American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2024 Annual Council Meeting
Thursday Evening, September 26, 2024, through Saturday, September 28, 2024
Mandalay Bay Resort Hotel and Convention Center

Background information has been prepared on the resolutions that were submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council.

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

Asynchronous testimony will open on Thursday, August 29 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2024 resolutions will be posted on the Council engagED when asynchronous testimony opens. After clicking on the link provided:

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

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

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

The asynchronous platform is the only method to introduce testimony until the live Reference Committee hearings in Las Vegas. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. All comments should be addressed to the Reference Committee Chair or the Council Speaker. **Please do not direct any communications to another member, including anyone who has posted comments before you, with whom you may or may not agree.** Proper decorum is expected within the asynchronous testimony platform as well as the in-person Reference Committee hearings during the Council meeting.

Comments should be concise so as to not exceed an equivalent of 2 minutes of oral testimony. Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this online testimony for the Council meeting, you hereby acknowledge and agree to abide by ACEP's Meeting Conduct Policy.

Asynchronous testimony will close at 12:00 noon Central time on Wednesday, September 18. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Monday, September 23 and will be the starting point for the live Reference Committee hearings during the Council meeting in Las Vegas on Friday, September 27.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or

individual section tabs from the Table of Contents. You will also find separate compendiums of the President-Elect candidates, Board of Directors candidates, and the resolutions. Additional documents may be added over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Las Vegas!

Your Council Officers,

Melissa W. Costello, MD, FACEP
Speaker

Michael J. McCrea, MD, FACEP
Vice Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

DEFINITION OF COUNCIL ACTIONS

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 13-23

Larisa M. Traill, MD, FACEP (MI) – Chair
Laurel Barr, MD, FACEP (OH)
Amanda Irish, MD, MPH (IA)
Catherine A. Marco, MD, FACEP (PA)
Emily Mills, MD, FACEP (MI)
Aine Yore, MD, FACEP (WA)

Amanda Pairitz-Campo
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 24-42

Torree M. McGowan, MD, FACEP (GS) – Chair
Blake Bailey, DO, MBA, FACEP (PA)
Lisa M. Bundy, MD, FACEP (MS)
Joshua R. Frank, MD, FACEP (WA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchner, MD, MPH, FACEP (MI)

Erin Grossmann
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 43-62

Kurtis Mayz, JD, MD, MBA, FACEP – Chair
Sara Ann Brown, MD, FACEP – (IN)
Angela P. Cornelius, MD, FACEP (TX)
Dan Freess, MD, FACEP (CT)
Michael C. Smith, MD, MBA, FACEP (LA)
Carol Wright Becker, MD, FACEP (WV)

Travis Schulz, MLS, AHIP
George Solomon, MHS, FP-C, CCP-C, TP-C

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Stephen V. Cantrill, MD, FACEP *William P. Jaquis, MD, FACEP* *Christopher S. Kang, MD, FACEP* *Mark S. Rosenberg, DO, MBA, FACEP* *Gillian R. Schmitz, MD, FACEP*	
2	Commendation for JT Finnell, II, MD, MSc, FACEP, FACMI *Indiana Chapter*	
3	Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE *Douglas Char, MD, FACEP* *Kelly Gray-Eurom, MD, MMM, FACEP* *Aaron Kuzel, DO, MBA* **See Attachment A for list of additional individual cosponsors*	
4	Commendation for Christopher S. Kang, MD, FACEP *Washington Chapter*	
5	Commendation for Rami R. Khoury, MD, FACEP *Michigan College of Emergency Physicians*	
6	Commendation for Shari Purpura *Jay Brenner, MD, FACEP* *Michael J. McCrea, MD, FACEP* *John Moskop, PhD* *Raquel Schears MD, FACEP* *James D. Thompson, MD, FACEP* *Larisa M. Traill, MD, FACEP* **See Attachment A for list of additional individual cosponsors*	
7	In Memory of Neal F. Aulick II, MD, FACEP *Ohio Chapter* *Pennsylvania College of Emergency Physicians* *West Virginia College of Emergency Physicians*	
8	In Memory of Marilyn J. Gifford, MD *Douglas Hill, DO, FACEP* *Carla Murphy, DO, FACEP* *Colorado Chapter*	
9	In Memory of Veronica Greer, MD *Texas College of Emergency Physicians*	
10	In Memory of Christopher H. Linden, MD, FACEP *Massachusetts College of Emergency Physicians*	
11	In Memory of Gregory L. Walker, MD, FACEP *Michigan College of Emergency Physicians*	

