year under review. If the pay-for-performance program was eliminated, this bonus will likely end. Currently, 70-80% of the participants in CEDR join for the pay-for-performance bonus opportunity. If this program is ended; CEDR will not be sustainable as a data registry. ACEP may have to bring additional funding for it to remain self-sustaining as a tool for quality improvement and gaining data insights. Eliminating CEDR altogether would cause a revenue loss of \$3.6 million with a net profit of \$335,526. The larger loss would be non-financial to the membership/success of emergency medicine and staff. ACEP would lose its data leadership, quality measures would become non-operational, and the industry would lose methods for emergency physician performance/quality measurement. Additionally, approximately 15 ACEP staff positions would be eliminated if CEDR is not sustainable.

The Emergency Medicine Foundation (EMF) is an independent organization and does consider directed research funds for targeted research.

¹ "AMIA Calls on HHS to Decouple Clinical Documentation and Administrative Requirements." *American Medical Informatics Association* 29 January 2019: <https://www.amia.org/news-and-publications/press-release/amia-calls-hhs-decouple-clinical-documentation-and-administrative>

ACEP Strategic Plan Reference

Goal 1: Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Objective D: Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay-for-performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of approximately 15 ACEP staff members.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted. Directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment.

Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards referred to the Board. Called for ACEP to collaborate and build coalitions with non-medical organizations involved in developing quality standards and engage with regulatory entities such as CMS, Joint Commission, and the National Quality Forum.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care and effective ED information sharing systems to incentivize EDs to perform intensive case management for high utilizers

Amended Resolution 17(10) CMS payment Model Pilot Projects adopted. Directed ACEP to continue to develop models for appropriate payment for patient care services provided by emergency physicians and when appropriate, engage CMS.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted. Directed ACEP to closely monitor Medicare contractor behavior regarding interpretation of guidelines and addressing inconsistent and unreasonable policy.

Prior Board Action

June 2017, approved the Quality & Patient Safety Committee's recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Reviewed and approved an information paper "The Role and Value of Emergency Medicine in Accountable Care Organizations" in November 2015 which discussed metrics and quality measures for emergency medicine.

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

Amended Resolution 17(10) CMS payment Model Pilot Projects adopted.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 34(20)
SUBMITTED BY: New York Chapter
SUBJECT: Public/School Bleeding Control Kit Access and Training

PURPOSE: Support access to bleeding control kits in all schools and public venues nationwide and support the expansion of bleeding control training in schools and communities to support educated use of these kits.

FISCAL IMPACT: Budgeted expenses for the Until Help Arrives program.

1 WHEREAS, The average person is not prepared to be a first responder in the event of a crisis; and

2
3 WHEREAS, There are programs available from the American College of Emergency Physicians (Until Help
4 Arrives) and the American College of Surgeons (Stop the Bleed) to increase confidence and teach lifesaving skills;
5 and

6
7 WHEREAS, Every minute that passes in a hemorrhage situation waiting for emergency care to arrive
8 increases morbidity and mortality; and

9
10 WHEREAS, Multiple states have already passed laws funding or requiring bleeding control kits and training
11 in public schools; and

12
13 WHEREAS, Public sites and schools are already required to have public access automated external
14 defibrillators (AEDs) accessible; therefore be it

15
16 RESOLVED, That ACEP support access to bleeding control kits in all schools and public venues nationwide
17 akin to the automated external defibrillators (AED) access programs; and be it further

18
19 RESOLVED, That ACEP support the expansion of bleeding control training in schools and communities to
20 support educated use of these kits in the event of an emergency until help arrives.

Background

This resolution calls for ACEP to support access and training for bleeding control kits in all schools and public venues.

ACEP was a key stakeholder of the “Stop the Bleed” campaign when it was initiated by the White House and the National Security Council in October of 2015. The White House campaign was headed by ACEP member Richard Hunt, MD, FACEP, who was assigned as the Director for Medical Preparedness Policy at the National Security Council.

The initial decision was for ACEP to support the objectives of the “Stop the Bleed” campaign, which included public access to bleeding control kits and public training on their use. This was accomplished by promoting the campaign through the Prehospital-EMS Care Section, other related ACEP Sections, and ACEP’s National EMS Week Campaign. The American College of Surgeons – Committee on Trauma (ACS-COT) had a public focused bleeding control course already developed and ACEP was invited to partner on promotion of this course.

ACEP staff were tasked in the spring of 2018 to develop a new public-focused in-person course to include bleeding

control and lay-person CPR and present it in a course length of 60 minutes or less. Around the same time period, ACEP was approached by staff at the U.S. Dept of Health and Human Services (HSS)/Office of the Assistant Secretary for Preparedness and Response (ASPR) to support and help promote a new online bleeding control course they had developed. After reviewing the ASPR course, ACEP staff pursued integrating the bleeding control content into the new course in development by ACEP. ASPR agreed to allow use of their bleeding control content as well as the course name, [Until Help Arrives](#).

ACEP partnered with an existing vendor, Simulab, to develop resources for the course including several different bleeding control kits and a training kit designed specifically for the ACEP course. ACEP released the new Until Help Arrives course, which includes bleeding control and compression-only CPR, during *ACEP19* in Denver, CO. Plans were in place to market and promote the course aggressively during the spring/summer 2020 but has been delayed because of the impact of COVID-19. Staff are exploring options for an on-line version of the course should in-person public training be delayed long term.

The authors of this resolution are aware of the Until Help Arrives campaign and fully support it but believe emphasis on supporting access to the necessary equipment in schools and public venues is still needed.

ACEP Strategic Plan Reference

Goal 1 –Improve the Delivery System for Acute Care

Objective H – Position ACEP as a leader in emergency preparedness and response. This objective has a specific tactic to promote “Until Help Arrives” with a special emphasis on pilot projects involving chapters, outside partners, businesses, and civic groups.

Fiscal Impact

Budgeted expense for the Until Help Arrives program.

Prior Council Action

None

Prior Board Action

June 2019, approved funding for the Until Help Arrives campaign.

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 35(20)

SUBMITTED BY: Sara Brown, MD FACEP Alaska Chapter
Angela Cornelius, MD FACEP Georgia College of Emergency Physicians
John McManus, MD FACEP Government Services Chapter
Gina Piazza, DO FACEP Indiana Chapter
Allen Yee, MD FACEP Kansas Chapter
Air Medical Transport Section Maryland Chapter
EMS-Prehospital Care Section Texas College of Emergency Physicians

SUBJECT: Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care

PURPOSE: Take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

FISCAL IMPACT: Budgeted staff resources to convey ACEP’s position to federal Executive and Legislative branch officials.

1 WHEREAS, In 2016, The National Academy of Sciences published “A National Trauma Care System:
2 Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury” Recommendation
3 10: Congress, in consultation with the U.S. Department of Health and Human Services, should identify, evaluate, and
4 implement mechanisms that ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless
5 component of health care delivery rather than merely a transport mechanism; and
6

7 WHEREAS, EMS operates at the intersection of healthcare, public health, and public safety and integration
8 across the continuum of care delivery is essential to optimizing patient outcomes and to managing costs effectively; and
9

10 WHEREAS, Through an estimated nearly 26 million transport calls annually, prehospital EMS care is delivered
11 directly to patients, in the locations where help is needed, providing a measurable effect on mortality to certain life-
12 threatening medical emergencies; and
13

14 WHEREAS, EMS agencies are forced to limit services because of poor reimbursement, which leads to extended
15 delays for interfacility transports particularly in rural areas; and
16

17 WHEREAS, The groundbreaking work of innovative EMS clinicians to deliver healthcare as Mobile Integrated
18 Health or Community Paramedicine programs has demonstrated the benefit of these mobile providers of healthcare to
19 improve health and decrease cost of more conventional healthcare delivery models; and
20

21 WHEREAS, Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year trial payment model, in
22 which the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and clinicians to:
23 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations; 2)
24 transport to an alternative destination partner; or 3) provide treatment in place with a qualified health care partner, either
25 on the scene or connected using telehealth, and as a result, the ET3 model aims to improve quality and lower costs by
26 reducing avoidable transports to the ED and unnecessary hospitalizations following those transports; and

27 WHEREAS, EMS has demonstrated during the COVID-19 pandemic their ability to respond in new and
28 innovative ways to deliver medical care to include telehealth platforms, assisting with disease screening and testing, treat
29 and non-transport protocols, and providing immunizations; and
30

31 WHEREAS, EMS has stood with our emergency department partners on the front lines to provide care in this
32 pandemic and countless other disasters and EMS should be reimbursed for these services both within and outside of
33 pandemic response; and
34

35 WHEREAS, The Department of Transportation National Highway Traffic Safety Administration (NHTSA)
36 Office of EMS (and its precursor entities) has been the only federal agency to provide continuous support to the national
37 EMS systems development since the publication of the paper, “Accidental Death and Disability: the Neglected Disease of
38 Modern Society” by the National Academies of Sciences in 1966; and
39

40 WHEREAS, The NHTSA Office of EMS has led the development and maintenance of the National EMS
41 Information System (NEMSIS), the standardized repository for all EMS clinical care records; and
42

43 WHEREAS, The evolution of the healthcare system in the United States, to include the integration of prehospital
44 care as an outcomes-driven, appropriately remunerated, patient-centered element, will require the shared efforts of all
45 relevant stakeholders, including professional organizations (ACEP, NAEMSP, ACS-COT, NAEMT, AAA, NASEMSO,
46 etc.) and governmental agencies (NHTSA, DHS, DHHS, DOD, FCC, CMS, HRSA, etc.); and
47

48 WHEREAS, Emergency physicians are leaders in prehospital care, serving as medical directors, systems
49 directors, educators, and as care providers and they should play an integral role in evolution of the healthcare system as it
50 seeks to integrate prehospital care as a seamless component; and therefore be it
51

52 RESOLVED, That ACEP take a leadership role to ensure the inclusion of prehospital care (e.g., emergency
53 medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and be it
54 further
55

56 RESOLVED, That ACEP advocate for bidirectional data integration between hospitals and EMS; and be it
57 further
58

59 RESOLVED, That ACEP advocate for appropriate payment of EMS services to include all clinical services
60 separate from transport; and be it further
61

62 RESOLVED, That ACEP advocate for the development of a payment structure for EMS medical direction and
63 oversight including physician field response; and be it further
64

65 RESOLVED, That ACEP advocate for additional support to the National Highway Traffic Safety Administration
66 Office of EMS to allow for further federal leadership of EMS systems development and evolution and expansion of the
67 National EMS Information System; and be it further
68

69 RESOLVED, That ACEP collaborate with other stakeholder organizations to promote legislation that will allow
70 for the integration of reimbursed prehospital care into a seamless patient-centered system of healthcare delivery.

Background

This resolution directs ACEP to take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

The essence of this resolution revolves around the role ACEP should play in the development and support of the Mobile Integrated Healthcare/Community Paramedicine (MIH/CP) model of patient care. ACEP's legislative and regulatory priorities currently include working to promote appropriate guidelines and procedures for community paramedicine.

In June 2016, the ACEP MIH/PC Task Force developed an [information paper](#) on these issues. As stated in the primer: "Mobile integrated healthcare and community paramedicine (MIH/CP) is a term applied to a new model of community-based health care service delivery that often primarily uses emergency medical services (EMS) personnel and systems to provide acute medical care, coordination of services, healthcare maintenance, post-acute care, and prevention services to patients outside of routine EMS transport service to hospital destination care." While each community may have unique needs that may benefit from various aspects of this health care delivery model, there are several core services this model is designed to address – chronic disease management and injury prevention, reduced 911 requests and transports for non-urgent patients, and the ability to provide appropriate follow-up care for high-risk patients without hospital readmission. Since EMS services in the United States are essentially reimbursed only when an appropriate transport to a hospital, skilled nursing facility (SNF), or for renal dialysis treatments are provided, the MIH/PC model also seeks to derive reimbursement for these alternative services.

Proponents of the MIH/PC model suggest patients' health would be improved by helping them manage their chronic diseases, such as diabetes, high blood pressure, and high cholesterol, as well as reducing common injuries. This would be achieved through home visits/wellness checks to verify compliance with prescription medications and simple home improvements to prevent accidents. The MIH/PC model would also decrease "down time" between EMS calls and improve access to primary care services, especially in rural communities where many patients lack access to primary care and use 911 and EMS to receive health care services in non-emergency situations. Additional benefits of an MIH/PC model would be improved patient satisfaction with their overall health care experience and improved access to timely early warning signs of worsening conditions. Finally, by reducing non-emergency transports, it is argued that the system is keeping those resources available for true emergencies.

The Center for Medicare and Medicaid Innovation (CMMI) within the HHS' Center for Medicare & Medicaid Services (CMS) has established a demonstration program, the "Emergency Triage, Treat, and Transport (ET3) Model," to test the MIH/PC system and its potential benefits to Medicare beneficiaries and the Medicare program overall. ET3 is a voluntary, five-year payment model designed to "provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call." Under this model, CMS will reimburse Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers to either: (1) transport the patient to a hospital ED or other covered destination (see above), (2) transport to an alternative destination partner (primary care/urgent care), or (3) provide treatment in place with a qualified health care partner (either on the scene or connected using telehealth). These determinations would be made by establishing a medical triage line for low-acuity calls within an existing 911 dispatch operation.

As a result, the ET3 model "aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports." Any individual who calls 911 and is connected to a dispatch system that has incorporated a medical triage line under the model would be screened for eligibility for medical triage services prior to ambulance initiation. Upon arriving on scene, participating ambulance suppliers and providers may triage Medicare FFS beneficiaries to one of the model's interventions upon ambulance dispatch following a 911 call.

During the development of ET3, ACEP submitted comments to CMMI about important patient safeguards that should be incorporated into the model. Specifically, ACEP stated "all triage, treatment, transport, and destination decisions should be through direct oversight with EMS medical director physicians." While acknowledging the health care providers delivering these services should be credentialed by their participating EMS system's clinical oversight body, ACEP urged the model to "require the highest level of consult available, ideally with the EMS physician who is substantively familiar with resources available to the EMS system in the area it serves." ACEP further urged CMMI to require all EMS system applicants "to attest in their application that they will commit, attain, and maintain contemporaneous direct medical oversight by physicians board-certified in EMS Medicine." Finally, understanding that aspects of the demonstration project will likely change over time, ACEP highlighted one essential aspect that must remain – "proper safeguards for patient safety and responsible triage, treatment, transportation, and destination decisions obtained with continuous EMS medical director physician oversight."

The ET3 model was supposed to begin on May 1, 2020 but has been delayed until the fall because of COVID-19.

ACEP has long acknowledged the critical role EMS, and EMS physician medical directors, play as an integral component in the continuum of acute medical care. According to ACEP's "[Emergency Medical Services Interfaces with Health Care Systems](#)" policy statement: "EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare, providing acute medical assessment and interventional care contemporaneous with navigation of patients. Patients, particularly those with time-critical conditions, are best served in geographically appropriate health care facilities having the specialized capabilities and services, either on site or via appropriate communications modalities, required for their evidence-based, optimal clinical outcomes. Appropriate funding of coordinated continuum of care systems (e.g., trauma systems) is essential to promoting the availability of regionalization of healthcare. EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of healthcare to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients. EMS destination protocols must be constructed with the substantive leadership of the EMS system's physician medical director(s), always based primarily upon evidence-based clinical rationale, factoring geographical operational realities."

While appropriate physician oversight/supervision remains a core concept for ACEP, other factors that may be relevant for consideration by the ACEP Council regarding the long-term viability of these programs are financing, liability, the Prudent Layperson Standard (PLS), and the Emergency Medical Treatment and Labor Act (EMTALA).

Generally, where MIH/PC models currently exist, they are funded by grants or subsidized by hospital or other health care entities as cost saving vehicles, particularly in response to bundled payments and formation of Accountable Care Organizations (ACOs). As mentioned previously, CMS/CMMI is about to undertake the ET3 demonstration and while the administration of the program will be funded through normal federal appropriations, reimbursement for the services provided for either alternate transportation or on-site treatment will come from the Medicare Trust Fund. There is no current long-term model for financing these programs and no standardized reimbursement for MIH/PC activities at the federal level.

Since paramedics and EMTs provide health care services under the EMS physician medical director's license, the expanded practice roles for EMS physician medical directors involved with MIH/PC likely will require different malpractice coverage. The expanded services addressing wellness, prevention, care for the chronically ill, post-discharge care, social support networks, and increasing compliance for a local population. In addition to the potential added liability these services may create, the actual role of providing medical direction for an MIH/PC program may not be covered under the EMS medical director's traditional insurance plan.

Regarding PLS and EMTALA, ACEP has stressed that patient safety must always be the primary defining element when considering alternatives to ambulance response, ambulance transportation, and/or non-emergency department destinations. Per ACEP's "[Patient Autonomy and Destination Factors in Emergency Medical Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs](#)" policy statement: "Patients utilizing a prudent layperson standard of a medical emergency accessing emergency care via 911 (or equivalent) public safety answering points with acute, unscheduled, and undifferentiated medical conditions should be transported to an emergency department with clinical capabilities consistent with emergency care needs. Similar patients, but with stable, differentiated medical conditions that may be suitable for transportation to a destination other than an emergency department (e.g., mental health facility, sobering center, physician's clinical office) must be afforded at that alternative destination a medical screening exam (MSE) and stabilizing treatment by a qualified medical professional in accordance with [EMTALA]."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted staff resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

Resolution 34(13) Community Paramedicine adopted. Directed ACEP to develop a policy statements on the definition of community paramedicine and the role of the pre-hospital provider in community paramedicine; develop guidelines and standards and a clinical model.

Prior Board Action

June 2018, approved the policy statement "[Patient Autonomy and Destination Factors in Emergency Medical Services \(EMS\) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs](#);" replacing the following rescinded/sunsetted policy statements: Alternate Ambulance Transportation and Destination (2001-2018); Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018); and Refusal of Medical Aid (2000-2018).

June 2018, approved the policy statement "[Relationship Between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine](#)."

February 2018, approved the policy statement "[Emergency Medical Services Interfaces with Health Care Systems](#);" replacing the following rescinded policy statements: Ambulance Diversion (1991-2018); Emergency Ambulance Destination (1983-2018); EMS Regionalization of Care (2013-2018); and Interfacility Transportation of the Critical Care Patient and Its Medical Direction (1999-2018).

October 2017, approved the policy statement "[The Role of the Physician Medical Director in Emergency Medical Services Leadership](#);" replacing the following rescinded/sunsetted policy statements: Leadership in Emergency Medical Services (1995-2017); Medical Direction for Staffing of Ambulances (1999-2017); Medical Direction of Emergency Medical Services (1984-2017); Physician Medical Direction of Emergency Medical Services Dispatch Programs (1998-2017); and Professional Liability Insurance for EMS Medical Control Activities (1985-2017).

June 2016, reviewed the information paper "[Mobile Integrated Healthcare/Community Paramedicine \(MIH/CP\) Primer](#)."