Resolution #	Subject/Submitted by	Reference Committee
12	In Memory of Jesse A. Weigel, MD, FACEP *Pennsylvania College of Emergency Physicians*	
13	Allocation of Councillors – Bylaws Amendment *Colorado Chapter* *Louisiana Chapter* *Pennsylvania College of Emergency Physicians*	A
14	College Parliamentary Authority – Bylaws Amendment *Bylaws Committee* *Board of Directors* *Council Steering Committee*	A
15	College Parliamentary Authority - Council Standing Rules Amendment *Council Steering Committee*	A
16	International Members Serving as Section Officers – Bylaws Amendment *Bylaws Committee* *Board of Directors* *Cruise Ship Medicine Section* *International Emergency Medicine Section*	A
17	Removing Gendered Pronouns from ACEP's Bylaws – Bylaws Amendment *Jacob Altholz, MD* *Scott Pasichow, MD, MPH, FACEP*	A
18	ACEP Council and Scientific Assembly Meeting Location *Alicia Mikolaycik Gonzalez, MD, FACEP* *Aimee Moulin, MD, FACEP* *David Terca, MD, FACEP* *Randall Young, MD, FACEP* *California Chapter* *Nevada Chapter* *New York Chapter*	A
19	Vetting Intended Speakers with Divisive Language or Ideologies for ACEP Events *Diversity, Inclusion, Health Equity Section* *Social Emergency Medicine Section*	A
20	Advisory Council for All of Emergency Medicine *Pennsylvania College of Emergency Physicians*	A
21	Printable Volunteer Recognition Certificate *Alecia Gende, DO, FACEP* *Sarah Hoper, MD, FACEP* *AAWEP Section*	A
22	Support for the "Well Workplace" Policy Statement *Wellness Section* *Arizona College of Emergency Physicians* *Colorado Chapter* *District of Columbia Chapter*	A
23	Supporting a Statement Affirming Diversity, Equity, and Inclusion in Emergency Medicine *Diversity, Inclusion & Health Equity Section* *Social Emergency Medicine Section*	A

Resolution #	Subject/Submitted by	Reference Committee
24	Address ED Boarding and the Medicare Three-Midnight Rule for Post Acute Rehabilitation *James Humble, MD* *Virginia College of Emergency Physicians* *Dual Training Section* *Observation Medicine Section* *Young Physicians Section*	B
25	Boarding – Follow the Money *John Bibb, MD, FACEP* *Fred Dennis, MD, FACEP* *New Mexico Chapter* *Exploring Retirement Section*	B
26	Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events *Erik Blutinger MD FACEP* *Elaine Rabin MD FACEP* *Nicholas Stark, MD, MBA* *Arjun Venkatesh, MD, FACEP* *New York Chapter* *Quality Improvement & Patient Safety Section* *Young Physicians Section*	B
27	Continuous Physician Staffing for Rural Emergency Departments *Rural Emergency Medicine Section* *Social Emergency Medicine Section* *Oklahoma Chapter* *Michigan College of Emergency Physicians* *Virginia College of Emergency Physicians*	B
28	Data Gathering on Free Standing EDs: Examining Regulations, Services Offered, and Staffing Policies *Utah Chapter*	B
29	Minimum Standards for Freestanding Emergency Departments *Utah Chapter*	B
30	Hospital Network Requirements for Emergency Physicians *Elisabeth Giblin, MD* *Paul Kivela, MD, FACEP* *Bing Pao, MD, FACEP* *Thomas Sugarman, MD, FACEP* *California Chapter*	B
31	NEMPAC Contributions Transparency and Ethical Standards *Diversity, Inclusion & Health Equity Section* *Social Emergency Medicine Section*	B
32	Preventing Harmful Health Care Deals *Pennsylvania College of Emergency Physicians*	B
33	Promotion of Nursing in Emergency Medicine *Pennsylvania College of Emergency Physicians*	