Resolution 34(13) Community Paramedicine adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

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



RESOLUTION: 36(20)
SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter
SUBJECT: Telehealth Free Choice

PURPOSE: Support legislation that would: 1) make the CMS telehealth waivers that are allowed during the COVID-19 public health emergency permanent; 2) require insurers to allow enrollees to pick any physician and allow physicians to provide telehealth services for acute unscheduled care to any or all their insured patients; 3) require insurers to pay physicians and non-physician health providers for telehealth services at the same rate that the equivalent services are paid at when delivered in-person; 4) support penalties for insurers for any intentional actions that prevent access to necessary acute unscheduled care.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, Telehealth can provide effective and well needed care to patients from a remote location; and

2
3 WHEREAS, Telehealth increase access to patients who may otherwise be unable to receive medical attention;

4 and

5
6 WHEREAS, Telehealth is often an equivalent, sometimes superior, alternative to in-person care; and

7
8 WHEREAS, Telehealth has been used at numerous emergency departments for years and is received by
9 patients and practitioners; and

10
11 WHEREAS, Allowing patients to choose a physician or non-physician provider to provide healthcare services
12 to them is fair and would be well received; and

13
14 WHEREAS, CMS allows and does not limit the number of licensed physicians to provide services to CMS
15 patients; and

16
17 WHEREAS, CMS has realized the potential benefits offered to patients using telehealth; and

18
19 WHEREAS, During the SARS-CoV-2/COVID-19 pandemic, CMS waived many restrictions on telehealth,
20 including cost-sharing requirements, requiring the patient to be located at certain locations, and not reimbursing at
21 parity, or reimbursing at all, for telehealth services; and

22
23 WHEREAS, Some third-party payers restrict access by providing telehealth services but only to employed
24 non-physician providers or other employed health care workers; therefore be it

25
26 RESOLVED, That ACEP support legislation to make the CMS waivers that were allowed during the COVID-
27 19-declared emergency related to telehealth permanent, i.e., allow patient to be at any location, allow provider to be at
28 any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that
29 reflects the service provided; and be it further

30
31 RESOLVED, That ACEP support legislation mandating all payers to allow patients to select the physician of
32 their choice, whether employed, within the health insurer's network, or outside of insurer's network, without
33 restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; and be it
34 further

35 RESOLVED, That ACEP support legislation requiring all payers to pay parity to physician and non-physician
36 health providers for telehealth services as would be paid for in-person services for appropriate or equivalent care; and
37 be it further

38
39 RESOLVED, That ACEP support penalties to insurers for intentional actions, rules or policy that limit,
40 restrict, delay, deny or prevent access to necessary acute unscheduled care or services from the physician or non-
41 physician provider of the patient’s choice in an appropriate time period as determined by physicians in that region, or
42 national determined standard or in the payment to the practitioner for the care or services provided.

Background

This resolution calls on ACEP to support legislation that would: 1) make the CMS telehealth waivers that are allowed during the COVID-19 public health emergency permanent; 2) require insurers to allow their enrollees to pick any physician they choose and allow physicians to provide telehealth services for acute unscheduled care to any or all their insured patients; 3) require insurers to pay physicians and non-physician health providers for telehealth services at the same rate that the equivalent services are paid at when delivered in-person; and 4) support penalties for insurers for any intentional actions that prevent access to necessary acute unscheduled care.

In accordance with ACEP’s policy statement “[Emergency Medicine Telehealth](#),” which was revised and approved in February 2020, ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians. Before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED) evaluation and management (E/M) codes to the list of approved Medicare services. During the PHE, CMS took numerous steps to expand the use of telehealth under Medicare. Specifically, CMS temporarily added many codes, including all five ED E/M codes, to the list of approved telehealth services. That means that these codes are reimbursable under Medicare when delivered remotely via telehealth at the same rate as they are when the services are delivered in-person. Further, CMS used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas.

Over the spring and summer, administration officials, including the CMS Administrator, Seema Verma, have been vocal in their support of making some of the telehealth flexibilities available during the PHE permanent. **However, CMS does not have the legal authority to permanently waive the originating site and geographic restrictions.** Eliminating these telehealth restrictions requires legislation from Congress. ACEP sent a [letter](#) calling on Congress to take action immediately. Specifically, ACEP called on Congress to enact [S.2741, the Creating Opportunities Now for Necessary and Effective Care Technologies \(CONNECT\) for Health Act](#). This vital legislation sets the stage for permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve patient outcomes. In the letter to Congress and in a [separate opinion article](#), ACEP also called on state Medicaid programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare’s to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

ACEP’s policy statement “[Emergency Medicine Telehealth](#)” addresses two other key themes of this resolution – free choice of physicians and payment parity for telehealth services. With respect to patient choice of physicians providing telehealth services, ACEP “supports patient choices in the selection of a telemedicine provider, but with the understanding that by the nature of emergencies and hospital credentialing practices, a choice may not be available, as is also true of in-person staffing in emergency departments.” Further, with respect to reimbursement for telehealth services, ACEP believes that “telehealth services, like other health care services, should be reimbursed at a fair market value for the services rendered.” ACEP also “supports current efforts by the American Medical Association and other

stakeholders in advocating for appropriate billing and fair payment for services rendered by emergency physicians providing telehealth services.” The language in the statement builds off of Amended Resolution 28(14) Fair Payment for Telemedicine Services that directed ACEP to work with appropriate parties at the federal and state levels to advocate or legislation and regulation that will provide fair payment by all payers for appropriate services provided by telemedicine.

Finally, related to the last resolve, ACEP has historically pushed back against attempts from insurers to restrict access to care by narrowing their networks or limiting their benefit packages and has also supported penalties on insurers that have violated certain regulatory requirements. For example, ACEP [believes](#) that all insurance plans should cover all ten essential health benefits (EHBs), one of which is emergency services. Without such guaranteed coverage, consumers can be left with a narrow set of benefits that do not ensure access to the items and services they need to manage their health conditions. Further, in 2018, ACEP [endorsed](#) a CMS policy to impose civil monetary penalties and take other enforcement actions on Medicare Advantage Organizations (MAOs) that do not comply with provider directory requirements. Maintaining adequate networks is essential to ensuring that patients have access to the care they need. Finally, ACEP wrote a [letter](#) to CMS calling on the agency to add emergency physicians and other safety net providers in the list of specialty types that are subject to CMS network adequacy standards for Medicare Advantage plans. Currently, emergency medicine is not one of the specialty types that is subject to CMS’ standards. In that same letter, ACEP urged CMS to reward MA plans that choose to contract with telehealth providers who specialize in emergency medicine.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

May 2020, reviewed the information paper “[COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.](#)”

February 2020, approved the revised policy statement “[Emergency Medicine Telehealth;](#)” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

June 2016, approved the policy statement ““[Ethical Use of Telemedicine in Emergency Care.](#)”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015, approved the revised policy statement “[Definition of Emergency Medicine;](#)” revised April 2008 and April 2001; reaffirmed October 1998; revised April 1994 with current title; originally approved March 1986 as “Definition of Emergency Medicine and the Emergency Physician.”

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

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



RESOLUTION: 37(20)

SUBMITTED BY: Government Services Chapter
Illinois College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians Ohio Chapter
Pennsylvania College of Emergency Physicians
Emergency Telehealth Section

SUBJECT: Telehealth Implementation, Reimbursement, and Coverage

PURPOSE: 1) advance the responsible implementation of telehealth practices that are consistent with established policies and guidelines; 2) advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity telehealth visits; and 3) oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, There is a shortage of primary care and specialty physicians relative to need in large portions of
2 the United States; and

3
4 WHEREAS, Limited access to primary, emergency, and specialty healthcare leads to delays in care with
5 significant associated negative impact on health outcomes; and

6
7 WHEREAS, Transportation limitations and geographical location of healthcare practitioners pose barriers to
8 seeing a healthcare provider for millions of Americans; and

9
10 WHEREAS, Coordinating occupational, social, and family obligations with scheduling in-person healthcare
11 visits places significant burden on many Americans, particularly on individuals with elevated baseline risks related to
12 diminished socioeconomic status and social determinants of health; and

13
14 WHEREAS, Patients in rural areas have greater difficulty accessing care, elevated mortality rates from
15 common diseases, and higher percentages of unintentional drug overdose deaths; and

16
17 WHEREAS, In 2018, 21% of individuals with substance use disorders who perceived a need for treatment did
18 not know where to go to get treatment; and

19
20 WHEREAS, Limitations in the availability of primary and specialty care including post-acute care leads to
21 costly utilization of acute care and hospital-based services; and

22
23 WHEREAS, The COVID-19 pandemic has prompted rapid expansion of telehealth services to ensure ongoing
24 delivery of care and maintenance of physician practices while limiting in-person healthcare visits for the protection of
25 patients and healthcare facility staff; and

26
27 WHEREAS, Published evidence of telehealth outcomes has been encouraging in relation to improved access
28 to care, patient satisfaction, and outcomes; but, ongoing investigation of benefits and potential risks to guide definitive
29 recommendations of best practice is needed; and

31 WHEREAS, The American Medical Association (AMA), American College of Emergency Physicians
32 (ACEP), and other specialty organizations have developed guidelines regarding the ethical and responsible
33 implementation of telehealth practice, confidentiality, and patient safety standards; and
34

35 WHEREAS, The Centers for Medicare and Medicaid Services (CMS) have expanded reimbursement for
36 telehealth services including live video telemedicine visits, store and forward technology, remote patient monitoring,
37 email/phone/fax communication, and eConsults; and
38

39 WHEREAS, Forty-two states and the District of Columbia have passed private payer reimbursement
40 regulation or legislation including mandated parity for telehealth and in person medical visits in 5 states, but there
41 remains significant variability in state legislation guiding the reimbursement of telehealth; and
42

43 WHEREAS, Proposed telehealth legislation in some states has sought to apply restrictions to the care
44 delivered via telemedicine for reasons other than patient safety; therefore, be it
45

46 RESOLVED, That ACEP advance the responsible implementation of telehealth practice consistent with
47 policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific
48 best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; and be it
49 further
50

51 RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for state and federal
52 legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video
53 physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient
54 monitoring, eConsults, and store and forward technology; and be it further
55

56 RESOLVED, That ACEP oppose restrictions to telehealth care unless those restrictions are consistent with
57 established best practices, confidentiality, or patient safety protections.

References

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Background

This resolution calls on ACEP to: 1) advance the responsible implementation of telehealth practices that are consistent with established policies and guidelines; 2) advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity telehealth visits; and 3) oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

ACEP is actively engaged in advocacy efforts aimed at advancing the use of telehealth in emergency medicine.

In accordance with ACEP's policy statement "[Emergency Medicine Telehealth](#)," which was revised and approved in February 2020, ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians. From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. Before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED) evaluation and management (E/M) codes to the list of approved Medicare services. During the PHE, CMS took numerous steps to expand the use of telehealth under Medicare, all of which were endorsed by ACEP. Specifically, CMS temporarily added many codes, including all five ED E/M codes, to the list of approved telehealth services and allowed emergency physicians to perform medical screening exams – a component of the Emergency Medical Treatment and Labor Act (EMTALA) – a via telehealth.

Further, CMS used its unique "1135" waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas. ACEP has submitted a letter to Congress calling for the permanent removal of these two restrictions. ACEP supports [S.2741, the Creating Opportunities Now for Necessary and Effective Care Technologies \(CONNECT\) for Health Act](#), which sets the stage for permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve patient outcomes. In the letter to Congress and in a [separate opinion article](#), ACEP also called on state Medicaid programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare's to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

The "[Emergency Medicine Telehealth](#)" policy statement previously mentioned discusses ACEP's position on reimbursement for emergency telehealth services. ACEP believes that "telehealth services, like other health care services, should be reimbursed at a fair market value for the services rendered." In addition, ACEP "supports current efforts by the American Medical Association and other stakeholders in advocating for appropriate billing and fair payment for services rendered by emergency physicians providing telehealth services." The language in the policy statement builds off of Amended Resolution 28(14) Fair Payment for Telemedicine Services that directed ACEP to work with appropriate parties at the federal and state levels to advocate or legislation and regulation that will provide fair payment by all payers for appropriate services provided by telemedicine.

Finally, related to the last resolved calling on ACEP to "oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections," it is important to highlight CMS' [telehealth proposals](#) in the Calendar Year (CY) 2021 Physician Fee Schedule and Quality Payment Program proposed rule. In the proposed rule, CMS examines which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 PHE should remain on the list permanently. Codes on this list are reimbursable under Medicare when delivered remotely via telehealth at the same rate as they are when the services are delivered in-person. CMS proposes to keep ED E/M code levels 1-3 (CPT codes 99281-99283) on the approved telehealth list for the remainder of the year after the PHE expires (i.e., if the PHE ends in January 2021, the codes would remain on the list until December 31, 2021). However, CMS did not propose to include ED E/M levels 4 and 5 (CPT codes 99284 and 99285) on the list of approved Medicare services past the duration of the PHE. CMS believes that ED E/M code levels 4 and 5 cannot truly be conducted via two-way, audio/video telecommunications technology, because of the characteristics of patients who receive the services, the clinical complexity involved, the urgency for care, and the need for complex decision-making. Given CMS' stance on the appropriateness of delivering telehealth in certain circumstances, the Council should consider which restrictions, if any, it believes should be in place regarding the use of telehealth services.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

May 2020, reviewed the information paper “[COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.](#)”

February 2020, approved the revised policy statement “[Emergency Medicine Telehealth](#),” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

June 2016, approved the policy statement “[Ethical Use of Telemedicine in Emergency Care.](#)”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015, approved the revised policy statement “[Definition of Emergency Medicine](#),” revised April 2008 and April 2001; reaffirmed October 1998; revised April 1994 with current title; originally approved March 1986 as “Definition of Emergency Medicine and the Emergency Physician.”

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 38(20)

SUBMITTED BY Government Services Chapter Pennsylvania College of Emergency Physicians
Illinois College of Emergency Physicians Diversity, Inclusion, & Health Equity Section
Minnesota Chapter Emergency Telehealth Section
Missouri College of Emergency Physicians Rural Emergency Medicine Section
Ohio Chapter

SUBJECT: Universal Access to Telehealth Care

PURPOSE: Advocate for universal access to telehealth in all rural and underserved areas of the United States and to support innovative strategies to improve individual access to broadband and cellular technology.

FISCAL IMPACT: Budgeted staff resources.

1 WHEREAS, Access to primary, emergency, and specialty healthcare is limited for many Americans leading
2 to delays in care with significant associated negative impact on health outcomes; and
3

4 WHEREAS, The pandemic has demonstrated a growing place for telehealth in emergency care; and
5

6 WHEREAS, Transportation limitations and geographical location of healthcare practitioners pose barriers to
7 seeing a healthcare provider for millions of Americans; and
8

9 WHEREAS, The COVID-19 pandemic highlights that without high-quality broadband communication
10 services telehealth usage is drastically limited; and
11

12 WHEREAS, Access to broadband is a social determinant of health and therefore important to health equity;
13 and
14

15 WHEREAS, Structural inequalities in availability of healthcare services disproportionately disenfranchise the
16 poor, racial minorities, and other vulnerable communities; and
17

18 WHEREAS, According to a Pew Research Center survey conducted in 2019, 18% of low-income American
19 adults do not use the internet; and
20

21 WHEREAS, A Pew Research Center survey from 2019 indicates that low-income Americans have
22 substantially limited access to technology capable of connecting to telehealth care since only 71% have a smartphone,
23 54% have access to a home desktop or laptop computer, 36% own a tablet, and 56% have home broadband access;
24 and
25

26 WHEREAS, Patients in rural areas have greater difficulty accessing care, elevated mortality rates from
27 common diseases, and higher percentages of unintentional drug overdose deaths; and
28

29 WHEREAS, According to a Pew Research Center survey conducted in 2019, only 63 percent of rural
30 Americans say they have a broadband internet connection at home and are 12% less likely to have a smartphone,
31 limiting patients' access to telehealth in these communities; and
32

33 WHEREAS, The pandemic has made more evident disparities in telehealth capacity among low-income
34 populations, with inadequate broadband services a barrier particularly in rural communities; and

35 WHEREAS, As a result of the COVID-19 pandemic, the FCC has bolstered funding of its Telehealth
36 Program, the Centers for Medicare and Medicaid Services has expanded its telehealth policy, and there is bipartisan
37 Congressional support to strengthen broadband infrastructure, indicating interest by policymakers to expand
38 broadband infrastructure in rural and underserved communities; and

39
40 WHEREAS, Initiatives such as the Department of Housing and Urban Development’s ConnectHome pilot
41 and ConnectHomeUSA Expansion programs have capitalized on public-private partnerships to expand access to
42 broadband services, internet-capable devices, as well as digital education for low-income Americans; therefore, be it
43

44 RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for universal access to
45 telehealth care through expanded broadband infrastructure and wireless connectivity to all rural and underserved areas
46 of the United States as well as supporting innovative strategies to improve individual access to broadband and cellular
47 technology.

References:

1. Bauerly BC, McCord RF, Hulkower R, Pepin D. Broadband Access as a Public Health Issue: The Role of Law in Expanding Broadband Access and Connecting Underserved Communities for Better Health Outcomes. *J Law Med Ethics*. 2019;47(2_suppl):39-42. doi:10.1177/1073110519857314
2. “How The Rapid Shift To Telehealth Leaves Many Community Health Centers Behind During The COVID-19 Pandemic,” Health Affairs Blog, June 2, 2020. DOI: 10.1377/hblog20200529.449762
3. Pew Research Center, April 22, 2019. “10% of Americans Don’t Use the Internet. Who Are They?”
4. Pew Research Center, May 7, 2019. “Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption.”
5. Pew Research Center, June 2019. “Mobile Technology and Home Broadband 2019”.
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7. [AMA Telemedicine Policy](https://www.ama-assn.org/media/22056/download). American Medical Association Advocacy Resource Center. 2017. Available at: <https://www.ama-assn.org/media/22056/download>. Accessed 6/10/2020.

Background

This resolution calls on ACEP to advocate for universal access to telehealth in all rural and underserved areas of the United States and to support innovative strategies to improve individual access to broadband and cellular technology.

ACEP is actively engaged in advocacy efforts aimed at advancing the use of telehealth in emergency medicine.

The resolution cites recent analyses showing that many low-income Americans as well as individuals in rural areas do not have access to smart phones or broadband internet, thereby limiting their ability to receive vital telehealth services. Further, ACEP’s information paper [“Delivery of Emergency Care in Rural Settings”](#) specifically discusses the barriers that broadband and equipment availability /interoperability present in rural areas. The paper states that “although the costs of obtaining the hardware for telehealth assessments have been rapidly decreasing and may be minimal, some areas may lack sufficient capital or knowledge to establish a telehealth site or may be geographically located in areas without internet or broadband access. Another barrier relates to not having compatible interfaces among different healthcare providers. The information should flow seamlessly across the system. The implementation group of the telehealth program needs to consider both the electronic and spoken language challenges in the planning process.” The paper concludes by stating that telehealth dramatically improves “the access of health care across rural and underserved areas across the nation and the world. This system enables rural providers to maintain their knowledge base and skills and improves the rural populations’ access to needed, but difficult-to-recruit, specialists which can be lifesaving in the rare/high-risk scenarios when the full-time recruitment of a particular specialist for an area would be cost prohibitive. Telehealth use in the rural ED helps to bring a vast array of specialty expertise to the bedside in environments that are otherwise unable to provide these services.”

In accordance with ACEP’s policy statement [“Emergency Medicine Telehealth”](#) (most recently revised in February 2020), ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians.

From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. The Medicare statute currently restricts reimbursement for telehealth to services performed in rural areas. During the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive this restriction, as well as another restriction called the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home). ACEP has [supported](#) legislation that would permanently eliminate these restrictions, thereby allowing low-income Medicare beneficiaries in urban, underserved communities to also receive telehealth services from any location, including their home.

With respect to funding for broadband infrastructure, as referenced in the resolution, the Federal Communications Commission (FCC) has implemented initiatives to support health care providers who want to stand up telehealth programs in rural and underserved communities. First, the FCC established a [\\$200 million telehealth program](#) for healthcare providers responding to the COVID-19 PHE. Congress appropriated the funds as part of the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act. Through the COVID-19 Telehealth Program, the FCC helped healthcare providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. The FCC has closed applications for this program.