Resolution #	Subject/Submitted by	Reference Committee
34	Reimbursement for Emergency Physician Services Provided Out-of-Hospital *Pennsylvania College of Emergency Physicians*	B
35	Sharing of Protected Health Information *Massachusetts College of Emergency Physicians* *New York Chapter*	B
36	EMTALA Reform to Improve Patient Access to Necessary Care *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Texas College of Emergency Physicians* *Locums Tenens Emergency Medicine Section* *Wellness Section*	B
37	Reinforcing EMTALA in Pregnancy Related Emergency Medical Care *Emily Ager, MD* *Michael Bresler, MD, FACEP* *Joshua da Silva, DO, FACEP* *Kelly Quinley, MD* *Monica Rakesh Saxena, MD, JD* *Rachel Solnick, MD* *Sophia Spadafore, MD* *Katherine Wegman, MD* *AAWEP Section* *California Chapter*	B
38	Termination of Pregnancy *Michael Bresler, MD, FACEP* *Monica Saxena, MD, JD* *Kelly Quinley, MD* *Sarah Hoper, MD, FACEP* *AAWEP Section* *California Chapter* *Ohio Chapter*	B
39	Urgent Care Transparency on Available Resources and Credentials *Pennsylvania College of Emergency Physicians*	B
40	Telehealth Emergency Physician Standards *New York Chapter*	B
41	Workplace Violence Data Collection *Wellness Section* *Arizona College of Emergency Physicians* *Colorado Chapter* *District of Columbia Chapter* *South Carolina Chapter*	B
42	Workplace Violence *New York Chapter*	B
43	Addressing Challenges Related to the New ABEM Oral Board Exam Format *Young Physicians Section* *California Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
44	Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations *Rural Emergency Medicine Section*	C
45	Climate Change Research and Education in Emergency Medicine *Tabitha Baca, MD* *Marc Futernick, MD, FACEP* *Gayle Galletta, MD, FACEP* *Rita Manfredi-Shutler, MD, FACEP* *Dana Mathew, DO, FACEP* *Scott Mueller, DO, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *David Terca, MD, FACEP* *Kreager Taber, MS4* *Alexandra Thran, MD, FACEP* *California Chapter* *Vermont Chapter*	C
46	Human Trafficking Training for All Emergency Medicine Residents *Michael J. Bresler, MD, FACEP* *Gus M. Garmel, MD, FACEP* *Nicole Exeni McAmis, MD* *California Chapter* *Colorado Chapter* *Georgia College of Emergency Physicians* *Massachusetts College of Emergency Physicians* *West Virginia College of Emergency Physicians*	C
47	Human Trafficking is a Public Health Crisis *Michael Bresler, MD, FACEP* *Gus Garmel, MD, FACEP* *Nicole Exeni McAmis, MD* *California Chapter* *Colorado Chapter* *Massachusetts College of Emergency Physicians* *New York Chapter* *Oregon Chapter* *West Virgina College of Emergency Physicians* *Wisconsin Chapter*	C
48	Alarm Fatigue *Laurel Barr, MD, FACEP* *Elyse Lavine, MD, FACEP* *Samuel Sondheim, MD* *AAWEP Section* *Quality Improvement & Patient Safety Section* *Young Physicians Section*	C
49	Centralized Repository of Credentialing Data *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Texas College of Emergency Physicians* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C

Resolution #	Subject/Submitted by	Reference Committee
50	Communication to Established Patients Being Referred to the Emergency Department *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
51	Consultant Communication and Feedback to Referring Emergency Physicians *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
52	Delegation of Critical Care to Non-Physician Practitioners *Louisiana Chapter*	C
53	Emergency Nursing and Emergency Department Accreditation *Pennsylvania College of Emergency Physicians*	C
54	Mandated Public Health Screening *New York Chapter*	C
55	Patient Experience Reporting *New York Chapter*	C
56	Patient and Visitor Code of Conduct *New York Chapter*	C
57	Rationalizing Communication of Imaging Hazards to Improve Care *Marco Coppola, DO, FACEP* *Robert Suter, DO, FACEP* *Locums Tenens Emergency Medicine Section* *Wellness Section*	C
58	Reducing Waste in Our Emergency Departments *Rita Manfredi-Shutler, MD, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *Alexandra Thran, MD, FACEP* *Vermont Chapter*	C
59	Tap Water is Sufficient Treatment *Tabitha Baca, MD* *Marc Futernick, MD, FACEP* *Gayle Galletta, MD, FACEP* *Rita Manfredi-Shutler, MD, FACEP* *Dana Mathew, DO, FACEP* *Scott Mueller, DO, FACEP* *Kristen Nordenholz, MD, FACEP* *Matthew Siket, MD, FACEP* *David Terca, MD, FACEP* *Kreager Taber (MS4)* *Alexandra Thran, MD, FACEP* *California Chapter* *Vermont Chapter*	C
60	Lethal Means Firearm Safety Counseling *Ashley Foster, MD, FACEP* *Sophia Lin, MD* *Theresa Walls, MD, MPH* *Pediatric Emergency Medicine Section*	C