The FCC also has finalized regulations implementing a [Connected Care Pilot Program](#). This separate three-year Pilot Program will provide up to \$100 million of support to help defray health care providers’ costs of providing connected care services. ACEP supported this program and offered [comments](#) to the FCC when it was first proposed. The FCC has not yet begun accepting applications for this program.

Finally, on September 1, the U.S. Department of Health and Human Services (HHS), the FCC, and U.S. Department of Agriculture [announced](#) that they have signed a Memorandum of Understanding to work together on a Rural Telehealth Initiative. Through this new initiative, these departments will collaborate and share information that will address health disparities, resolve service provider challenges, and promote broadband services and technology to rural areas.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

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.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

May 2020, reviewed the information paper “[COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.](#)”

February 2020, approved the revised policy statement “[Emergency Medicine Telehealth;](#)” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs.

August 2017, reviewed the information paper “[Delivery of Emergency Care in Rural Settings.](#)”

June 2017, approved policy statement “[Definition of Rural Emergency Medicine.](#)”

June 2016, approved the policy statement “[Ethical Use of Telemedicine in Emergency Care.](#)”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control.

June 2015, approved the revised policy statement “[Definition of Emergency Medicine;](#)” revised and approved April 2008 and April 2001; reaffirmed October 1998; revised April 1994 with the current title; originally approved March 1986 as “Definition of Emergency Medicine and the Emergency Physician.”

Amended Resolution 28(14) Fair Payment for Telemedicine Services.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine.

Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

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



RESOLUTION: 39(20)

SUBMITTED BY: Marisa Dowling, MD
James Maloy, MD

SUBJECT: Urging the Prohibition of Law Enforcement Use of Rubber Bullets and Tear Gas for Crowd Control

PURPOSE: Join the American Academy of Ophthalmology in condemning the use of rubber bullets (and similar projectiles) and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, ACEP advocates for tolerance and respect for the dignity of all persons and supports the goal of
2 a society free from violence^{1,2}; and

3
4 WHEREAS, All Americans have the rights of freedom of speech and public assembly³; and

5
6 WHEREAS, ACEP, while recognizing the role of law enforcement in our society, notes that certain police
7 methods of crowd control have the potential to threaten the health of citizens⁴; and

8
9 WHEREAS, ACEP acknowledges that law enforcement use of rubber bullets and tear gas, though non-lethal,
10 can cause life-altering eye injuries, up to and including blindness^{5,6,7}; therefore be it

11
12 RESOLVED, That ACEP join the American Academy of Ophthalmology in condemning the use of rubber
13 bullets (and similar projectiles) and tear gas to control or disperse crowds and calling on all law enforcement officials
14 to permanently and immediately end these practices.

Background

The resolution calls for ACEP to join the American Academy of Ophthalmology (AAO) in condemning the use of rubber bullets and similar projectiles and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

On June 3, the AAO issued a [release](#) condemning the use of rubber bullets, other projectiles such as paintballs used to mark protestors, or tear gas to disperse protestors, and on June 4, the AAO issued an official [statement](#) on the use of rubber bullets for crowd dispersion. The statement reads:

“In the past week, Americans engaged in peaceful protests have been blinded by the use of rubber bullets fired at the face.

¹ <https://www.acep.org/patient-care/policy-statements/non-discrimination-and-harassment/>

² <https://www.acep.org/patient-care/policy-statements/violence-free-society/>

³ 1st Amendment, United States Constitution

⁴ <https://www.acep.org/life-as-a-physician/why-does-diversity-matter/>

⁵ <https://www.nytimes.com/2016/08/29/world/asia/pellet-guns-used-in-kashmir-protests-cause-dead-eyes-epidemic.html>

⁶ <https://www.nytimes.com/2019/11/19/world/americas/chile-protests-eye-injuries.html>

⁷ <https://www.aao.org/newsroom/news-releases/detail/nation-s-ophthalmologists-condemn-use-of-tear-gas->

While classified as non-lethal, they are not non-blinding. These life-altering injuries are a common result of urban warfare, rioting and crowd dispersion. We have seen it around the world, and we now see it in the United States.

Following numerous serious injuries in the past two weeks, the American Academy of Ophthalmology calls on domestic law enforcement officials to immediately end the use of rubber bullets to control or disperse crowds of protesters. The Academy asks physicians, public health officials and the public to condemn this practice.

Americans have the right to speak and congregate publicly and should be able to exercise that right without the fear of blindness. You shouldn't have to choose between your vision and your voice."

The AAO's statement was endorsed by a number of other organizations, including the American Academy of Allergy, Asthma and Immunology, the American Academy of Family Physicians, the American College of Surgeons, the American Geriatrics Society, the American Society of Nephrology, the Council of Medical Specialty Societies, the Sociedad Chilena de Oftalmología (Chilean Society of Ophthalmology), and the Society of Interventional Radiology.

Rubber bullets, projectiles such as pepper balls or paintballs, pepper spray, and tear gas, are "less-lethal" alternatives used by law enforcement to control riots or disperse protestors. While described as "less-lethal," these can often still result in serious injuries or death. In the U.S., recent nationwide protests against the use of force and violence by law enforcement have seen these tools employed against peaceful protestors, including injuries to [members of the media](#) and [other innocent bystanders](#).

Rubber bullets and other kinetic impact projectiles (KIPs) can cause a number of serious injuries such as blindness, permanent disabilities, nerve damage, fractures, and even death. A [2017 study](#) in the British Medical Journal examined data on injuries and death from the use of KIPs:

"...these projectiles have caused significant morbidity and mortality during the past 27 years, much of it from penetrative injuries and head, neck and torso trauma. Given their inherent inaccuracy, potential for misuse and associated health consequences of severe injury, disability and death, KIPs do not appear to be appropriate weapons for use in crowd-control settings."

Regarding the use of tear gas, pepper spray, or other chemical irritants, as AAO notes, tear gas does not typically cause irreversible injury to the eye but can still cause severe eye injuries. Nevertheless, tear gas or pepper spray can cause other serious injuries, especially for those with underlying health conditions such as asthma or chronic obstructive pulmonary disease (COPD), potentially resulting in respiratory failure or death.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 34(18) Violence is a Health Issue adopted. Directed ACEP to recognize violence as a health issue addressable through medical and public health interventions, and to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

Resolution 14(15) Body-Worn Cameras for Police not adopted. Directed ACEP to create a policy statement endorsing laws requiring police officers to wear body-worn cameras.

Resolution 22(10) Police Pursuits not adopted. Directed ACEP to strongly encourage use of safer alternatives to police pursuits, support enactment of laws requiring law enforcement agencies to accept responsibility for their actions regarding police pursuits and support mandatory tracking of pursuit-related injury data by NHTSA.

Amended Resolution 21(08) Excited Delirium adopted. Directed ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

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 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

April 2019, revised and approved the policy statement “[Violence-Free Society;](#)” reaffirmed June 2013; revised and approved January 2007; reaffirmed 2000; originally approved January 1996.

June 2018, approved the revised policy statement “[Non-Discrimination and Harassment;](#)” revised and approved April 2012 with the current title; originally approved October 2005.

Amended Resolution 34(18) Violence is a Health Issue adopted.

Substitute Resolution 41(05) Non-Discrimination adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

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

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



2020 Council Meeting Reference Committee Members

Reference Committee C Emergency Medicine Practice Resolutions 40-52

Hilary Fairbrother, MD, FACEP (TX) Chair
Shamie Das, MD, FACEP (GA)
Heather M. Heaton, MD, FACEP (MN)
Todd Slesinger, MD, FACEP (FL)
Alison Smith, MD, MPH, (UT)
Nicole A. Veitinger, DO, FACEP (OH)

Margaret Montgomery, RN, MSN
Paul Krawietz
Mandi Mims, MLS



RESOLUTION: 40(20)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: Addressing Critical Need for PPE by Emergency Physicians During a Pandemic

PURPOSE: 1) Develop a stockpile of airborne and contact level PPE to include five N95 respirators, five surgical masks, five gowns and one face shield that would be available to members on request during a pandemic to mitigate delays from normal supply chains. 2) ACEP partner with hospitals and other organizations to donate or sell PPE stockpiled for members when their expiration dates near and replenish the stockpile to maintain adequate volumes for members.

FISCAL IMPACT: Based on prices as of August, the estimated costs for purchasing the PPE stockpile for 40,000 members is \$1,345,600. If prices returned to pre-COVID levels, total purchase costs would be approximately \$156,000. The expense would be repeated prior to the expiration date of each type of PPE, which could be partially offset if buyers could be found sometime prior to the expiration date. Additional unknown expense to store the stockpiled PPE and mailing/shipping costs. Additional staffing may also be required.

1 WHEREAS, The recent coronavirus disease of 2019 (COVID-19) pandemic has resulted in critical supply
2 shortages of personal protective equipment (PPE) for healthcare workers (HCW)¹; and
3

4 WHEREAS, appropriate use of PPE by HCWs can protect them from contracting COVID-19 and other
5 infections^{2,3}; and
6

7 WHEREAS, COVID-19 guidelines recommend HCWs wear gloves, eye protection, gown and at least a
8 simple mask for routine care or an N95 respirator for care during aerosol generating procedures^{4,5}; and
9

10 WHEREAS, Despite efforts to reuse, reclaim, repurpose and create PPE, the shortage remains and the demand
11 during the COVID-19 pandemic has created cost mark ups as high as 1,500% for simple masks, 1,513% for N95
12 respirators and 2000% for gowns^{6,7}; and
13

14 WHEREAS, The Strategic National Stockpile was inadequately maintained and has been unable to meet the
15 demand for PPE by HCWs⁸; and
16

17 WHEREAS, ACEP dues stand at \$615 per year and this would be an ACEP benefit available for members;
18 therefore be it
19

20 RESOLVED, That ACEP develop a stockpile of airborne and contact level personal protection equipment
21 that would include five N95 respirators, five surgical masks, five gowns, and one face shield available to members on
22 request during a pandemic to mitigate delays from normal supply chains; and be it further
23

24 RESOLVED, That ACEP partner with hospitals or other organizations to donate or sell personal protection
25 equipment stockpiled for members when the expiration dates are near to prevent waste and automatically replenish the
26 stockpile to maintain adequate volumes for our membership.

References:

1. Ranney ML, Griffeth V, Jha AK. Critical Supply Shortages - The Need for Ventilators and Personal Protective Equipment during the Covid-19 Pandemic. *N Engl J Med.* 2020;382(18):e41.
2. Yao W, Wang T, Jiang B, et al. Emergency tracheal intubation in 202 patients with COVID-19 in Wuhan, China: lessons learnt and international expert recommendations. *Br J Anaesth.* 2020.
3. Offeddu V, Yung CF, Low MSF, Tam CC. Effectiveness of Masks and Respirators Against Respiratory Infections in

- Healthcare Workers: A Systematic Review and Meta-Analysis. *Clin Infect Dis*. 2017;65(11):1934-1942.
4. CDC. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Centers for Disease Control and Prevention. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>. Published 2020. 41 Updated 2020-05-18. Accessed 2020-05-26.
 5. Alhazzani W, Moller MH, Arabi YM, et al. Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19). *Crit Care Med*. 2020.
 6. Livingston E, Desai A, Berkwits M. Sourcing Personal Protective Equipment During the COVID-19 Pandemic. *JAMA*. 2020.
 7. Berklan J. Analysis: PPE costs increase over 1,000% during COVID-19 crisis. McKnight's Long-Term Care News. <https://www.mcknights.com/news/analysis-ppe-costs-increase-over-1000-during-covid-19-crisis/>. 48Published 2020. Updated 2020-04-09. Accessed 2020-05-26.
 8. Budd K. Where is all the PPE? AAMC News. <https://www.aamc.org/news-insights/where-all-ppe>. Published 2020. Updated 2020-03-27. Accessed 2020-05-26.

Background

The resolution calls for ACEP to develop a stockpile of airborne and contact level personal protection equipment to include five N95 respirators, five surgical masks, five gowns and one face shield that would be available to members on request during a pandemic to mitigate delays from normal supply chains. Additionally, the resolution requests that ACEP partner with hospitals and other organizations to donate or sell PPE stockpiled for members when their expiration dates near and replenish the stockpile to maintain adequate volumes for members.

From the early appearance of COVID-19 in the United States and across much of the world, and continuing to a large degree to this day, one of the most significant obstacles to providing appropriate care to patients and protecting the emergency medical personnel responding to the pandemic has been the widespread critical shortage of N95 respirators and other PPE. Inadequate initial stockpiles followed by demand that quickly overwhelmed normal supply chains put emergency physicians and other health care workers at immediate significant risk as they were forced to reuse PPE far beyond safety limitations or work with substandard or even homemade materials in desperate efforts to provide a minimal level of protection while taking care of their patients.

ACEP worked to address the catastrophic impacts of the PPE shortages on multiple fronts. In March 2020, ACEP issued the policy statement [COVID-19: Personal Protective Equipment \(PPE\) During the Pandemic](#). The policy included a statement that “close contact during procedures or processes (including a physical examination) that generate potentially infectious aerosols requires a higher level of PPE that includes an N95 respirator.” In April 2020, the College issued an additional statement [COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment \(PPE\)](#), which stated in part that “Processes and procedures that create higher risk, such as close contact and aerosolizing procedures, require full PPE, including N95s. Because the inadequate PPE supply increases the risk to our physicians, they have taken to buying their own PPE or utilizing donations from other industries. ACEP urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.”

In March, ACEP partnered with GetUsPPE.org to help get PPE to the frontlines of the COVID-19 pandemic, by coordinating donations of PPE to hospitals in need. ACEP reached out to 28 trade associations as a part of this collaborative campaign to drive more PPE donations to local emergency departments. ACEP also partnered with [Project N95](#), the National Critical Equipment Clearinghouse for PPE and critical equipment, to vet suppliers claiming to have large quantities of quality PPE for sale and connect legitimate suppliers with hospitals, health systems and local and state governments looking to make bulk purchases.

ACEP launched a campaign to engage its membership to send their members of Congress an email urging them to ensure PPE is prioritized for frontline personnel. As of August 23, there were 34,917 individuals who have already taken action.

Early in March, ACEP sent every member of Congress and other policymakers a series of key policy changes necessary to mitigate the impact and spread of the virus in the U.S. and support emergency physicians and other frontline responders to the pandemic.

Outraged by the growing reports of employers retaliating against frontline health workers who are trying to ensure workplace safety during this pandemic, ACEP partnered with leading health care organizations to issue a joint statement on March 30 : [Urgent Call for Federal Action to Address Medical Equipment Shortages](#). The statement called for an increase in the PPE supply and deployment to the areas in most critical need.

ACEP has worked with key decisionmakers within the Trump Administration and Congress to address many issues facing emergency physicians, especially those related to PPE. For example, the College has had weekly conversations with the Centers for Disease Control and Prevention (CDC) to discuss best clinical practices, share experiences from the ground, and hear more about current or upcoming guidance that could impact emergency physicians and their patients. ACEP has shared the insights it has gleaned from the CDC on [ACEP's COVID-19 website](#) and the [COVID-19 communications hub](#). ACEP has also shared personal (anonymized) stories of its members about ongoing struggles obtaining PPE or being able to use their own PPE without fear of reprisal with the Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), and the American Hospital Association. In the last week of March 2020, ACEP had a call with TJC to convey the College's concerns that hospitals were punishing or forbidding staff from wearing their self-purchased or donated PPE. On March 31, TJC issued a [statement](#) supporting emergency physicians' right to bring their own standard face masks or respirators to wear at work when their healthcare organizations cannot provide access to PPE routinely that is commensurate with their risk of exposure. TJC also posted an [FAQ](#) about this statement.

On April 28, ACEP hosted its Virtual Hill Day during which nearly 500 ACEP members representing 45 states conducted 306 online meetings with legislators to discuss COVID-19 concerns: PPE, hazard pay, liability relief, and more. Nearly 50% of the meetings were with legislators or senior staff, and ACEP members were able to share their personal perspectives from the front lines.

On June 26, ACEP submitted its [response](#) to the Senate Health, Education, Labor, and Pensions (HELP) Committee regarding its "Preparing for the Next Pandemic" [white paper](#), focused on five areas where Congress should work with federal departments and agencies, states, and the private sector. In the letter, ACEP raised significant concerns about the inappropriate allocation and re-use of PPE.

On July 2, the House Select Subcommittee on the Coronavirus Crisis held a hearing, "The Administration's Efforts to Procure, Stockpile, and Distribute Critical Supplies," to examine efforts to acquire PPE, COVID-19 testing supplies, and other critical supplies needed to respond to the coronavirus pandemic. ACEP submitted a [letter](#) for the record to highlight ongoing shortages of these supplies and how they affect emergency physicians' ability to effectively treat patients during the pandemic.

As some PPE became sporadically available for individual purchase, ACEP worked to provide members ways to take advantage of those opportunities. On June 16, ACEP announced its partnership with Amazon. The partnership allowed members priority access to cleaning supplies, PPE, and more. In August, ACEP partnered with Project N95 and more than a dozen other national specialty societies to provide members of the participating societies a one-week window to purchase N-95 masks and other PPE at volume prices.

The volume pricing available through the Project N95 offer included:

- N95 Respirators: \$4.56/mask – \$5.11/mask
- Isolation Gowns (AAMI Level 1): \$1.41/gown
- Face Shields: \$0.84/shield
- Surgical Masks were not included in the offering but were available through Project N95 at \$0.29 – \$0.58.

While the amounts charged through the special offering represented a substantial discount from what could be purchased individually in August, they were significantly higher than the costs of PPE prior to the pandemic. According to a [report by the Society for Healthcare Organization Procurement Professionals](#) (SHOPP), prices that skilled nursing facilities and assisted living centers paid pre-COVID were:

- N95 Respirators: \$0.38/mask
- Isolation Gowns: \$1.41/gown
- Face Shields: \$0.50/shield
- 3-Ply Surgical Masks: \$0.05

ACEP currently has more than 40,000 members and it is unknown how many members would request PPE from the stockpile. Based on 40,000 members, ACEP would need to purchase and stockpile:

- 200,000 N95 respirators: \$4.75/mask = \$950,000
- 200,000 isolation gowns: \$0.25/gown = \$282,000
- 200,000 surgical masks: \$0.40/mask = \$80,000
- 40,000 face shields: \$0.84/shield = \$33,600

The total estimated expenditure is \$1,345,600. If prices return to pre-COVID levels as measured by the SHOPP report, the costs of providing all members with these same supplies would be \$76,000 for N95 respirators; \$50,000 for gowns; \$10,000 for surgical masks; and \$20,000 for face shields for a total expenditure of \$156,000. ACEP would incur additional costs for offsite storage to contain the stockpiled PPE, additional costs for mailing/shipping the PPE to members, and potentially additional staffing to manage the supply, demand, and monitoring of expiration dates, and reselling if possible prior to the expiration date.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective H - Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Based on prices as of August, the estimated costs for purchasing the PPE stockpile for 40,000 is \$1,345,600. If prices returned to pre-COVID levels, the total purchase costs would be approximately \$156,000. This expense would be repeated prior to the expiration date of each type of PPE, which could be partially offset if buyers could be found sometime prior to the expiration date. Additional unknown expense to store the stockpiled PPE and mailing/shipping costs. Additional staffing may also be required.

Prior Council Action

None

Prior Board Action

March 2020, approved the policy statement “COVID-19: [Personal Protective Equipment \(PPE\) During the Pandemic.](#)”

March 2020, approved the policy statement “[COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment.](#)”

June 2016, approved the revised policy statement “[Personal Protective Equipment Guidelines for Health Care Facility Staff.](#)” reaffirmed October 2009; originally approved August 2003.

April 2014, approved the revised policy statement “[Emergency Department Planning and Resource Guidelines.](#)” revised and approved October 2007, June 2004 and June 2001 with the current title; reaffirmed September 1996;

originally approved December 1985 with the title “Emergency Care Guidelines.” The policy statement includes a list of suggested equipment and supplies for emergency departments which includes “personal protective equipment- gloves, eye goggles, face mask, gowns, head and foot covers.”

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 41(20)
SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section
SUBJECT: Personal Protection Equipment

PURPOSE: Establish new policy statements that hospitals maintain adequate supply of personal protection equipment, employer or staffing company supply appropriate and adequate supply of personal protection equipment, and emergency physicians and other emergency workers be permitted to provide their own personal protection equipment.

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

1 WHEREAS, Personal protection equipment (PPE) is intended to protect healthcare and other workers from
2 various potentially harmful “things” including but not limited to viruses, bacteria, fungi, and other infectious
3 organisms, radioactive material, various vapors, heat, caustic substances and materials, acids, irritants, etc.; and
4

5 WHEREAS, PPE can include gloves, masks, respirators, eye protection, face shields, self-contained breathing
6 apparatus, impermeable gowns, a combination of these or many other items; and
7

8 WHEREAS, It is typically the host hospital’s duty to provide necessary equipment for workers at the facility
9 to protect themselves and/or others; and
10

11 WHEREAS, Many hospitals do not maintain adequate PPE supplies to protect the healthcare workers during
12 a disaster or pandemic as became obvious during the SARS-CoV-2/COVID-19 pandemic in 2020 in the United
13 States; and
14

15 WHEREAS, During the recent SARS-CoV-2/COVID-19 pandemic, many emergency physicians expressed
16 concerns that hospitals did not have sufficient supplies of PPE for healthcare workers to adequately protect
17 themselves as recommended by manufacturers of the PPE and medical personnel; and
18

19 WHEREAS, In April 2020, the ACEP statement on PPE in COVID-19: Personal protective equipment (PPE)
20 during the pandemic indicated: “that health care personnel (HCP) in the emergency department (ED) and emergency
21 medical services (EMS) should consider wearing a face mask or surgical mask during their entire shift if they are
22 providing patient care, unless the mask becomes soiled and needs replacement,”¹ but did not address its
23 recommendations when this recommendation conflicted with the recommended use of such PPE by the PPE
24 manufacturers; and
25

26 WHEREAS, A stronger worded recommendation or guidance statement from ACEP would help emergency
27 physicians in helping to protect themselves, their co-workers, and patients; and
28

29 WHEREAS, Some physicians and other health care workers obtained their own PPE to use at work to protect
30 themselves; and
31

32 WHEREAS, Some hospitals have policies that prohibit self-provided PPE to be used in their hospitals
33 creating concern from emergency physicians of being penalized for simply trying to protect themselves in the
34 workplace; therefore be it
35

36 RESOLVED, That ACEP establish a new policy that hospitals must maintain adequate supply of personal

37 protection equipment to supply all emergency and other workers that may be necessary during an infectious,
38 radioactive, chemical, or biologic disaster for at least a 60-day minimum when used as directed by the manufacturer;
39 and be it further

40
41 RESOLVED, That ACEP establish a new policy that in the event any hospital fails to provide adequate
42 personal protection equipment in terms of quantity, particular type. and quality, to its emergency workers the
43 employer or staffing company is responsible and will immediately supply appropriate and adequate personal
44 protection equipment for the physicians and non-physicians staffing the emergency department and other sites; and be
45 it further

46
47 RESOLVED, That ACEP establish a new policy supporting emergency physicians and other emergency
48 workers providing their own personal protection equipment without any penalty of any kind if the hospital or other
49 “employer” (staffing company) fails to provide adequate and sufficient personal protection equipment to be used as
50 intended by the manufacturer of the personal protection equipment.

ⁱ American College of Emergency Physicians April 2020 Statement on PPE. July 13, 2020. <https://www.acep.org/corona/covid-19-field-guide/work-safety/acep-statements-on-ppe/>

Background

This resolution calls for the College to establish new policy statements that hospitals maintain adequate supply of personal protection equipment, employer or staffing company supply appropriate and adequate supply of personal protection equipment, and emergency physicians and other emergency workers be permitted to provide their own personal protection equipment.

In March and April 2020, ACEP issued two statements that emphasized the role of the emergency care team as the front line in the recent SARS-CoV-2/COVID-19 pandemic and the importance of appropriate personal protective equipment.

The policy statement “[COVID-19: Personal Protective Equipment \(PPE\) During the Pandemic](#),” firmly emphasizes that “health care personnel (HCP) in the emergency department (ED) and emergency medical services (EMS) should consider wearing a face mask or surgical mask during their entire shift if they are providing patient care, unless the mask becomes soiled and needs replacement.”

The policy statement “[COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment \(PPE\)](#)” clearly states that “ACEP has and will continue to support the use of surgical masks with proper eyewear and other protective equipment for physicians and other individuals caring for patients, regardless of their complaint.” The College also advocated for hospitals to permit emergency physicians and other emergency workers to provide their own personal protection equipment by adding that “Because the inadequate PPE supply increases the risk to our physicians, they have taken to buying their own PPE or utilizing donations from other industries. ACEP urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.”

The College noted that emergency physicians and health systems around the country were facing severe shortages of PPE, such as N95 masks, that left many health professionals insufficiently protected in the midst of the SARS-CoV-2/COVID-19 pandemic. In March, ACEP partnered with [GetUsPPE.org](#) to help get PPE to the frontlines of the COVID-19 pandemic, by coordinating donations of PPE to hospitals in need. ACEP reached out to 28 trade associations as a part of this collaborative campaign to drive more PPE donations to local emergency departments. ACEP also partnered with [Project N95](#), the National Critical Equipment Clearinghouse for PPE and critical equipment, to vet suppliers claiming to have large quantities of quality PPE for sale and connect legitimate suppliers with hospitals, health systems and local and state governments looking to make bulk purchases.

ACEP received reports of workarounds that many of our physicians had to resort to that compromised the protection that appropriate PPE is designed to provide. Because of these reports and shortages, ACEP launched a campaign to

engage the ACEP membership to send their members of Congress an email urging them to ensure PPE is prioritized for frontline personnel. As of August 23, there were 34,917 individuals who have already taken action.

Additionally, early in March, ACEP sent every member of Congress and other policymakers a series of key policy changes necessary to mitigate the impact and spread of the virus in the U.S. and support emergency physicians and other frontline responders to the epidemic.

Outraged by the growing reports of employers retaliating against frontline health workers who are trying to ensure workplace safety during this pandemic, ACEP partnered with leading health care organizations to issue a joint statement on March 30: [Urgent Call for Federal Action to Address Medical Equipment Shortages](#). The statement called for an increase in the PPE supply and deployment to the areas in most critical need.

ACEP has worked with key decisionmakers within the Trump Administration and Congress to address many issues facing emergency physicians, especially those related to PPE. For example, the College has had weekly conversations with the Centers for Disease Control and Prevention (CDC) to discuss best clinical practices, share experiences from the ground, and hear more about current or upcoming guidance that could impact emergency physicians and their patients. ACEP has shared the insights it has gleaned from the CDC on [ACEP's COVID-19 website](#) and the [COVID-19 communications hub](#). ACEP has also shared personal (anonymized) stories of its members about ongoing struggles obtaining PPE or being able to use their own PPE without fear of reprisal with the Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), and the American Hospital Association. In the last week of March 2020, ACEP had a call with TJC to convey the College's concerns that hospitals were punishing or forbidding staff from wearing their self-purchased or donated PPE. On March 31, TJC issued a [statement](#) supporting emergency physicians' right to bring their own standard face masks or respirators to wear at work when their healthcare organizations cannot provide access to PPE routinely that is commensurate with their risk of exposure. TJC also posted an [FAQ](#) about this statement.

On April 28, ACEP hosted its Virtual Hill Day during which nearly 500 ACEP members representing 45 states conducted 306 online meetings with legislators to discuss COVID-19 concerns: PPE, hazard pay, liability relief, and more. Nearly 50% of the meetings were with legislators or senior staff, and ACEP members were able to share their personal perspectives from the front lines.

On May 21, the recently-established House Select Subcommittee on the Coronavirus Crisis held a virtual briefing featuring essential and frontline workers, including a prominent ACEP member. The panelists noted the personal risks exacerbated by a lack of adequate PPE, as well as the emotional and mental health toll the pandemic has taken on frontline workers. The panelists also discussed the lack of access to rapid testing, fair pay and compensation such as hazard pay, and paid leave protections. In response to a question from Rep. Andy Kim (D-CA) as to whether the U.S. is prepared for a potential second wave of infection, the panelists warned that we are not yet prepared given the lack of testing, PPE, scientific progress on fighting the virus, and inconsistent public health guidance.

On June 16, ACEP announced its partnership with Amazon. The partnership allowed members access to cleaning supplies, PPE, and more. ACEP's new central business account allowed members to purchase important supplies to keep their homes safe or supplement items they may need on shift before the general public.

On June 26, ACEP submitted its [response](#) to the Senate Health, Education, Labor, and Pensions (HELP) Committee regarding its "Preparing for the Next Pandemic" [white paper](#), focused on five areas where Congress should work with federal departments and agencies, states, and the private sector. In the letter, ACEP raised significant concerns about the inappropriate allocation and re-use of PPE.

On July 2, the House Select Subcommittee on the Coronavirus Crisis held a hearing, "The Administration's Efforts to Procure, Stockpile, and Distribute Critical Supplies," to examine efforts to acquire PPE, COVID-19 testing supplies, and other critical supplies needed to respond to the coronavirus pandemic. ACEP submitted a [letter](#) for the record to highlight ongoing shortages of these supplies and how they affect emergency physicians' ability to effectively treat patients during the pandemic.

On July 16, ACEP President, William Jaquis, MD, FACEP, and ACEP staff met with officials from the Occupational Safety and Health Administration (OSHA). During the meeting, ACEP shared de-identified stories from emergency physicians who have been penalized by their hospitals for wearing their own PPE or for speaking out publicly about PPE shortages or other issues. The College strongly urged OSHA to revise their standards and guidance to better protect emergency physicians and re-enforce their right to wear PPE that they believe keeps them safe. ACEP also asked OSHA to respond as quickly as possible to formal complaints filed by emergency physicians.

In August, ACEP partnered with Project N95 and more than a dozen other national specialty societies to provide members a one-week opportunity to purchase N-95 masks and other PPE at volume prices.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective H - Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff resources for development of policy statements.

Prior Council Action

None

Prior Board Action

March 2020, approved the policy statement “COVID-19: [Personal Protective Equipment \(PPE\) During the Pandemic.](#)”

March 2020, approved the policy statement “[COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment.](#)”

June 2016, approved the revised policy statement “[Personal Protective Equipment Guidelines for Health Care Facility Staff;](#)” reaffirmed October 2009; originally approved August 2003.

April 2014, approved the revised policy statement “[Emergency Department Planning and Resource Guidelines;](#)” revised and approved October 2007, June 2004 and June 2001 with the current title; reaffirmed September 1996; originally approved December 1985 with the title “Emergency Care Guidelines.” The policy statement includes a list of suggested equipment and supplies for emergency departments which includes “personal protective equipment-gloves, eye goggles, face mask, gowns, head and foot covers.”

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 42(20)

SUBMITTED BY: Florida College of Emergency Physicians
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians

PURPOSE: Develop policy statements addressing ethical, safety, and financial challenges faced by emergency physicians during the COVID-19 pandemic and in future medical crises.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, COVID-19 is a global pandemic caused by a virus with easy respiratory droplet transmission and
2 significant morbidity and mortality; and

3
4 WHEREAS, Emergency physicians are on the frontline of responding to the pandemic; and

5
6 WHEREAS, There have been many reports of inadequate personal protective equipment (PPE) for emergency
7 physicians and other emergency department and emergency medical services personnel; and

8
9 WHEREAS, There have been emergency physicians and other emergency department and emergency medical
10 services personnel who have suffered from COVID-19, some of whom have been critically ill or died as a result; and

11
12 WHEREAS, Emergency physicians and other emergency department and emergency medical services
13 personnel are at risk of transmitting COVID-19 to family members and others in close proximity to where they live or
14 work; and

15
16 WHEREAS, Some emergency physicians have had inadequate resources, specifically as relates to critical
17 care, relative to the patients they encountered during the pandemic; and

18
19 WHEREAS, There have been multiple reports of hospitals and other practice entities making disproportionate
20 and potentially permanent reductions in compensation or benefits beyond the demands of the current emergency and
21 recovery of the institution; and

22
23 WHEREAS, ACEP has put forward policy statements on personal protective equipment as relates to the
24 COVID-19 pandemic, but has not to date considered whether related policies more broadly applicable in future
25 pandemics or related events are needed; and

26
27 WHEREAS, Future pandemics may cause similar ethical concerns; therefore be it

28
29 RESOLVED, That ACEP develop policy statements to address:

- 30
31 1) the implications for emergency physicians of inadequate personal protective equipment;
32 2) conflicts with hospitals and practice organizations on the use of self-purchased personal protective
33 equipment;
34 3) crisis treatment standards; and
35 4) the proportionality of responses by hospitals and practice organizations toward emergency physicians'
36 compensation or benefits during times of pandemic illness or other similar events.

Background

This resolution calls for the College to develop policy statements addressing ethical, safety and financial challenges faced by emergency physicians during the COVID-19 pandemic and in future medical crises.

The novel coronavirus disease (COVID-19) is a global pandemic and continues to spread nationally and internationally. In carrying out their duty to provide medical treatment to patients affected by this dangerous virus, emergency physicians and other emergency medicine personnel have struggled to obtain adequate personal protective equipment (PPE) and other needed resources, specifically as they relate to patient critical care. These inadequate resources have endangered the lives of ACEP members and other medical professionals, their families and the community at large.

Further, as a result of reduced revenue caused by the cancellation of elective procedures in many states and a nationwide decline in emergency department visits, among other factors, hospitals and other practice management groups have reduced pay and benefits for many emergency physicians. [CBS News April 2020](#)

The Board of Directors approved several new policy statements related to the COVID-19 pandemic. ACEP also developed [a number of resources; including topic discussions, webinars, press releases, social media content, and a highly informative resource page](#) to assist emergency physicians with patient care:

- [“Stop the Spread: A Patient Guide to the Novel Coronavirus \(COVID-19\)”](#)
- Recognizing the importance of hospitals in defining roles and determining the level of resources needed to reduce the impact of the virus, the [“National Strategic Plan for Emergency Department Management of Outbreaks of COVID-19”](#) was developed and informs health care personnel, public health, and government officials at all levels about the necessary requirements for successful emergency department management.
- ACEP’s [“Field Guide to COVID-19 Care in the ED”](#) (Field Guide) was created to assist in the pandemic crisis. The Field Guide is a living document that will be updated as new information, guidance, and best practices evolve.
- During this COVID-19 public health crisis, concern of the critical shortage or lack of personal protective equipment (PPE) and other essential medical equipment continued to increase, as it had already endangered the lives of many, including the risk to health care providers. ACEP’s new policy statement [“COVID-19 Personal Protective Equipment \(PPE\) During the Pandemic”](#) addresses the CDC’s recommendation that healthcare personnel in the emergency department (ED) and emergency medical services (EMS) should consider wearing a face mask or surgical mask during an entire shift.
- It is imperative that health care providers receive the necessary resources and equipment critically needed to protect themselves, the health and welfare of their families, and the patients to whom they are providing lifesaving care. ACEP’s policy statement [“COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment \(PPE\)”](#) urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.
- A joint policy statement [“Care of Patients with Behavioral Health Emergencies and Suspected of Confirmed COVID-19”](#) for care of the behavioral health patient with suspected or confirmed COVID-19 was developed by the American Association for Emergency Psychiatry, ACEP, American Psychiatric Association, Coalition on Psychiatric Emergencies, Crisis Residential Association, and the Emergency Nurses Association.
- To stand up for the emergency physicians and healthcare professionals serving on the frontlines of the COVID-19 pandemic having their livelihoods threatened, ACEP issued a statement [“Now is Not the Time to Reduce Support for Health Care Heroes.”](#)

In 2014, ACEP created and distributed materials addressing the [Ebola virus disease \(EVD\)](#); however, COVID-19 and potential future pandemics will create similar ethical and medical practice concerns requiring policies with a more expansive application.

The Ethics Committee will work on two specific objectives for the 2020-21 committee year regarding COVID-19:

- Identify and develop educational opportunities and materials on ethics issues, including at least three articles for ACEP publications including:
 - Ethical review of the US healthcare system's response to the COVID-19 pandemic and ethical considerations for future pandemics.
- Develop a policy statement on the ethics of national pandemic disaster response.

Fifteen other ACEP committees also have objectives for the 2020-21 committee year to address COVID-19 and future pandemics.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

April 2020, approved the policy statement “[Care of Patients with Behavioral Health Emergencies and Suspected or Confirmed COVID-19.](#)”

April 2020, approved the policy statement “[Staffing Models and the Role of the Emergency Department Medical Director.](#)”

March 2020, approved the policy statement “[COVID-19 Personal Protective Equipment \(PPE\) During the Pandemic.](#)”

March 2020, approved the policy statement “[COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment \(PPE\).](#)”

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

June 2018, approved the revised policy statement “[Emergency Physician Contractual Relationships;](#)” revised 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.” As an adjunct to this policy statement, ACEP has prepared a policy resource education paper (PREP) titled, “[Emergency Physician Contractual Relationships.](#)”

June 2018, reaffirmed the policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles;](#)” reaffirmed April 2012; revised January 2006; originally approved November 2001.

July 2017, reviewed the Policy Resource and Education Paper (PREP) “[Circadian Rhythms and Shift Work.](#)” The PREP is an adjunct to the policy statement “[Emergency Physician Shift Work..](#)”

June 2017, approved the revised policy statement “[Emergency Physician Shift Work;](#)” revised June 2010 and September 2003; reaffirmed October 1998; originally approved September 1994. As an adjunct to this policy

statement, ACEP has prepared a policy resource education paper (PREP) titled, “[Circadian Rhythms and Shift Work.](#)”

June 2016, approved the revised policy statement “[Personal Protective Equipment Guidelines for Health Care Facility Staff](#),” reaffirmed October 2009; originally approved August 2003.

April 2016 approved the revised policy statement “[Fair Payment for Emergency Department Services](#),” originally approved April 2009.

October 2015, approved the revised policy statement “[Emergency Physician Rights and Responsibilities](#),” revised April 2008 and July 2001; originally approved September 2000.

April 2015, approved the revised policy statement “[Compensation Arrangements for Emergency Physicians](#),” revised April 2002 and June 1997; reaffirmed October 2008 and April 1992; originally approved June 1988.

Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

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



RESOLUTION: 43(20)

SUBMITTED BY: District of Columbia Chapter
Maryland Chapter
Diversity, Inclusion. & Health Equity Section

SUBJECT: Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions

PURPOSE: Promote transparency in institutional data for identification of disparities and biases in medical care; continue to encourage compliance with training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination in EDs and institutions at all levels.

FISCAL IMPACT: Budgeted section and staff resources. Potential unbudgeted costs for convening a task force and accrediting enduring CME course(s). Actual cost depends on the scope of the work, potential honorarium, and whether meetings will occur virtually or in person. Minimum cost for accrediting CME is \$12,000 per course offering.