Resolution #	Subject/Submitted by	Reference Committee
61	Safe Storage of Firearms *Andrea Green, MD, FACEP* *Michael McGee, MD, MPH, FACEP* *Ugo Ezenkwele, MD, FACEP* *Christopher L. Smith, MD, FACEP* *Alexndra Nicole Thran, MD, FACEP* *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section*	C
62	Stop the Bleed Education *Ugo Ezenkwele, MD, FACEP* *Andrea Green, MD, FACEP* *Michael McGee, MD, MPH, FACEP* *Christopher L. Smith, MD, FACEP* *Alexandra Nicole Thran, MD, FACEP* *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section*	C

Late Resolutions

63	Commendation for Todd B. Taylor, MD, FACEP *James Augustine, MD, FACEP* *Nicholas Genes, MD, PhD, FACEP* *Emily Hayden, MD, FACEP*	
64	In Memory of Amy H. Kaji, MD, PhD, MPH *Richelle Cooper, MD, MSHS, FACEP* *Gregory Hendey, MD, FACEP* *David Schriger, MD, MPH, FACEP* *Kabir Yadav, MDCM, MD, MSHS, FACEP* *Donald M. Yealy MD, FACEP*	
65	In Memory of Joseph Sabato, Jr., MD, FACEP *Massachusetts College of Emergency Physicians*	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(24)

SUBMITTED BY: William P. Jaquis, MD, FACEP
Christopher S. Kang, MD, FACEP
Mark S. Rosenberg, DO, MBA, FACEP
Gillian R. Schmitz, MD, FACEP

SUBJECT: Commendation for Stephen V. Cantrill, MD, FACEP

WHEREAS, Stephen V. Cantrill, MD, FACEP, has been a long standing member of ACEP's Clinical Policies Committee and ACEP's Epidemic Expert Panel; and

WHEREAS, Dr. Cantrill was selected to serve on the National Institute of Health's COVID-19 Treatment Guidelines Panel; and

WHEREAS, Dr. Cantrill was the sole emergency physician and representative for emergency medicine on this national panel; and

WHEREAS, Dr. Cantrill's service on this national panel entailed innumerable personal hours, more than 400 meetings, and 72 national treatment updates over the course of four years and through the conclusion of the historic COVID-19 pandemic federal health emergency; and

WHEREAS, Dr. Cantrill's expertise guided the triage, evaluation, management, and disposition of countless patients in the United States and around the world; and

WHEREAS, Dr. Cantrill represented and safeguarded the health, wellbeing, and professional identities of millions of emergency physicians and emergency care personnel in the United States; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Stephen V. Cantrill, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(24)

SUBMITTED BY: Indiana Chapter

SUBJECT: Commendation for J.T. Finnell, II, MD, MSc, FACMI, FACEP

WHEREAS, J.T. Finnell, II, MD, MSc, FACMI, FACEP, has served the American College of Emergency Physicians with highest distinction since becoming a member in 1990; and

WHEREAS, Dr. Finnell provided outstanding leadership to the Indiana Chapter through his service on its Board of Directors 2009-present, as chapter president 2013-14, and has maintained an active presence in the chapter; and

WHEREAS, Dr. Finnell was elected to the national ACEP Board of Directors in 2018 and served as Vice President of the Board 2022-23; and

WHEREAS, Dr. Finnell served as Board Liaison to the following committees: Academic Affairs Committee Clinical Policies Committee, Ethics Committee, Health Innovation Technology Committee, and the Research Committee; and

WHEREAS, Dr. Finnell served as Board Liaison to the Critical Care Medicine Section, Cruise Ship Medicine Section, Dual Training Section, Emergency Medicine Informatics Section, Emergency Ultrasound Section, Forensic Medicine Section, Medical Humanities Section, Research, Scholarly Activity, & Innovation Section, Wilderness Medicine Section, and the Young Physicians Section; and

WHEREAS, Dr. Finnell served as Board Liaison to the Emergency Medicine Group Ownership Task Force and the New Practice Models Task Force; and

WHEREAS, Dr. Finnell has passionately devoted his heart, energy, and dedication to his patients and all aspects of emergency medicine; and

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

RESOLVED, That the American College of Emergency Physicians commends and thanks J.T. Finnell, II, MD, MSc, FACMI, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION 3(24)

SUBMITTED BY: Douglas Char, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Aaron Kuzel, DO, MBA
**See Attachment A for list of additional cosponsors*

SUBJECT: Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE

WHEREAS, Mary Ellen Fletcher, CPC, CEDC, CAE, has been a valued and dedicated ACEP staff member since February 27, 2001; and

WHEREAS, Ms. Fletcher worked tirelessly for 10 years in the Reimbursement Department supporting the Reimbursement Committee and the Coding and Nomenclature Advisory Committee assisting with the assigned objectives; and

WHEREAS, Ms. Fletcher assisted in supporting the ACEP CPT and RUC teams for several years, including attending the CPT and RUC meetings, and was active in preparing the strategy and presentations that secured the wins in the 2007 Medicare Physician Fee Schedule that increased emergency medicine revenues collectively by $1 billion per year going forward; and

WHEREAS, Ms. Fletcher assisted in the planning and implementation of ACEP's Reimbursement and Coding Conferences for years, and earned her Certified Professional Coder (CPC) and Certified Emergency Department Coder (CEDC) credentials and helped to write the initial CEDC certification exam and study materials; and

WHEREAS, Ms. Fletcher has worked in the Governance Operations Department for the past 13 years supporting ACEP's Board of Directors, Council, committees, past leaders, and liaison representatives; and

WHEREAS, Ms. Fletcher obtained her Certified Association Executive (CAE) certification demonstrating her commitment as an association professional; and

WHEREAS, Ms. Fletcher has been instrumental in streamlining and improving ACEP's governance processes, particularly for the Council and committee operations, and continues to identify and implement process improvements; and

WHEREAS, Ms. Fletcher provides exceptional staff support to the ACEP Awards Committee, Council Steering Committee, Council Awards Committee, Council Reference Committees, and the Tellers, Credentials, & Elections Committee; and

WHEREAS, Ms. Fletcher's incredible memory, attention to detail, and strategic thinking enhances every project in which she was involved; and

WHEREAS, Ms. Fletcher's bright smile, cheery disposition, and infectious laugh will be remembered by everyone within ACEP who has had the pleasure to know her and work with her; and

WHEREAS**,** ACEP has benefited greatly from Ms. Fletcher's unique ability to adapt, amazing gift of patience, and willingness to attend to the needs of ACEP members and staff; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Mary Ellen Fletcher, CPC, CEDC, CAE, for her outstanding service and dedication to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for her extraordinary contributions.

List of Additional Cosponsors

Stephen Anderson, MD, FACEP
Andrew Bern, MD, FACEP
Michael Bishop, MD, FACEP
Jordan Celeste, MD, FACEP
Marco Coppola, DO, FACEP
Nicholas Cozzi, MD, MBA
Michael Gerardi, MD, FACEP
Sanford Herman, MD, FACEP
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Nicholas Jouriles, MD, FACEP
Steven Kailes, MD, FACEP
Jay Kaplan, MD, FACEP
Gary Katz, MD, MBA, FACEP
Paul Kivela, MD, MBA, FACEP
Jeffrey Linzer, MD, FACEP
Mark Meredith, MD, FACEP
Rebecca Parker, MD, FACEP
Debra Perina, MD, FACEP
Randy Pilgrim, MD, FACEP
John Proctor, MD, FACEP
John Rogers, MD, FACEP
Alex Rosenau, DO, FACEP
Mark Rosenberg, DO, MBA, FACEP
Michael Ruzek, DO, CPE, FACEP
Andrew Sama, MD, FACEP
Robert Schafermeyer, MD, FACEP
Gillian Schmitz, MD, FACEP
Sullivan Smith, MD, FACEP
Todd Taylor, MD, FACEP
James Thompson, MD, FACEP
Arlo Weltge, MD, FACEP
Florida College of Emergency Physicians
Indiana Chapter
NJ Chapter
Ohio Chapter
Tennessee College of Emergency Physicians