1 WHEREAS, ACEP advocates for tolerance and respect for the dignity of all persons and opposes all forms of
2 discrimination within healthcare¹; and
3

4 WHEREAS, Multiple studies have provided evidence for unconscious bias impacting the quality of care
5 certain patients receive²; and
6

7 WHEREAS, ACEP has recognized the importance of unconscious bias in clinical practice and has developed
8 an online course to assist all individuals in recognizing their own biases to curb their effects³; and
9

10 WHEREAS, ACEP recognizes that fostering a broad and inclusive healthcare environment and mitigating
11 clinicians' unconscious bias enhances patients' experience and health outcomes; therefore be it
12

13 RESOLVED, That ACEP promote transparency in institutional data to better identify disparities and biases in
14 medical care; and be it further
15

16 RESOLVED, That ACEP continue to encourage compliance with training to combat discrimination for all
17 clinicians; and be it further
18

19 RESOLVED, That ACEP continue to explore frameworks for integrating anti-discrimination into our
20 emergency departments and institutions at all levels including, but not limited to, patients, families, medical students,
21 staff, trainees, staff physicians, administration, and other stakeholders.

Background

This resolution calls for the College to promote transparency in institutional data for identification of disparities and biases in medical care; continue to encourage compliance with training to combat discrimination for all clinicians; and

¹<https://www.acep.org/patient-care/policy-statements/non-discrimination-and-harassment/>

²https://store.aamc.org/downloadable/download/sample/sample_id/168/

³<https://www.acep.org/life-as-a-physician/why-does-diversity-matter/>

continue to explore frameworks for integrating anti-discrimination in EDs and institutions at all levels.

In March 2018, ACEP, as a recommendation of the Diversity and Inclusion Task Force, launched the [Unconscious Bias in Clinical Practice](#) one-hour, accredited CME course. This course focuses on:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

Amended Resolution 14(19) Implicit Bias Awareness and Training was adopted by the Council and the Board of Directors. The resolution directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias. The Academic Affairs Committee was assigned to develop the policy statement, which will be completed in the 2020-21 committee year. The Diversity, Inclusion, & Health Equity Section continues to promote the [Unconscious Bias in Clinical Practice](#) course.

The Diversity, Inclusion, & Health Equity Section has several objectives that relate to this resolution:

- Develop strategies to create a true culture of promoting diversity and inclusion and of addressing issues of health equity within the emergency medical community.
- Promote practical and realistic solutions in efforts to address diversity, inclusion, and health equity within the emergency medicine community.
- Develop and present educational programs on the many facets of cultural competency, diversity, inclusion, unconscious bias, and health equity within emergency medicine.
- Generate awareness of and promote pathways to address unconscious bias in emergency medicine.
- Identify the impact of a diverse workforce on health equities and patient outcomes and workforce in Emergency Medicine.
- Develop and make available to members of the College a Diversity and Inclusion Toolkit.

ACEP's policy statement "[Non-Discrimination and Harassment](#)" advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender, identity or expression, sexual orientation, or any other classification protected by local, state, or federal law. ACEP's goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Discrimination and bias can serve as major drivers of influence on the quality of care provided in the emergency department toward individuals of underrepresented populations.

The information paper "[Disparities in Emergency Care](#)" includes three recommendations that directly supports the need for continued education related to cultural competence, clinical decision-making, and knowledge gaps among physicians that lack post-graduate education in emergency medicine.

1. Promote the evidence-based teaching of cultural competency.
2. Emphasize the use of clinical decision tools that standardize the approach to risk stratification and potentially reduce subjective bias.
3. Explore initiatives that address the "knowledge disparity" between rural and urban providers of emergency services, including providers who do not have post-graduate training in emergency medicine

ACEP's policy statement "[Workforce Diversity in Health Care Settings](#)" reinforces that hospitals and emergency physicians should work together to promote diversity in staffing of emergency departments.

ACEP's policy statement "[Cultural Awareness and Emergency Care](#)" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias as cultural awareness helps combat negative assumptions and discrimination. Implicit bias is recognized by the individual and mitigated through education recalling stereotypical thought processes. The recognition of bias can help prevent an individual from acting upon bias, which occurs in the form of discrimination.

Demonstrating the ongoing importance of this issue, 14 of ACEP's committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

One approach to address the third resolved of this resolution to explore frameworks for integrating anti-discrimination into emergency departments is to convene a task force. Additional implicit bias training courses could also be developed.

ACEP Strategic Plan Reference

Goal 2: Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted section and staff resources. Potential unbudgeted costs for convening a task force and accrediting enduring CME course(s). Actual cost depends on the scope of the work, potential honorarium, and whether meetings will occur virtually or in person. Minimum cost for accrediting CME is \$12,000 per course offering.

Prior Council Action

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

April 2020, approved the revised policy statement "[Cultural Awareness and Emergency Care](#);" reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

June 2018, approved the revised policy statement "[Non-Discrimination and Harassment](#);" revised and approved April 2012 with the current title; originally approved October 2005.

November 2017, approved the revised policy statement "[Workforce Diversity in Health Care Settings](#);" reaffirmed June 2013 and October 2007; originally approved 2001.

October 2017, reviewed the information paper "[Disparities in Emergency Care](#)."

April 2017, reviewed the information paper "Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management."

Substitute Resolution 41(05) Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA
Senior Manager, Development & Special Projects

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



RESOLUTION: 44(20)
SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP
SUBJECT: Due Process in Emergency Medicine

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy efforts. Potentially significant reduction in outside funding support.

1 WHEREAS, It is common knowledge that, despite an ACEP policy in favor of due process, many ACEP
2 members are denied due process as it regards to their ability to see patients in the emergency department; and
3

4 WHEREAS, This denial is often achieved by requiring a physician to automatically give up their rights to a
5 fair hearing outlined in the Medical Staff Bylaws when terminated by the entity holding the exclusive contract for
6 emergency services; and
7

8 WHEREAS, Hospital administrators can request or pressure the entity holding the exclusive contract for
9 emergency services to terminate an emergency physician thus avoiding the existing Joint Commission prohibition on
10 such administrative interference with the Medical Staff Bylaws and responsibilities, and
11

12 WHEREAS, Due process is considered a fundamental right that is essential to allow the physician to act in
13 the best interest of the patient; and
14

15 WHEREAS, The literature and recent examples during the pandemic confirm that emergency physicians can
16 be terminated for speaking up regarding the quality of care and patient safety; and
17

18 WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response
19 to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are
20 detrimental to its members or the public”; and
21

22 WHEREAS, The denial of due process is detrimental to ACEP members and the public; therefore, be it
23

24 RESOLVED, That ACEP adopt this policy; “No member of ACEP will, directly or indirectly, deny another
25 emergency physician the right to due process regarding their medical staff privileges and ability to see patients in an
26 emergency department. No member of ACEP will hold a management position with any entity that denies an
27 emergency physician of this right.”; and be it further
28

29 RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and
30 Responsibilities” through deletion and substitution as follows: “6. Emergency physicians ~~should~~ **shall** be accorded
31 due process before any adverse final action with respect to employment or contract status, the effect of which would
32 be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges
33 ~~should~~ **shall** not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health
34 status, limits placed by professional practice boards or state law. 7. Emergency physicians who practice pursuant to an

35 exclusive contract arrangement ~~should~~ shall not be required to waive their individual medical staff due process rights
36 as a condition of practice opportunity or privileges.”; and be it further

37

38 RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at
39 its meetings, provide sponsorship, other support or otherwise be associated with the ACEP will as of January 1, 2021
40 shall remove all restrictions on due process for emergency physicians. Physicians cannot be asked to waive this right
41 as it can be detrimental to the quality and safety of patient care. The entities affected include but is not limited to
42 physician groups, hospitals, and staffing companies.”

References:

Weiss LD. AAEM White Paper on Due Process Rights for Physicians. J Emerg Med 2007;33:439-40.

McNamara RM, Beier K, Blumstein H, Weiss LD, Wood J. A survey of emergency physicians regarding due process, financial pressures and the ability to advocate for patients. J Emerg Med 2013; 45: 111-116

Seattle Times article on Dr. Ming Lin <https://www.seattletimes.com/seattle-news/health/er-doctor-who-criticized-bellingham-hospitals-coronavirus-protections-has-been-fired/>

Background

This resolution directs the College to adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right. The resolution further calls for wording changes in the policy statement “Emergency Physician Rights and Responsibilities” and the adoption of a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

ACEP’s policy statement “[Emergency Physician Contractual Relationships](#)” includes the following provisions:

- ACEP supports the emergency physician receiving early notice of a problem with his or her performance and an opportunity to correct any perceived deficiency before disciplinary action or termination is contemplated.
- All entities contracting with or employing emergency physicians to provide clinical services, either indirectly or directly, should ensure an adequate and fair discovery process prior to deciding whether or not to terminate or restrict an emergency physician’s contract or employment to provide clinical services.
- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor’s contract with the hospital concerning termination of a physician’s ability to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.
- Emergency physician contracts should explicitly state the conditions and terms under which the physician’s contract can be reassigned to another contracting vendor or hospital with the express consent of the individual contracting physician.
- The emergency physician should have the right to review the parts of the contracting entities’ contract with the hospital that deal with the term and termination of the emergency physician contract.

The policy statement has an accompanying [Policy Resource and Education Paper \(PREP\)](#), which states in part: “The core issue behind language in emergency medicine contracts having to do with termination of the physician’s ability to practice is that of due process. Due process refers to the right to have a fair hearing, including input from the affected physician, prior to any decision being made about termination of the ability to practice (specifically the loss of hospital medical staff privileges). The concept of due process is felt to support the independence of a physician in advocating for patients without undue influence from extrinsic forces and preserves the sanctity of the physician-patient relationship. These forces may include non-medical concerns, such as financial, marketing, or political interests.”

The Joint Commission requires hospital medical staffs to provide due process for physicians. Section 10.01.01 of its Medical Staff Standards dictates that “There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions regarding reappointment, denial, reduction, suspension or revocation of privileges that may relate to quality of care, treatment, and services issues.” Additionally, the Health Care Quality Improvement Act of 1986 includes a provision that members of a professional review body are not shielded from liability for their professional review actions if they do not ensure due process for the physician facing that action.

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

ACEP’s policy statement “[Emergency Physician Rights and Responsibilities](#)” addresses the due process issue, stating in part:

“7. Emergency physicians should be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians’ medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law.

8. Emergency physicians who practice pursuant to an exclusive contract arrangement should not be required to waive their individual medical staff due process rights as a condition of practice opportunity or privileges.”

In 2018, ACEP and seven other emergency medicine organizations signed a letter to CMS Administrator Seema Verma. The letter noted that “Whether employed by hospitals or contracted groups, emergency physicians are often deprived of their due process rights via inclusion of a ‘waiver of due process rights’ clause in employment contracts. The letter requested CMS to guarantee physician due process rights by making them unwaivable and irrevocable. Also in 2018, ACEP and the other emergency medicine organizations supported the introduction of legislation that would prohibit the mandatory waiver of due process rights which many emergency physicians are forced to comply with as a condition of employment. An ACEP [press release](#) issued after introduction of the legislation quoted then president Dr. Paul Kivela who stated “This is an important safeguard that will ensure all emergency physicians have access to a fair due process procedure.”

The bill was introduced again with the new Congress in 2020 as [H.R. 6910](#), the “ER Hero and Patient Safety Act.” In April, a [letter](#) from ACEP President Dr. William Jaquis was sent to the bi-partisan cosponsors of the new bill, Congressmen Raul Ruiz and Roger Marshall, reaffirming ACEP’s support for legislation to ensure every emergency physician has due process rights. The letter notes, “The threat of termination or the actual termination of physicians without the right of a fair hearing prevents emergency physicians from fully advocating for their patients for fear of retribution. For these reasons, ACEP believes that all emergency physician contracts should include a due process clause regardless of whether those physicians are directly employed by a hospital or they provide emergency medical services at a hospital through a group or individual contract.” ACEP continues to encourage members to ask their representatives to cosponsor the bill through a [call to action](#), which has resulted in more than 1,000 contacts with members of Congress in support of the bill.

During the pandemic, emergency physicians have faced new threats to their employment. A Washington State emergency physician sued his hospital and group employer after losing his position at the hospital following his social media postings that claimed insufficient hospital efforts to protect staff from contracting the virus. There were also numerous reports of emergency physicians being threatened with termination for bringing their own PPE to work to better protect themselves. In a [statement](#) issued by ACEP, Dr. Jaquis stated, “Emergency physicians are prepared to handle virtually anything thrown at us as we seek to treat and heal our patients, however, we should not be forced to put our own lives at risk and have our jobs threatened simply for wearing our own supplied protective equipment.”

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

Adoption of a policy that prohibits members from denying other emergency physicians the right to due process regarding their medical staff privileges and prohibit members from holding management positions at entities that deny emergency physicians this right would presumably entail sanctions, including possible expulsion from membership, for members failing to abide by the policy. ACEP would be required to report any suspension or expulsion to the National Practitioners Data Bank. Enforcement of self-regulation codes, even if the enforcement is not anti-competitive, must be carried out in a manner that affords the alleged offender due process, which includes proper notice and a fair hearing. The ACEP Bylaws state that “Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.” The College Manual currently describes one process for addressing all disciplinary actions; the process currently used to adjudicate ethics charges.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings in order to provide adequate due process to the accused member. The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to revoke a member’s membership or deny an entity’s ability to exhibit, sponsor or advertise with ACEP may create additional potential liability risk for ACEP. Affected members could bring legal action against the College with claims of defamation, limiting professional opportunities, or denial of due process on the part of ACEP. Excluding an entity from being able to sponsor any ACEP activity could subject the College to a claim of restraint of trade. Such challenges can be mitigated by developing and adhering to strict processes.

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

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted committee and staff resources for policy development. Potentially significant reduction in outside funding support. The financial impact would depend on how many employing entities would stop sponsoring ACEP activities because of the requirement to remove all restrictions on due process for emergency physicians and how many entities and individual members would be accused of violating the policy and be subject to an ACEP investigation. Physician groups, staffing companies, and hospitals/clinics contributed \$1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities in 2019-20, representing about 24% of all corporate financial support for these activities. Additionally, ACEP's prescribed procedures for adjudicating accusations of member misconduct is time intensive for the Ethics Committee, Board of Directors, and staff involved in investigation and rendering decisions on ethics complaints.

Prior Council Action

Resolution 45(13) Revision of "AMA Principles for Physician Employment" referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician's right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

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

Resolution 29(11) Due Process for Emergency Physicians adopted. Directed ACEP to review and update the policy statement "Emergency Physician Contractual Relationships" regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

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

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including "With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process."

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to disclose their level of compliance with College policies on compensation and contractual relationships.

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

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

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

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

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

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

Prior Board Action

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

September 2018, approved the policy statement "[Due Process for Physician Medical Directors of Emergency Medical Services.](#)"

June 2018, approved the revised policy statement "[Emergency Physician Contractual Relationships;](#)" revised and approved October 4 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

July 2018, reviewed the PREP "[Emergency Physician Contractual Relationships](#)" as an adjunct to the policy statement "Emergency Physician Contractual Relationships."

October 2015, approved the revised policy statement "[Emergency Physician Rights and Responsibilities;](#)" revised and approved April 2008 and July 2001; originally approved September 2000

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

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

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

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

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

Substitute Resolution 10(01) Commercial Sponsorships adopted.

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

Amended Resolution 54(94) Due Process adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 45(20)

SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter

SUBJECT: Emergency Licensing and Protection in Disasters

PURPOSE: 1) Create new or reaffirm policy supporting that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official if the emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services, and practices within his/her area of knowledge and expertise. 2) Create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity if the emergency physician(s) practices within his/their area of knowledge or expertise.

FISCAL IMPACT: Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts and developing a policy statement.

1 WHEREAS, Natural and/or man-made disasters can and do occur within various parts of the United States
2 and globally; and

3
4 WHEREAS, Government is exempt from certain types of civil and criminal prosecution under the protection
5 of sovereign immunity; and

6
7 WHEREAS, Medical attention and treatment is often needed in such situations but can be unavailable or in
8 short supply; and

9
10 WHEREAS, Emergency physicians along with other healthcare personnel/professionals often respond to such
11 disasters; and

12
13 WHEREAS, Many other emergency physicians and other healthcare providers/professional would like to or
14 be willing to respond to such disasters; and

15
16 WHEREAS, “The American College of Emergency Physicians (ACEP) and the National Association of
17 Emergency Medical Services Physicians (NAEMSP) believe an organized approach is needed for the utilization of
18 unsolicited medical personnel who volunteer to respond to disaster scenes or mass casualty incidents”ⁱⁱ; and

19
20 WHEREAS, Despite the encouragement of the ACEP and NAEMSP for members to become affiliated with
21 pre-established disaster response organization, many needed physicians in a disaster are not pre-established with such
22 organizations thus resulting in less physicians being able to help in disasters who are willing to; and

23
24 WHEREAS, The emergency system, maintained by the [U.S. Department of Health and Human Services](#), is
25 aimed at recruiting medical professionals who are willing to volunteer in times of disasters and verifying their medical
26 credentials ahead of time; and

27
28 WHEREAS, The reality is that this is not well advertised, or promoted and many physicians and other health
29 care workers, who can provide valuable services to disaster victims, do not sign up or register in advanceⁱⁱ; and

30
31 WHEREAS, The response of enough qualified physicians during disasters is critical, if instead there could be

32 a simple method for confirming licensure in good standing in any US state or territory without requiring pre-
33 registration, instead by having a simple means to check if physicians are licensed in good standing in any US state or
34 territory, this would drastically increase the number of available and qualified emergency physicians who could assist
35 in disasters; and

36
37 WHEREAS, Most/all states have state licensing requirements and while many states allow care to be
38 provided without a medical license within the state under disaster or emergency situations, not all do; and

39
40 WHEREAS, The Federal Emergency Management Administration (FEMA), Department of Health and
41 Human Services (HHS), Department of Defense (DOD), Department of Homeland Security (DHS), or other federal,
42 state, or governmental agency could contact the Federation of State Medical Boards (FSMB) or maintain a national
43 registry from state medical licensing boards or licensing departments that does not require the physician to actively
44 register beforehand that shows all physicians who hold a medical license in good standing or without any reason not
45 to allow that physician to practice medicine in a disaster situation; and

46
47 WHEREAS, Convergent volunteerism is a reality whether planners plan for it or not; and

48
49 WHEREAS, FEMA acknowledges that everyone has the potential to contribute strength and resources in
50 times of emergency, that there are valuable and appropriate roles for unaffiliated spontaneous volunteers (sometimes
51 called “unsolicited volunteers”), that “the spontaneous nature of individual volunteering is inevitable; therefore, it
52 must be anticipated, planned for and manage,” and recommends: “emergency management experts and volunteer
53 organizations active in disasters (VOAD) partners are encouraged to identify and utilize all existing capacity for
54 integrating unaffiliated volunteers”ⁱⁱⁱⁱ; and

55
56 WHEREAS, While currently pacts may exist between some states that allow physicians licensed in one state
57 to become licensed and to practice in other states, these pacts have been slow to develop, becoming licensed in
58 multiple states can be labor and time intensive, do not include all 50 states and thus do not allow for maximum
59 availability to victims of disasters when the need arises; and

60
61 WHEREAS, State licensing requirements can be rather complex, difficult and time prohibitive especially
62 when trying to include all 50 states; and

63
64 WHEREAS, By allowing easing of licensing requirements during federal or state declared disasters, the
65 availability of qualified emergency physicians who are willing to provide care and treatment for victims of disasters
66 could be increased without affecting licensing requirements of states outside of declared disaster periods; and

67
68 WHEREAS, The current litigation environment varies between the 50 states and can be particularly severe in
69 some states, and can be a strong disincentive to provide much needed quality care particularly during times of
70 declared disasters; and

71
72 WHEREAS, It is important, fair, and the right thing to do to ensure liability protection to emergency
73 physicians and other healthcare workers who provide services within their expertise and at no charge during times of
74 state or federally declared man-made and natural disasters; and

75
76 WHEREAS, ACEP’s “[Good Samaritan Protection](#)” policy statement supports legislation to reduce liability
77 exposure and supports extension of existing good samaritan legislation to provide protection from liability for
78 emergency physicians who respond to emergencies outside the emergency department, including but not limited to in-
79 hospital and out of hospital emergencies, mass casualty incidents, and other disasters but does not specifically
80 mention this protection to emergency physicians who provide their services not-in-person, or remotely, as is the case
81 with Telehealth, electronically, via drones, etc.; and

82
83 WHEREAS, ACEP already supports sovereign immunity for emergency physicians in certain settings as
84 reflected by ACEP’s “[Reform of Tort Law](#)” policy statement that immunity should be given to emergency physicians
85 for emergency medical treatment and labor act (EMTALA) required services; therefore be it

86 RESOLVED, That ACEP create new or reaffirm policy that supports that all states and U.S. territories waive
87 standard licensing requirements including fees for emergency physicians to provide their services, whether in person
88 or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official and
89 afterwards until services related to the disaster are no longer needed, so long as emergency physician holds a license
90 in good standing in any U.S. state or territory, does not charge for his/her services and practices within his/her area of
91 knowledge and expertise; and be it further

92
93 RESOLVED, That ACEP create new policy that supports legislation protecting any/all emergency physicians
94 who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting
95 these emergency physicians immunity and holding them harmless for any services, that they provide to patients
96 during disasters and aftermath so long as the emergency physician(s) practices within his/their area of knowledge or
97 expertise.