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 4(24)

SUBMITTED BY: Washington Chapter

SUBJECT: Commendation for Christopher S. Kang, MD, FACEP

WHEREAS, Christopher S. Kang, MD, FACEP, has served the College diligently throughout his entire career in emergency medicine starting with his terms as the Washington Chapter Treasurer, and Chapter President; and

WHEREAS, During Dr. Kang's tenure as national ACEP president, he brought honor to the Washington Chapter by hosting the 2013 ACEP Scientific Assembly in Seattle; and

WHEREAS, Dr. Kang's leadership progressed to the National ACEP Board of Directors from 2015-2024, and during that time he served in the highest positions of leadership in the College including Secretary-Treasurer, Chair of the Board, President-Elect, President, and Immediate Past President; and

WHEREAS, During Dr. Kang's service as Secretary-Treasurer of both the Washington Chapter and National ACEP Board of Directors he navigated challenging times with fiscal responsibility; and

WHEREAS, Dr. Kang fought hard in his leadership roles to bring respect back to the working members in the trenches, with a priority to return emergency physicians to the standing they deserve; and

WHEREAS, Along this journey, Dr. Kang has served in many roles and as Board Liaison to numerous committees, sections, and task forces, including the Board Liaison to the Workforce Task Force whose goal was to study and make recommendations for recruitment and retention of membership following the peak of the COVID pandemic; and

WHEREAS, Dr. Kang believes in the science of emergency medicine, and in addition to being the Residency Research Director at Madigan Army Medical Center, he served on the Board of Trustees of the Emergency Medicine Foundation and commits to all levels including being a member of the Wiegenstein Legacy Society; and

WHEREAS, Dr. Kang, as an Army veteran, served overseas, and since his return to Washington State he has practiced at Madigan Army Medical Center and is a leader in their residency program, as well as being active in the Government Services Chapter; and

WHEREAS, Dr. Kang believes in uniting all the fields in the House of Medicine and has been an active liaison to the American Medical Association, the American College of Surgeons, and many others; and

WHEREAS, Dr. Kang has a field training history in trauma from his experience in the Army and he has extended that to bridge the combined expertise of ACEP and the American College of Surgeons and he has become the first emergency medicine trained ACEP Board member to be an editor of the Advanced Trauma Life Support text; and

WHEREAS, Dr. Kang shines brightest in the roles he has played as a mentor, and his mentorship at the local, state, national, and governmental levels has been instrumental in bestowing multiple Council Horizon and Council Teamwork awards within ACEP; and

WHEREAS, Dr. Kang will continue to serve the College and be involved with the practice of emergency medicine and dedicated to the mission of ACEP; therefore be it

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(24)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Commendation for Rami R. Khoury, MD, FACEP

WHEREAS, Rami R. Khoury, MD, FACEP, has served the American College of Emergency Physicians with distinction since joining as a member in 2001; and

WHEREAS, After completing the Michigan College of Emergency Physicians Leadership Development Program in 2012, Dr. Khoury has served the Michigan College with distinction including as an elected member of the MCEP Board of Directors from 2013-20, MCEP President from 2018-19, and chair of the Legislative Committee from 2015-19; and

WHEREAS, Dr. Khoury's innovative work pertaining to pain management and opiate abuse paved the way for many pain management initiatives in the state of Michigan and his health finance advocacy has tangibly improved reimbursement for emergency physicians in the state of Michigan; and

WHEREAS, Dr. Khoury was elected to the ACEP Board of Directors in 2021 and has served with dedication from 2021-24; and

WHEREAS, Dr. Khoury has served as ACEP Board Liaison to numerous committees, including the Clinical Emergency Data Registry Committee; the Diversity, Equity, and Inclusion Committee; the Health Innovation Technology Committee; and the Quality & Patient Safety Committee; and

WHEREAS, Dr. Khoury has served as ACEP Board Liaison to multiple sections, including the Diversity, Inclusion, and Health Equity Section; the Emergency Medicine Workforce Section; the Emergency Medicine Informatics Section; the Pain Management and Addiction Medicine Section; the Palliative Medicine Section; and the Quality Improvement and Patient Safety Section; and