98
99 *Immunity: an order whereby a physician cannot commit a legal wrong and is immune to civil suit or criminal prosecution.

ⁱ ACEP Policy Statement approved October 2017. [Unsolicited Medical Personnel Volunteering at Disaster Scenes](#).

ⁱⁱ NPR. July 15, 2020. < <https://www.npr.org/sections/health-shots/2020/03/21/819172512/theres-a-federal-system-for-signing-up-medical-volunteers-but-it-s-neglected>>

ⁱⁱⁱ Federal Emergency Management Administration. July 15, 2020. *Managing Spontaneous Volunteers in Times of Disaster* and July 2019. *Preventing a Disaster Within the Disaster*

Background

This resolution requests ACEP to: 1) Create new or reaffirm policy supporting that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official if the emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services, and practices within his/her area of knowledge and expertise; and 2) Create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity if the emergency physician(s) practices within his/their area of knowledge or expertise.

ACEP has multiple policy statements that address this resolution as described below. One of the key points in the resolution that is difficult to address is “waive standard licensing requirements including fees.” While ACEP could develop a policy statement, or revise an existing policy statement, it is unlikely that licensing requirements and fees would be suspended.

Despite the willingness of many physicians to provide support in a disaster situation, and who do not register in advance to provide such support, it can create a dangerous situation for physicians that are not trained in disaster response and entering into unstable environments.

ACEP’s policy statement “[Support for National Disaster Medical System and Other Response Teams](#)” supports the National Disaster Medical System (NDMS) and encourages further development and funding of the program. ACEP also supports its members who participate in the Disaster Medical Assistance Teams (DMAT), Urban Search and Rescue (USAR teams), or other federal or state-sponsored medical teams.

ACEP’s policy statement “[Disaster Medical Response](#)” supports a national credentialing mechanism and up-to-date database of available physicians and medical volunteers who could be deployed as needed in the face of a national emergency. A policy and program must be in place to provide these responders with workers’ compensation and medical liability protection when deploying to a disaster at the request of the federal or state government.

ACEP’s policy statement “[Good Samaritan Protection](#)” supports good samaritan protection legislation designed to reduce liability exposure. ACEP also supports the extension of existing good samaritan legislation to provide

protection from liability for emergency physicians who respond to emergencies outside the emergency department, including but not limited to in-hospital and out-of-hospital emergencies, mass casualty incidents, and other disasters.

ACEP's policy statement "[Health Care System Surge Capacity Recognition, Preparedness, and Response](#)" includes the following excerpt: Legislation should be enacted where necessary to mitigate provider liability issues during crisis situations.

ACEP's policy statement "[Hospital Disaster Physician Privileging](#)" includes language that The Joint Commission (TJC) has put forth standards (TJC Standard EM.02.02.13) to address Hospital Disaster Physician Privileging. During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners (LIP).

ACEP's policy statement "[Unsolicited Medical Personnel Volunteering at Disaster Scenes](#)" is a joint statement with the National Association of EMS Physicians that encourages "members to become affiliated with pre-established disaster response organizations. This includes becoming pre-registered as disaster response personnel through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), which is present in every state and provides for license verification, personnel notification, and rostering of response teams." This is contrary to the information in the sixth Whereas statement, beginning in line 16, indicating that ACEP and NAEMSP "believe an organized approach is needed for the utilization of unsolicited medical personnel who volunteer to respond to disaster scenes or mass casualty incidents."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts and developing a policy statement.

Prior Council Action

Resolution 58(05) Disaster Medical Response referred to the Board. Requested ACEP to recommend to the Federal Emergency Management Agency (FEMA) that they establish a national credentialing mechanism for the deployment of physicians in a national emergency.

Substitute Resolution 41(94) Disaster Response Program adopted. Endorsed the concept of volunteer medical disaster programs at the local level and that, ideally, the volunteer response or emergency physicians and their integration into existing state and federal disaster plans and resources should be coordinated by chapters.

Substitute Resolution 19(91) Disaster Medical Care adopted. Supported the position that every community needs a comprehensive backup system for immediate emergency medical care and directed ACEP to develop guidelines for the development of such systems.

Resolution 38(89) Mitigation of the Effects of Natural Disasters adopted. Supported the concept of global disaster mitigation and planning and that ACEP supports members activity in disaster planning, leadership, health care, educational activities, and networking with other disaster care organizations.

Amended Resolution 31(88) National Disaster Medical System (NDMS) adopted. Directed ACEP to make members aware of the Disaster Medical Assistance Team (DMAT) within the framework of the NDMS and encourage leadership roles within NDMS by specifically seeking a seat on the panel of health and medical preparedness.

Substitute Resolution 37(86) Disaster Plan adopted. Directed ACEP to assume a leadership role in mass casualty incident education and management and provide access for information to interested physicians and suppliers to aid in relief efforts.

Resolution 56(85) National Disaster Medical System adopted. Directed ACEP to continue to support the National Disaster Medical System.

Prior Board Action

June 2019, approved the revised policy statement “[Support for National Disaster Medical System and Other Response Teams](#),” revised and approved June 2013 with the current title; revised and approved October 2006; originally approved March 1999 replacing Resolution 56(85) National Disaster Medical System and Substitute Resolution 19(91) Disaster Medical Care.

June 2019, reaffirmed the policy statement “[Disaster Medical Response](#),” revised and approved June 2013; originally June 2006

February 2018, approved the revised policy statement “[Good Samaritan Protection](#),” revised and approved June 2012; reaffirmed September 2005; originally approved September 1999.

October 2017, reaffirmed the policy statement “[Health Care System Surge Capacity Recognition, Preparedness, and Response](#),” revised and approved October 2011; originally approved August 2004.

October 2017, approved the revised policy statement “[Hospital Disaster Physician Privileging](#),” revised and approved January 2010 with current title; originally approved February 2003 titled “Hospital Disaster Privileging.”

October 2017, approved the revised policy statement “[Unsolicited Medical Personnel Volunteering at Disaster Scenes](#),” reaffirmed October 2008; originally approved June 2002.

Substitute Resolution 41(94) Disaster Response Program adopted.

Substitute Resolution 19(91) Disaster Medical Care adopted.

Resolution 38(89) Mitigation of the Effects of Natural Disasters adopted.

Amended Resolution 31(88) National Disaster Medical System (NDMS) overruled.
Substitute Resolution 37(86) Disaster Plan overruled.

Resolution 56(85) National Disaster Medical System adopted.

Background Information Prepared by: Patrick Elmes, EMT-P
EMS & Disaster Preparedness Manager

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 46(20)
SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section
SUBJECT: Employment Information

PURPOSE: Establish a database that would allow physicians to review employers and contract management groups (CMGs) in a confidential online environment and create policies opposing employers from discouraging or disciplining physicians choosing to post such reviews.

FISCAL IMPACT: Unbudgeted costs for design and development of the job database platform is estimated at \$91,800 for the initial release. Cost for future enhancements and maintenance of the platform, for at least the three years following the release, is estimated at 20% of the initial platform cost or \$18,360 per year. Additional costs would need to be allocated for a Product Owner role, outside of Technology Services. Additional staff time may be required in the roles of stakeholders and subject matter experts.

1 WHEREAS, Many emergency physicians work for or are contracted by others to provide their professional
2 services; and
3
4 WHEREAS, Knowing what is a safe or an appropriate staffing model can be difficult unless one understands
5 the specifics of an emergency department or medical facility; and
6
7 WHEREAS, It is difficult to be able to get enough information from asking questions on the phone or in an
8 interview; and
9
10 WHEREAS, Employers or contract management groups may create, or influence, staffing models and work
11 environments that emergency physicians believe to be unsafe for patient care and for the safe and enjoyable practice
12 of emergency medicine; and
13
14 WHEREAS, The opinions of other emergency physicians who have worked in a work environment or with a
15 particular employer, or contract management group, that one is considering to work in, or with, would be valuable to
16 that emergency physician before having to make a decision as to whether to pursue or accept a job at a particular
17 facility with a particular employer or contract management group; and
18
19 WHEREAS, A database that contains the opinions, or ratings, of other emergency physicians on various
20 employers, contract management groups or facilities, would be useful and valuable to emergency physicians looking
21 for employment or a new position; and
22
23 WHEREAS, Such a database would only contain information from emergency physicians who work for
24 employers or contract management group and would not be influenced by employers or contract management groups;
25 therefore be it
26
27 RESOLVED, That ACEP create new policy to establish a confidential “Job Database” or direct such a
28 database to be created and controlled by an emergency physician controlled entity with the top priority of what is best
29 for emergency physicians, that allows emergency physicians to provide their ratings, and/or opinions regarding
30 employers and contract management groups (CMGs) for only those employers and CMGs that they have worked for
31 or been contracted in an anonymous manner that is not accessible by or can be influenced by employers or contract
32 management groups that is only accessible by other emergency physicians; and be it further

33 RESOLVED, That ACEP establish new policy that opposes employers or contract management groups from
34 discouraging, obstructing, preventing or otherwise preventing any emergency physician from providing information
35 or obtaining information from a confidential Job Database developed by ACEP; and be it further
36

37 RESOLVED, That ACEP establish new policy opposing penalty or punishment of any kind, actual or the
38 withholding of benefit, to any emergency physician who provides information to, or receives information from, a
39 confidential Job Database developed by ACEP.

Background

This resolution asks the College to establish a database that would allow physicians to review employers and contract management groups (CMGs) in a confidential online environment and create policies opposing employers from discouraging or disciplining physicians choosing to post such reviews.

Employer review websites, such as Glassdoor.com and Indeed.com are frequently used by potential employees to research the opinions of a company's current and former employees regarding organizational policies and work conditions. Such sites may contain valuable information for physicians researching an employer or CMG; however, there is a risk that postings may contain false or misleading information from disgruntled employees. It is possible employers may file suit against the publisher or author of negative reviews for claims of defamation or breach of confidentiality agreements. Such risks could be mitigated by creating and maintaining strict user terms and conditions.

The publisher of an employer review website is required to carefully screen all postings and take precautions to protect the identity of users while prohibiting employers from accessing the site. Should ACEP act as publisher of the reviews, it would require ACEP to assign an employee to monitor, review, and possibly research users and postings to ensure the confidentiality of users is protected and that suspected false posts are deleted.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Unbudgeted costs for design and development of the job database platform is estimated at \$91,800 for the initial release. Cost for future enhancements and maintenance of the platform, for at least the three years following the release, is estimated at 20% of the initial platform cost or \$18,360 per year. Additional costs should be allocated for a Product Owner role, outside of Technology Services. Additional staff time may be required in the roles of stakeholders and subject matter experts

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

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



RESOLUTION: 47(20)

SUBMITTED BY: Emergency Medicine Residents' Association
Pennsylvania College of Emergency Physicians

SUBJECT: Honoring Employment Contracts for Graduating Emergency Medicine Residents

PURPOSE: Partner with EMRA to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

FISCAL IMPACT: Budgeted committee and staff resources to assist with communication efforts or additional policy development related to encouraging employers to honor their employment contracts with graduating residents.

1 WHEREAS, Many emergency medicine residency graduates have had their first employment contracts
2 cancelled or amended during the COVID-19 pandemic; and
3

4 WHEREAS, The median educational debt for medical school graduates was \$192,000 in 2017 with three-
5 quarters of all graduates having some level of debt¹; and
6

7 WHEREAS, Debt has significantly altered career and life decisions for current and recently graduated
8 emergency medicine residents²; and
9

10 WHEREAS, ACEP believes that physicians who begin the practice of emergency medicine in the 21st
11 century must have completed an accredited emergency medicine residency training program and be eligible for
12 certification by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency
13 Medicine (AOBEM)⁴, and
14

15 WHEREAS, Only 61.1% of practicing emergency medicine clinicians in the United States are emergency
16 medicine physicians with 14.3% being non-emergent physicians and 24.5% being advanced practice providers³; and
17

18 WHEREAS, 27.1% of counties have no emergency medicine clinicians and 41.4% of counties have no
19 emergency physicians reimbursed by Medicare fee-for-service Part B³; and
20

21 WHEREAS, Residency trained emergency physicians have been shown to significantly improve mortality,
22 particularly among patients with the highest severity of illness, while bringing down admission rates⁵; and
23

24 WHEREAS, Graduating emergency medicine physicians comprise the future of the specialty; therefore be it
25

26 RESOLVED, That ACEP partner with the Emergency Medicine Residents' Association to encourage all
27 employers to honor their employment contracts with graduating emergency medicine resident physicians.

References:

1. <https://www.aamc.org/system/files/reports/1/august2017anupdatedlookatattendancetandmedicalstudentdebtatu.pdf>
2. <https://pubmed.ncbi.nlm.nih.gov/27181080/>
3. Hall, MK et al. (2018). State of the National Emergency Department Workforce: Who Provides Care Where? Annals of Emergency Medicine. 2018;72(3):302-307.
4. <https://www.acep.org/patient-care/policy-statements/the-role-of-the-legacy-emergency-physician-in-the-21st-century/>
5. <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2753679>

Background

This resolution calls for ACEP to partner with EMRA to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

Since the outbreak of the COVID-19 pandemic, many hospitals, emergency medicine groups, and emergency physicians have reported significant reductions in patient volumes as people with other conditions of varying acuity avoided going to the emergency department due to fears of contracting the coronavirus.

A [report by the Medical Group Management Association](#) states that, as early as April, medical group practices of all sizes and specialties have experienced significant financial hardship from the pandemic, noting that “97 percent of practices have experienced a negative financial impact directly or indirectly related to COVID-19.” The report also states that “on average, practices report a 55% decrease in revenue and 60% decrease in patient volume since the beginning of the COVID-19 crisis.”

A [report](#) by physician search firm Merritt Hawkins demonstrated the dramatic drop in recruitment efforts for physicians since the start of the pandemic. It reported that physician search engagements, which had increased for the 12 months ending March 31, declined by more than 30 percent in the next 60 days.

Hospitals and groups were forced to respond to the dramatic decline in revenue. Many did so through a reduction in physician hours and shifts, as well as furloughs of physicians and other staff.

Another significant ramification from the cost-cutting measures imposed as a result of the impact of COVID-19 has involved new residency graduates having their first employment contracts cancelled or amended. EMRA reports numerous incidents of residents having their contracts pulled back after they were signed by both parties. An EMRA Board member experienced a 15% reduction in hours, 10% cut in pay, and elimination of a bonus payment. Other residents have reported being sent to staff different facilities than what was initially promised. EMRA leadership reports these trends appear to be worsening.

A [statement released by EMRA](#) on April 27 states: “Rescinding emergency medicine physician employment contracts in the middle of a global pandemic, exactly when we need to remain vigilant, will hurt our health care system’s readiness. Now is not the time to cripple the front lines and devastate our newest emergency medicine attendings.” The statement added that EMRA “strongly encourages employers to honor their commitments to graduating emergency medicine residents and fellows. While we acknowledge the COVID-19 pandemic has changed the health care landscape, we ask employers to explore every option to fulfill the employment contracts already offered to graduating emergency medicine residents. We urge health care administrators to care for their frontline workers in the same way those emergency medicine physicians are caring for patients: with an eye to the common good rather than the bottom line.”

In considering ways that ACEP might partner with EMRA to encourage employers to honor their employment contracts with graduating residents, EMRA leadership suggested potential approaches that could include efforts to:

- Encourage groups to restructure their contracts so that promises can be upheld, and residents can still join the intended group, understanding they may not get the same contract/hours.
- Have employers provide reassurance to residents that terms of the contract will be met should volumes return in the future.
- Reward and recognize employers willing to hire graduating residents in the current climate.
- Advocate for removal of “all cause” termination language in contracts for new graduates, which allow contracts to be dissolved for any reason within a certain number of days’ notice.

ACEP issued a press release on April 7 under the title “[Now is Not the Time to Reduce Support for Health Care Heroes.](#)” The press release included a quote from ACEP President Dr. William Jaquis, stating “Cutting benefits or reducing shifts in today’s environment is akin to signing a ‘Do Not Resuscitate’ order for many emergency departments and the physicians that care for the patients, especially those in rural or underserved areas.”

ACEP's policy statement "[Emergency Physician Contractual Relationships](#)" includes a provision that states "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." The Policy Resource & Education Paper (PREP) "[Emergency Physician Contractual Relationships](#)" is an adjunct to the policy statement.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted committee and staff resources to assist with communication efforts or additional policy development related to encouraging employers to honor their employment contracts with graduating residents.

Prior Council Action

None

Prior Board Action

July 2018, reviewed the Policy Resource & Education Paper (PREP) "[Emergency Physician Contractual Relationships](#)" as an adjunct to the policy statement "Emergency Physician Contractual Relationships."

June 2018, approved the revised policy statement "[Emergency Physician Contractual Relationships](#);" revised and approved 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."

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 48(20)
SUBMITTED BY: New York Chapter
SUBJECT: Residency Program Expansion

PURPOSE: 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.

FISCAL IMPACT: Budgeted task force and staff funds.

1 WHEREAS, Emergency medicine residency is the only pathway to emergency medicine board certification;
2 and

3
4 WHEREAS, In 2011, there were 150 residencies approved by the Accreditation Council for Graduate
5 Medical Education (ACGME) with 1,607 emergency medicine PGY-1 positions offered, while 2018 saw a rise to 220
6 ACGME-approved residencies with 2,278 PGY-1 positions offered; and

7
8 WHEREAS, The change in overall numbers comes both from previously approved American Osteopathic
9 Association residencies along with the proliferation of newly accredited ACGME residencies; and

10
11 WHEREAS, There has not been objective criteria in place for the determination of need for approval of new
12 residencies by the ACGME specifically in terms of an assessment of emergency medicine workforce needs; and

13
14 WHEREAS, Contract management groups and other private entities have begun to build, control, and take
15 over ACGME-accredited residencies without demonstrable commitment to educational needs or emergency medicine
16 workforce stewardship; therefore be it

17
18 RESOLVED, That ACEP engage the Accreditation Council for Graduate Medical Education and other
19 relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency
20 medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and
21 expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited
22 emergency medicine residency programs.

Background

This resolution calls for ACEP to engage the ACGME and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

ACEP has a long history of supporting the development, expansion, and funding of emergency medicine residency programs as well as studying current and future needs of the emergency medicine workforce.

In November 1987, the Board of Directors adopted the position that there was a shortage of board-certified emergency physicians and the projection for physician supply through the year 2010 would drop by 1.6%. An ACEP task force charged with studying the issue at the time reported that while supply would drop, there would be an increase in demand because of increasing population, need for access to care, an increasingly aging population, and increasing

demand for full time faculty. In 1987 there were 73 emergency medicine residency programs producing approximately 430 graduates a year. The task force recommended that the College explore ways to increase the number of residency training slots within existing programs as well as through the creation of new residency training programs. The task force recommended that the College encourage private and public sources of funding for residencies to address the projected shortage.

The 1998 ACEP workforce study, [A Study of the Workforce in Emergency Medicine](#), found that less than 50% of the necessary emergency medicine physician workforce was able to fully staff U.S. EDs and that the current number of emergency medicine residency programs was not projected to provide a significant increase in the available emergency medicine workforce. A follow-up study, [A Study of the Workforce in Emergency Medicine: 1999](#), was published in *Annals of Emergency Medicine*. In 2001, the Board was asked to accept a report from the Staffing Task Force looking at current use of paramedics and EMTs and their future roles and to, “provide a special analysis of the ability for emergency medicine residency programs being able to meet the educational requirements for residency training while at the same time meeting the training requirements for paraprofessionals who will work in the ED.” The task force surveyed emergency medicine residency directors and residents in June 1999 and found that 66% of residents and 45% of residency director respondents believed that there would be some competition for career positions with non-physician providers.

A [2008 workforce study](#), published in *Annals of Emergency Medicine*, found that while younger physicians were more likely to be emergency medicine trained or emergency medicine board certified, many non-emergency medicine trained/emergency medicine board-certified physicians still provided coverage in EDs and that demand for rural emergency medicine care would likely continue with shortages likely to increase in rural areas.

In July 2009, a Future of Emergency Medicine Summit was convened. The consensus from summit attendees was that there would not be enough emergency medicine residency trained board-certified emergency physicians to meet the needs of all emergency patients in the U.S. for at least the next 20 years. It was noted that midlevel providers would provide some of the care in EDs, particularly where physician shortages exist. Summit participants recommended increasing the number of emergency medicine trainees with a corollary increase in GME funding, improving the geographic distribution of residency trained board certified emergency physician incentives for rural practice, increasing the number and size of emergency medicine programs, including loan forgiveness programs and targeting rural hospitals to host emergency medicine programs. In 2011, representatives from the 2009 meeting reconvened following the enactment of the Patient Protection and Affordable Care Act. The group [published](#) an update to their 2009 report. Regarding physician shortages in emergency medicine, the group recommended that policies to secure funding for additional training positions should be developed and residency training programs should provide increased exposure to rural practice.

In 2018, a workgroup of the ACEP Board of Directors was appointed to discuss trends in emergency medicine, such as future workforce needs, the role of physician assistants and nurse practitioners, consolidation of the employment market, and other concerns. It was determined that two task forces would be appointed: Emergency PA/NP Utilization Task Force and Emergency Medicine Workforce Task Force. The Emergency PA/NP Task Force included representation from all stakeholders in the provision of care of emergency patients. Their primary objective was to recommend the scope of practice for physician assistants (PAs) and nurse practitioners (NPs) in the ED, considering such factors as membership growth, education, training and experience, patient acuity, employment models, and the utilization of adjuncts such as telemedicine and other forms of oversight. Their final report was provided to the Board of Directors in April 2020. The primary objective of the multi-organizational Emergency Medicine Workforce Task Force is to assess the current and future emergency medicine workforce with assistance from an outside expert to review the literature and existing data on current and projected emergency medicine workforce needs. The task force launched in November of 2018. A final report is expected from the outside consultant in December 2020. The task force will then continue its work incorporating the consultant’s report and recent publications. Their final report is expected in June 2021.

A recent [2020 study](#) in *Annals of Emergency Medicine* examined changes in the current U.S. emergency medicine workforce compared to 2008. While the study found an overall increase in physicians since 2008 (up by 9,774), of the 48,835 clinically active emergency physicians, 19% were neither emergency medicine trained nor emergency medicine board certified. Those 19% non-emergency medicine trained, or emergency medicine board-certified

physicians were more likely to be men and international medical graduates. They were also older and more likely to be in rural areas. While the density of emergency physicians has increased overall since 2008 (14.9 per 100,000 U.S. population), the increase is not reflected evenly between urban, large rural, and small rural (1.4, -0.4, -3.7 respectively). The study noted the continued need for effective delivery of care in rural and underserved areas. The study suggests that it is likely that as this group of physicians retire, and as urban areas continue to see increases in newly trained emergency medicine physicians, rural areas are likely to experience further shortages.

According to the [ACGME](#), in 2018-19 there were a total of 7,940 emergency medicine residents in a total of 247 programs (63 of which had initial accreditation). Since the single-accreditation system, emergency medicine is one of the top four specialties with the highest 5-year increase in total number of programs. From 2014-15 to 2018-19, emergency medicine saw a 47.9% increase in programs. The number of active residents from 2014-15 to 2018-19 has increased by 33.6% from 5,941 to 7,940. Across specialties, approximately half of sponsoring institutions with ACGME-accredited programs are General/Teaching Hospitals (47.7%) and the next largest group is Academic Medical Centers/Medical Schools (15%). Academic Medical Centers/Medical Schools account for 9.7% more programs than general/teaching hospitals and have almost the same number of residents (ACGME Databook). It should be noted that the Residency Review Committee of the ACGME is obligated to accredit any residency that meets its criteria and will not be influenced by concern about an excess or deficit of physicians in that specialty.

GME funding for training programs is complex. GME funds are comprised of federal, state, and private monies. The federal government remains the largest funder of GME, covering approximately [86% of training costs](#). In 2018, the [Congressional Budget Office](#) estimated that approximately \$15 billion in Medicare and Medicaid was spent on GME. Private funds are difficult to quantify but as the Institute of Medicine noted in their 2014 [report](#), “may be significant.” The report also notes that while nationally, private funding might represent a small fraction of overall GME funding, for some programs it might be a significant support. The ACGME published a position paper in 2011, [Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME](#), (an update to their 2002 guidance) outlining principles for sponsoring institutions and programs using industry GME funds. [Some](#) have cited changes in accreditation regulations over the years (reduced work hours for residents, increased supervision requirements, etc.) as driving up the cost of training. With increased costs and capped funding from federal sources, some institutions have turned to private funding, through industry or philanthropy, to cover the costs of training. Other institutions have embraced training programs as a way to recoup some operating costs, solve physician shortages, and increase productivity. In the case of one [study](#), they found that eliminating GME programs would have a negative impact on their hospital’s bottom line. In the case of Hahnemann University Hospital, owned at the time by a private equity firm, while in bankruptcy proceedings attempted to auction off its residency positions even though this move was seen as illegal by CMS. ACEP sent a letter to the ACGME on November 18, 2019, informing them of ACEP’s opposition to the sale of Hahnemann’s GME slots and any further commoditization of GME slots.

Residency training programs and graduates are frequently faced with a changing funding landscape, evolving accreditation standards, shifting patient population needs, and challenges with the distribution of its workforce.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted funds for task force study on workforce issues and staff time.

Prior Council Action

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted. Directed ACEP to support CMS in opposing the sale of GME slots and oppose any sale or other commoditization of GME slots.

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 Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Amended Substitute Resolution 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 creating adequate numbers of emergency medicine residency positions and achieving optimal funding for those positions.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted. Directed ACEP to work with appropriate organizations and agencies to develop strategies to implement protections for resident physicians to complete their training in the event of residency program closures.

Resolution 31(96) Cooperative Training Programs in Emergency Medicine and Family Medicine not adopted. Called for ACEP to study the Canadian model of family physicians and generalists in emergency medicine and consider the implications for emergency care in the US. Additionally, work with other organizations to facilitate the development of combined residency training programs in family medicine and emergency medicine as well as a joint specialty certification by ABEM and ABFP.

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.

Amended Substitute Resolution 45(91) Emergency Medicine Residencies adopted. Directed the College to work with all appropriate organizations and agencies to obtain increased funding for emergency medicine residency programs.

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.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted. Directed ACEP to work with other organizations to continue to provide support, guidance, information, and other appropriate materials for individuals and institutions interested in developing emergency medicine residency programs.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted. Directed ACEP to encourage development of new models for funding graduate medical education.

Prior Board Action

June 2020, filed the report of the Emergency PA/NP Utilization Task Force.

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted.

September 2018, approved appointing the Emergency PA/NP Utilization Task Force to consider the evolution of the role and scope of practice of physician assistants and nurse practitioners in the emergency department.

June 2018, approved the revised policy statement “[Resident Training for Practice in Non-Urban/Underserved Areas](#),” reaffirmed April 2012 and October 2006; originally approved in June 2000.

June 2018, reaffirmed the policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles](#),” reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

June 2018, approved the revised policy statement “[Financing of Graduate Medical Education in Emergency Medicine](#),” revised and approved October 2012, reaffirmed September 2005; originally approved September 1999.

February 2018, reaffirmed the policy statement “[Emergency Medicine Workforce](#),” reaffirmed April 2012 and June 2006; revised and approved September 1999 with the current title; originally approved November 1987 titled “Manpower.”

November 2017, approved the revised policy statement “[Workforce Diversity in Health Care Settings](#),” reaffirmed June 2013 and October 2007; originally approved October 2001.

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

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

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

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted.

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

Amended Substitute Resolution 45(91) Emergency Medicine Residencies 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 adopted by the Board 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.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted.

November 1987, adopted the position that, based on current and projected numbers of graduates from emergency medicine residency training programs, there will be a significant shortage of appropriately trained and certified emergency physicians. Additionally directed that a task force be appointed to develop strategies to meet the shortage.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 49(20)

SUBMITTED BY: Forensic Medicine Section
William Green, MD, FACEP
Sally Henin, MD, FACEP
Ralph Riviello, MD, FACEP
Heather Rozzi, MD, FACEP
William Smock, MD
Michael L. Weaver, MD, FACEP

SUBJECT: Strangulation Policy Statement and Educational Resources

PURPOSE: 1) Create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement. 2) Work with specialty and stakeholder organizations to develop an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Intimate partner violence (IPV) and sexual assault (SA) are serious public health problems; and

2

3 WHEREAS, Many IPV and SA victims seek treatment in the emergency department; and

4

5 WHEREAS, Non-fatal strangulation is a form of asphyxia characterized by external pressure on the neck
6 closing the blood vessels or airway; and

7

8 WHEREAS, Studies indicate that 23 to 68% of female IPV victims and up to 25% of SA victims will
9 experience strangulation; and

10

11 WHEREAS, Strangulation is an indicator of the escalation of violence and associated with increased risk of
12 serious injury and even death in cases of IPV; and

13

14 WHEREAS, Strangulation has been identified as one of the most lethal forms of IPV and SA; and is used to
15 exert power over a victim by taking from them control of their own body; and

16

17 WHEREAS, When strangled, unconsciousness and anoxic brain injury may occur within seconds and death
18 within minutes; and

19

20 WHEREAS, Oftentimes, even in fatal cases, there is no external evidence of injury from strangulation, yet
21 because of underlying brain damage due to hypoxia or vascular injuries during the strangulation assault, victims may
22 have serious internal injuries or consequences, including death, even days, or weeks later; and

23

24 WHEREAS, There has been increased awareness of the use of chokeholds/carotid restraint by law
25 enforcement as a potentially dangerous and truly represents lethal force; and in addition, there are several reports of
26 serious injury, including embolic strokes, to individuals when training on these techniques by performing them on
27 each other; and

28

29 WHEREAS, Many emergency medicine providers lack specialized training and knowledge to identify the
30 signs and symptoms of strangulation, they mistakenly focus only on the presence of visible or airway injuries when
31 imaging should have also been considered to rule out internal injury, and this lack of training has led to the

32 minimization of this type of violence, exposing victims to potential serious, short- and long-term health consequences,
33 permanent brain damage, and increased likelihood of death; and
34

35 WHEREAS, There are no specific guidelines or recommendations regarding the emergency department
36 management of the non-fatal strangulation victim, including history taking, physical examination, radiographic
37 imaging, treatment, disposition, and documentation; therefore be it
38

39 RESOLVED, That ACEP create a policy statement acknowledging the seriousness of strangulation in
40 intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement; and
41 be it further
42

43 RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of
44 Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders to
45 create an information paper on the emergency department evaluation, treatment, and management of strangulation and
46 available resources.

Background

This resolution requests that ACEP create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement, and that ACEP work with specialty and stakeholder organizations to develop an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

The “[2019 Model of the Clinical Practice of Emergency Medicine](#),” developed by seven emergency medicine organizations, lists core patient conditions that present to emergency departments. In Item 18.1.9.4 Neck trauma, strangulation is listed as a disorder for which patient acuity could be critical, emergent, or lower acuity. Patient acuity level is fundamental to determining the priority and sequence of tasks to manage the patient.

Clinical signs and symptoms of non-fatal strangulation vary from patient to patient and may not appear for 24 to 36 hours, while the absence of external neck injuries does not exclude strangulation, all of which can make it difficult to identify this injury.

As an adjunct to the ACEP policy statement, “[Management of the Patient with the Complaint of Sexual Assault](#),” ACEP’s Forensic Medicine Section prepared the ebook, “[Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient](#)” that is available on the ACEP Web site. Chapter 16 of the ebook is titled “Strangulation.” This chapter addresses the challenges, physiology, mechanisms, definitions, pathophysiology, clinical symptoms and caveats, clinical findings, clinical evaluation, management, and documentation related to strangulation. There are also examples of a documentation chart for non-fatal strangulation cases, medical release form and questions to ask the victim.

The International Association of Forensic Nurses has developed a position statement on non-fatal strangulation and a [documentation toolkit](#), both available online on their website. The Emergency Nurses Association has a Topic Brief, “[An Overview of Strangulation Injuries and Nursing Implications](#),” available on their website.

The Training Institute on Strangulation Prevention has various resources (e.g., brochures, training DVD, webinars) on the topic, available at no charge on their Web site: <https://www.strangulationtraininginstitute.com>. The goals of the Institute are to: enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled; improve policy and practice among the legal, medical, and advocacy communities; maximize capacity and expertise; increase offender accountability; and ultimately enhance victim safety.

The 2017 Council referred Resolution 48(17) Non-Fatal Strangulation to the Board of Directors. The resolution directed ACEP to work with other organizations to develop educational resources and programs related to the evaluation and management of non-fatal strangulation, and for ACEP to develop a policy statement on the seriousness of non-fatal strangulation and a clinical practice guideline for the evaluation and treatment of non-fatal strangulation in the emergency department. The Board assigned the referred resolution to the Clinical Policies Committee with the directive to review and provide a recommendation regarding further action. Members of the Clinical Policies Committee performed a literature search and reviewed the resources and materials available on the topic. The committee concluded there was not enough evidence to develop a clinical policy, that a policy statement was not the ideal means of disseminating educational content, and that there were multiple sources of educational content available on non-fatal strangulation. In September 2018, the Clinical Policies Committee recommended to the Board of Directors that a clinical policy or policy statement on non-fatal strangulation not be developed but that existing educational materials on the topic be further disseminated. It was suggested that the Forensic Medicine Section provide links to additional resources on their ACEP microsite and submit a course proposal for an ACEP meeting on this topic.

It is not known at this time whether additional research on this topic has been published without performing another literature search.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings, including novel delivery methods.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Resolution 48(17) Non-Fatal Strangulation was referred to the Board. This resolution directed ACEP to work with other organizations to develop educational resources and programs related to evaluation and management of non-fatal strangulation, develop a policy statement on its seriousness, and develop a clinical practice guideline.

Prior Board Action

September 2018, adopted the recommendation of the Clinical Policies Committee to take no further action on Referred Resolution 48(17) Non-Fatal Strangulation.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

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



RESOLUTION: 50(20)

SUBMITTED BY: Alan Heins, MD, FACEP
Rachel Solnick, MD
American Association of Women Emergency Physicians Section
Observation Medicine Section
Vermont Chapter

SUBJECT: Support for Expedited Partner Therapy

PURPOSE: 1) Develop a clinical policy supporting the use of expedited partner therapy. 2) Develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy. 3) Work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Sexually transmitted infections (STIs) in America are at all-time highs and increasing; and

2
3 WHEREAS, From 2014 to 2018, gonorrhea cases increased by 63% to over 583,000 cases and chlamydia
4 increased by 19% to 1.8 million cases – the most ever reported to the Centers for Disease Control (CDC)¹; and

5
6 WHEREAS, The rate of ED patients with STIs has risen more quickly than the general increase of ED
7 patients and from 2009-2013 there was a 39% increase in ED visits that included an STI diagnosis²; and

8
9 WHEREAS, Patients at highest risk for STIs are more likely to have poor access to healthcare and thus rely
10 on the ED for their care³⁻⁵; and

11
12 WHEREAS, STIs are a matter of health disparities and ED patients treated for STI are more likely to be non-
13 white, younger, and lower-income^{2,6}; and

14
15 WHEREAS, Untreated STIs can increase susceptibility to HIV and has especially harmful effects for women
16 by causing pelvic inflammatory disease, which the CDC estimates causes infertility in 24,000 women in the U.S. each
17 year⁷; and

18
19 WHEREAS, STIs are a preventable drain on the healthcare system economy carrying an estimated lifetime
20 cost of \$678 million attributed to gonorrhea and chlamydia⁸; and

21
22 WHEREAS, Traditional methods of partner notification (informing partners of patients with STIs of their
23 exposure) have yielded poor results and in areas of highest infection rates partner notification rates were as low as
24 12% and 17% for chlamydia and gonorrhea, respectively⁹; and

25
26 WHEREAS, Expedited partner therapy (EPT) is the practice of treating sex partners of persons with a
27 laboratory-confirmed STI without medical evaluation of the partners to treat and prevent ongoing transmission of
28 STIs; and

29
30 WHEREAS, EPT is recommended for heterosexual partners who are unlikely to access timely evaluation and
31 treatment and EPT provides source patient counseling, written instructions for the partner on treatment and
32 prevention, and uses drugs with a low risk of anaphylaxis and medications are dispensed with instructions about
33 adverse effects; and

34 WHEREAS, Partners receiving EPT are encouraged to seek additional medical evaluation as soon as possible
35 to discuss screening for other STIs, including HIV infection; and

36
37 WHEREAS, In randomized controlled trials, EPT has shown to be more effective compared to unassisted
38 referrals at decreasing rates of source patient reinfection or persistent infection compared to standard partner referral
39 and in a systematic review of trials of over 12,000 patients there were no drug-related adverse effects or allergic
40 reactions reported¹⁰⁻¹²; and

41
42 WHEREAS, California established a hotline to record any adverse events from EPT prescriptions and
43 received no calls for the full 10 years it was running and similarly, according to the Centers for Disease Control and
44 Prevention (CDC), there have been no cases of malpractice associated with the practice of EPT¹³; and

45
46 WHEREAS, EPT is recommended by the CDC, American College of Obstetrics and Gynecology, American
47 Academy of Family Physicians, American Osteopathic Association, Society of Adolescent Medicine, American
48 Academy of Pediatrics, and the American Bar Association; and

49
50 WHEREAS, EPT has gained legal acceptance in many states over the past decade because of state-specific
51 pharmacy or medical board decisions and the passage of state laws or regulations allowing the practice; and

52
53 WHEREAS, EPT is currently permissible in 44 states, potentially allowable in 5 states (Alabama, Kansas,
54 New Jersey, Oklahoma, South Dakota, Puerto Rico), and only prohibited in South Carolina; therefore be it

55
56 RESOLVED, That ACEP develop a clinical policy supporting the use of expedited partner therapy; and be it
57 further

58
59 RESOLVED, That ACEP develop model legislation that removes legal obstacles to expedited partner
60 therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care
61 professionals that choose to prescribe expedited partner therapy; and be it further

62
63 RESOLVED, That ACEP work with state and local health departments and key stakeholders to develop
64 expedited partner therapy protocols.

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13. McCool-Myers M, Smith AD-Y, Kottke MJ. Expert Interviews on Multilevel Barriers in Implementing Expedited Partner Therapy for Chlamydia. *J Public Health Manag Pract*. August 2019. doi:10.1097/PHH.0000000000001054

Background

This resolution calls for ACEP to: 1) develop a clinical policy supporting the use of expedited partner therapy; 2) develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and 3) work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

Expedited partner therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. The [CDC](#) reports that cases of STIs have steadily increased since 2014. Limited resources mean that many partners are unable to receive standard treatment. The [CDC](#) has also concluded that, although ongoing evaluation is necessary, EPT is a useful option to facilitate partner management.

Currently, 45 states allow EPT (instead of 44 as reflected in the Whereas statement). It is potentially allowed in four states (instead of five as reflected in the Whereas statement), and prohibited in South Carolina. Some states have created programs specifically geared towards EPT. In 2014, the [Illinois Department of Public Health](#) used EPT along with other education to improve treatment outcomes in gonorrhea and chlamydia. The Minnesota Department of Health has created online guidance for using [EPT for Chlamydia trachomatis and Neisseria gonorrhoeae](#). Both states found that more education on EPT was needed both for the public and practitioners.

While ACEP has a clinical policy on [Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy \(2016\)](#), there is not a clinical policy specifically on EPT or STI transmission. The [American Osteopathic Association \(AOA\)](#) has a statement advocating for the use of EPT. [The American Academy of Family Physicians \(AAFP\)](#) also has a statement in support of EPT.

There is research that supports EPT as an effective option to facilitate partner management. A [clinical trial](#) published in 2010 found that EPT was superior to standard partner referral across a wide spectrum of sociodemographic and behaviorally defined subgroups. A [randomized controlled trial](#) from 2011 found that EPT was less costly and it treated more partners than standard partner referral. A [Cochrane Systematic Review](#) published in 2013 concluded that more research was needed on EPT. A [randomized controlled trial](#) published in 2015 concluded that more education is needed in order to make EPT effective.

An ACEP clinical policy supporting expedited partner therapy could provide guidance and education to members on the use of EPT. Model legislation could provide further guidance, specifically in states where EPT is potentially allowable or prohibited. Partnering with state and local health departments could provide education to the public, while providing protocols for practitioners.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

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

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RESOLUTION: 51(20)

SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Telehealth Disaster Pilot and Educational Resources

PURPOSE: 1) Create new policy promoting federal, state, and private funding for pilot projects and studies to provide care to disaster victims and rescue workers using telehealth and other technology. 2) Study the effectiveness of using telehealth for the evaluation and treatment of disaster victims. 3) Create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools.

FISCAL IMPACT: Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts, and policy development.

1 WHEREAS, Natural and man-made disasters occur within the United States and throughout the world and
2 affect people of all races, ages, genders, and people groups; and
3

4 WHEREAS, During disasters there is often a shortage of medical providers to provide emergency/disaster
5 care to victims of disasters and disaster workers; and
6

7 WHEREAS, Even during disasters when there are significant medical relief efforts including supplies and
8 personnel in a disaster area, often the medical areas are underutilized because many patients are unable to reach these
9 medical areas to receive evaluation and/or treatment; and
10

11 WHEREAS, Funding is important for the success of disaster care delivery and education of first responders
12 and disaster workers of natural and man-made disasters; and
13

14 WHEREAS, Telehealth, digital health, and other technology could improve the delivery of care to victims of
15 disasters and reach victims in remote or other hard-to-travel or access areas, that might otherwise not be able to be
16 treated; and
17

18 WHEREAS, Many first responders may not be familiar with the use of telehealth or being able to properly
19 serve as a presenter in a disaster or emergency setting during care using telehealth or other technology; and
20

21 WHEREAS, Telehealth is well accepted by providers and patients and being effectively used in many
22 medical facilities and in some disaster settings with good preliminary results; therefore be it
23

24 RESOLVED, That ACEP create new policy that promotes federal, state, and private funding for pilot projects
25 and studies to help provide care, once a disaster is officially declared by a state or federal agency, entity or official, to
26 disaster victims and rescue workers using telehealth and other technology as tools and to study the effectiveness of
27 using telehealth as a vehicle for the evaluation and treatment of disaster victims and patients; and be it further
28

29 RESOLVED, That ACEP create new policy that encourages federal, state, and private funding to develop and
30 implement telehealth and other technology educational programs and training of first responders and disaster workers
31 to become more familiar with such tools to improve access, evaluation of, and the care delivered to victims of natural
32 and man-made disasters.

Background

The resolution requests ACEP to: 1) Create new policy promoting federal, state, and private funding for pilot projects and studies to provide care to disaster victims and rescue workers using telehealth and other technology. 2) Study the effectiveness of using telehealth for the evaluation and treatment of disaster victims. 3) Create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools

In accordance with ACEP's policy statement "[Emergency Medicine Telehealth](#)" (most recently revised in February 2020), ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians.

Disaster medicine is a unique and continuously evolving environment for emergency care. The unique nature of disaster care includes, but is not limited to, challenges of access to patients, austere conditions, environmental challenges, and shortages of facilities and personnel. The marriage of telehealth, disaster medicine response, and new technologies such as drone use, is still a novel and increasingly used concept. ACEP is in a unique position in having the expertise and means to accomplish furthering the concepts described in the resolution.

From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. The Medicare statute currently restricts reimbursement for telehealth to services performed in rural areas. During the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) used its unique "1135" waiver authority that only exists during a national emergency to temporarily waive this restriction, as well as another restriction called the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home). This waiver significantly expanded the use of telehealth during a national emergency.

The Federal Communications Commission (FCC) has implemented initiatives to support health care providers who want to stand up telehealth programs in rural and underserved communities during the COVID-19 PHE. Specifically, FCC established a [\\$200 million telehealth program](#) for healthcare providers responding to the COVID-19 PHE. Congress appropriated the funds as part of the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act. Through the COVID-19 Telehealth Program, the FCC helped healthcare providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. The FCC has closed applications for this program.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts, and policy development.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the positive, negative, and potential unintended consequences of telemedicine; and develop appropriate policy assuring appropriate doctor-patient relationships are maintained.

Resolution 36 (14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in Telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 20(13) Disaster Research adopted. Directed ACEP to work with other organizations to develop guidelines for evaluation of new or ongoing projects in disaster preparedness, response, effectiveness of interventions, and outcomes research and research funding.

Prior Board Action

February 2020, approved the revised policy statement “[Emergency Medicine Telehealth](#),” originally approved January 2016.

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

June 2018, approved the revised policy statement “[Disaster Medical Services](#),” reaffirmed April 2012 and October 2006; revised and approved June 2000; reaffirmed March 1997; originally approved June 1985.

June 2016, approved the policy statement “[Ethical Use of Telemedicine in Emergency Care](#).”

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted.

Resolution 36 (14) Development of a Telemedicine Policy for Emergency Medicine adopted.

Amended Resolution 20(13) Disaster Research adopted.

Background Information Prepared by: Patrick R. Elmes, EMT-P
EMS & Disaster Preparedness Manager

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



RESOLUTION: 52(20)
SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP
SUBJECT: The Corporate Practice of Medicine

PURPOSE: 1) Review and report on the legal and regulatory matters related to the corporate practice of medicine in each state; 2) Develop policy stating that upon request from groups facing loss of their contract to a corporate entity, ACEP and the relevant state chapter will provide a written review of the legality of the corporation obtaining the contract for emergency services; 3) ACEP and the chapter will work with other organizations in petitioning appropriate state authorities to investigate if the corporate practice of medicine is occurring in a state where it is prohibited; and 4) Convene a meeting of other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

FISCAL IMPACT: Budgeted committee and staff resources for policy development Additional unbudgeted and substantial staff resources to develop a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine in each state. Additional staff resources to advocate for states to investigate whether the potential corporate practice of medicine is occurring contrary to state law. Unbudgeted travel and meeting costs of up to \$10,000 to convene a meeting of specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

1 WHEREAS, A significant number of the nation’s emergency departments are controlled by a staffing
2 company with private equity backing or ownership; and
3

4 WHEREAS, Optum, a subsidiary of the United Healthcare insurer, has recently taken ownership of
5 emergency medicine practices; and
6

7 WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states to keep the business
8 interest out of the physician-patient relationship; and
9

10 WHEREAS, The CPOM doctrine has as its main purpose the protection of patients and the avoidance of the
11 commercialization of the practice of medicine; and
12

13 WHEREAS, In states where the CPOM doctrine and the state Medical Practice Acts prohibit lay ownership of
14 a medical practice an ACEP member can be subject to a detrimental licensure action through the State Board of
15 Medicine if they are found to be aiding or abetting the illegal practice of medicine; and
16

17 WHEREAS, The original Bylaws of ACEP stated that “an emergency physician will not associate himself in
18 any fashion with any institution which permits medical practice other than by a physician;” and
19

20 WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response
21 to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are
22 detrimental to its members or the public”; and
23

24 WHEREAS, The CPOM can be detrimental to the member and the public; therefore be it
25

26 RESOLVED, That ACEP will prepare a comprehensive review of the legal and regulatory matters related to
27 the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a
28 resource and announced to members as an available electronic download; and be it further

29 RESOLVED, That ACEP adopt as policy: “The ACEP, in concert with its relevant component state chapter,
30 in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to
31 physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians
32 whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the
33 corporation obtaining the contract for emergency services.”; and be it further
34

35 RESOLVED, That ACEP, in those states that are found to have existing prohibitions on the corporate practice
36 of medicine, along with the relevant state chapter, will petition the appropriate authorities in that state to examine the
37 corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the
38 state professional societies of anesthesia and radiology in this effort and solicit the support of the state medical
39 society; and be it further
40

41 RESOLVED, That ACEP will convene a meeting with representatives of physician professional associations
42 representing anesthesiologists, radiologists, hospitalists, dermatologists, and other specialties affected by private
43 equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

References:

<https://www.texmed.org/CPMwhitepaper/>
<https://www.ama-assn.org/media/7661/download>

Background

This resolution calls for ACEP to review and report on the legal and regulatory matters related to the corporate practice of medicine in each state. Additionally, it directs ACEP to develop policy stating that upon request from groups facing loss of their contract to a corporate entity, the College and the relevant state chapter will provide a written review of the legality of the corporation obtaining the contract for emergency services, and that the College and chapter will work with other organizations in petitioning appropriate state authorities to investigate if the corporate practice of medicine is believed to be taking place in a state where it is prohibited. It also directs ACEP to convene a meeting of other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

A 2015 AMA [Issue Brief](#) on the corporate practice of medicine states: “The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. This doctrine arises from state medical practice acts and is based on a number of public policy concerns, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation’s obligation to its shareholders may not align with a physician’s obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician’s independent medical judgment. While most states prohibit the corporate practice of medicine, almost every state has broad exceptions, such as for professional corporations and employment of physicians by certain health care entities.”

It also notes that “every state allows for the creation of professional corporations, which are corporations organized for the specific purpose of rendering a professional service. State statutes often specify how the professional corporations should be structured, who can participate as shareholders or owners and who must serve on the board of directors. Most states restrict the shareholders, owners, or board of directors of a professional corporation to persons licensed to render the same professional service as the professional corporation.” About 30 states have explicit restrictions, and exceptions, to the corporate practice of medicine.

Some state medical boards have issued opinions as to whether certain practices violate corporate practice of medicine restrictions and, according to the AMA, the question is often decided on whether employment agreements specify that physicians maintain independent medical judgement in those arrangements.

As independently incorporated entities, ACEP chapters have autonomy to determine their own actions, within the parameters of ACEP and chapter bylaws and may not choose to work with ACEP as directed in the resolution.

ACEP's policy statement "[Emergency Physician Rights and Responsibilities](#)" states that "Emergency physician autonomy in clinical decision making should be respected and should not be restricted other than through reasonable rules, regulations, and bylaws of his or her medical staff or practice group. This includes reasonable, good faith deviations from current, published ACEP Clinical Policies based upon the particular clinical situation in a given patient. Emergency physician autonomy should not be restricted by cost-saving guidelines, rules, or protocols. The physicians must have the ability to do what they believe in good faith is in the patient's best interest at all time."

ACEP's policy statement "[Emergency Physician Contractual Relationships](#)" states that "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."

Last year, the Council and the Board adopted Resolution 58(19) Role of Private Equity in Emergency Medicine. Part of the resolution directed the College to study the market penetration of non-physician owned emergency medicine groups and their impacts on physicians. Additionally, it called for ACEP to work with other organizations to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur. In response to the resolution, ACEP President William Jaquis, MD, FACEP, appointed an Emergency Medicine Group Ownership Task Force. The task force is chaired by former ACEP President Andrew Sama, MD, FACEP, and consists of members representing a variety of different employment models. The task force developed an RFP to study the market penetration of all emergency medicine ownership models, and research their respective impacts on physicians and their practices and, to the extent possible, their unique impacts on quality of care and cost of care. In August, the Board of Directors accepted the recommendation to retain the services of Milliman to lead this research effort. As of this writing, final contract negotiations are underway, with the project likely to begin in September and a goal of providing a final report to the 2021 Council. A status report on this resolution has been prepared for the 2020 Council.

As referenced in the sixth Whereas statement, the original ACEP Bylaws from 1968 included a provision that "No person shall remain a member of the College unless he is of good moral character and agrees to abide by the Principles of Medical Ethics of the American Medical Association and the American College of Emergency Physicians Principles of Ethical Practice." The Principles of Ethical Practice consisted of six statements, one of which read: "The emergency physician shall not associate himself in any fashion with any institution which permits medical practice by other than a physician." In 1976, the ACEP Council removed the Principles of Ethical Practice from the Bylaws and made them separate official ACEP policy. Additionally, in 1976, the Bylaws were amended to state that the AMA Principles of Medical Ethics and ACEP's Principles of Ethical Practice and other related ACEP policy statements are the principles of ethics of ACEP. In 1979, the Board of Directors approved removing all references to ACEP's Principles of Ethical Practice from College literature and that the AMA Principles of Medical Ethics would be referenced instead. In June 1997, the Board of Directors adopted the "[Code of Ethics for Emergency Physicians](#)," most recently approved January 2017.

As referenced in the seventh Whereas statement, in 2004, ACEP sought and received an Advisory Opinion from the Federal Trade Commission (FTC) regarding issues raised in two Council resolutions referred to the Board in 2003. The resolutions were 17(03) Certificate of Compliance and 18(03) Intention to Bid for a Group Contract. While the FTC Advisory Opinion noted that ACEP could respond to "behavior of market participants that it believes are detrimental to its members or the public," it raised a number of potential antitrust concerns about actions contemplated by both resolutions. The FTC Advisory Opinion stated that "ACEP may not unreasonably restrict competition among its members in order to force all contractual relationships between emergency physicians and holders of contracts to provide emergency services to hospitals into its preferred model."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee and staff resources for policy development. Additional unbudgeted and substantial staff resources to develop a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine in each state. Additional staff resources to advocate for states to investigate whether the potential corporate practice of medicine is occurring contrary to state law. Unbudgeted travel and meeting costs of up to \$10,000 to convene a meeting of specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities

Prior Council Action

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted. The resolution called for ACEP to study and report annually the market penetration of non-physician ownership of emergency medicine groups and the effects that these groups have on physicians and ACEP advocacy efforts. It further directed the College to advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcies, or other adverse events of their employer/management company. Additionally, ACEP was directed to partner with other medical societies to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur.

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

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including “With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.”

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

Resolution 58(95) Sales of Emergency Department Contracts not adopted. The resolution asked that ACEP’s lobbying efforts be directed toward federal and state legislation that would ban the sale of emergency department contracts.

Resolution 5(76) Principles of Ethical Practice adopted. This Bylaws amendment removed the “Principles of Ethical Practice” from the ACEP Bylaws and made it an official policy of the College. Additionally amended the Bylaws to state that the AMA Principles of Medical Ethics and ACEP’s Principles of Ethical Practice and other related ACEP policy statements are the principles of ethics of ACEP.

Prior Board Action

August 2020, approved the recommendation of the Emergency Medicine Group Ownership Task Force to contract with Milliman to conduct research on the landscape and market penetration of group ownership models and seek to identify unique impacts of different models on emergency physicians, cost of care, and quality of care.

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

June 2018, approved the revised policy statement “[Emergency Physician Contractual Relationships](#),” revised and

approved October 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled “Contractual Relationships between Emergency Physicians and Hospitals.”

July 2018, reviewed the PREP “[Emergency Physician Contractual Relationships](#)” as an adjunct to the policy statement “Emergency Physician Contractual Relationships.”

January 2017, approved the revised “[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.”

October 2015, approved the revised policy statement “[Emergency Physician Rights and Responsibilities](#),” revised and approved April 2008 and July 2001; originally approved September 2000

September 2004, approved submitting the report to the Council on Referred Resolution 17(03) and Referred Resolution 18(03) with the FTC Advisory Opinion.

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

1979, approved removing all references to ACEP’s Principles of Ethical Practice from College literature and that the AMA Principles of Medical Ethics would be referenced instead.

Resolution 5(76) Principles of Ethical Practice adopted.

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



Late Resolution

RESOLUTION: 53(20)
SUBMITTED BY: Maryland Chapter of Emergency Physicians
SUBJECT: In Memory of Lindsey J. Myers, MD

1 WHEREAS, With the untimely death of Lindsey Jo Myers, MD, on April 11, 2020, ACEP lost a gifted
2 communicator, a tireless emergency medicine advocate, and a committed believer in the Hippocratic Oath; and
3

4 WHEREAS, Dr. Myers received her medical degree from the Eastern Virginia School of Medicine in 2008
5 and completed her emergency medicine residency at Geisinger Medical Center in Danville, Pennsylvania in 2011
6 where she was a life flight physician as well; and
7

8 WHEREAS, Dr. Myers had a long and distinguished service as a member of ACEP and both the North
9 Carolina and then the Maryland Chapter totaling 10 years; and
10

11 WHEREAS, Dr. Myers served her community for ten years as an emergency physician and tirelessly worked
12 at Carteret Health Care in Morehead, North Carolina, East Medical Center in New Bern, North Carolina, and
13 Peninsula Regional Medical Center in Salisbury as well as Atlantic General Hospital in Berlin, Maryland; and
14

15 WHEREAS, Dr. Myers additionally practiced emergency medicine and touched many lives with her
16 kindness, compassion, and desire to truly help mankind; and
17

18 WHEREAS, Dr. Myers was recognized for her deep empathy and compassion for medicine which earned her
19 the exuberant gratitude and admiration of her patients, colleagues, friends, and family and will forever be an
20 inspiration to them; and
21

22 WHEREAS, Dr. Myers will be missed by her many friends and colleagues who were privileged to know her
23 for her strength of character, the warmth of her smile, and as the epitome of what an emergency physician is, but most
24 importantly that she knew that kindness mattered; therefore, be it
25

26 RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the
27 accomplishments and contributions of a gifted emergency physician Lindsey Jo Myers, MD and extends condolences
28 and gratitude to her family and friends for her service to the specialty of emergency medicine and to patient care.