WHEREAS, Dr. Khoury has been active in multiple ACEP committees, including the State Legislative and Regulatory Committee, the Council Tellers, Credentials, and Elections Committee, and the Council Steering Committee, as well as in ACEP Council for nine years prior to his election to the Board of Directors; and

WHEREAS, Dr. Khoury has served on the Emergency Medicine Foundation Board of Trustees from 2022-24; and

WHEREAS, Dr. Khoury has been a steadfast supporter of the National Emergency Medicine Political Action Committee; and

WHEREAS, Dr. Khoury is known for his diplomatic nature, his well-reasoned opinions, his dedication as a mentor to future physician leaders and medical students, and his willingness to advocate for both emergency physicians and emergency department patients; therefore be it

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION 6(24)

SUBMITTED BY: Jay Brenner, MD, FACEP
Michael J. McCrea, MD, FACEP
John Moskop, PhD
Raquel Schears MD, FACEP
James D. Thompson, MD, FACEP
Larisa M. Traill, MD, FACEP
**See Attachment A for list of additional individual cosponsors*

SUBJECT: Commendation for Shari Purpura

WHEREAS, Shari Purpura, was a dedicated ACEP staff member from January 29, 2015, through March 15, 2024; and

WHEREAS, Ms. Purpura was an exceptional staff liaison for the ACEP Bylaws Committee and the ACEP Ethics Committee; and

WHEREAS, Ms. Purpura worked tirelessly assisting every chapter of the College in updating, streamlining, and improving their bylaws; and

WHEREAS, Ms. Purpura not only supported the Ethics Committee members in their endeavors, but also ethically interacted with all College members she encountered; and

WHEREAS, During the COVID-19 pandemic she was not only invaluable in assisting the committees in navigating operational shifts and facilitating meetings, but also in supporting ACEP chapters through urgent bylaws amendments allowing chapters to continue operations remotely; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Shari Purpura for her outstanding service and commitment to the College, its chapters, and the specialty of emergency medicine.

List of Additional Individual Cosponsors

ACEP Bylaws Committee Members

Sara Chakel, MD FACE
Doug Char, MD, FACEP
Joshua da Silva, MD FACEP
Amye Farag, MD
Anna Heffron, MD, PhD
Fred Kency, Jr, MD, FACEP
Kurtis Mayz, JD, MD, FACEP
Michael McCrea, MD, FACEP
Scott Pasichow, MD, FACEP
James Paxton, MD, FACEP
Paul Pomeroy, MD, FACEP
Annabella Salvador-Kelly, MD, FACEP
Annalise Sorrentino, MD, FACEP
Larisa Traill, MD, FACEP
Bradford Walters, MD, FACEP
Luke Wohlford, MD, MHP

ACEP Ethics Committee Members

Nathan Allen, MD, FACEP
Andrew Aswegan, MD FACEP
Eileen Baker, MD, PhD, FACEP
Paul Bissmeyer, DO
Kelly Bookman, MD, FACEP
Samantha Chao, MD
Elizabeth P. Clayborne, MD, MA, FACEP
Michele Delpier, MD, FACEP
Arthur Derse, MD, JD, FACEP
Monisha Dilip, MD
Venkata Ramana Feeser, MD
John Finnell MD, FACMI, FACEP
Joel Geiderman, MD, FACEP
Rebecca Goett, MD, FACEP
James Hall, MD, MPH, FCCM, FAWM, FACEP
Kenneth Iserson, MD, FACEP
Breanne Jacobs, MD, FACEP
Karen Jubanyik-Barber, MD
Nicholas Kluesner, MD, FACEP
Gregory Larkin, MD FACEP
Catherine Marco, MD, FACEP
Evie Marcolini, MD, FACEP
Kenneth Marshall, MD, FACEP
Daniel Martin, MD, MBA, FACEP
Derek Martinez, DO
Norine McGrath, MD, FACEP
Michael O'Brien, DM, FAEMS, FACEP
Aasim Padela, MD, FACEP
Haley Sauder, MD
Tamar Sauer, MD
Raquel Schears, MD, FACEP
Jeremy Simon, MD, FACEP
Laura Vearrier, MD, DBe, FACEP
Dina Wallin, MD, FACEP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 7(24)

SUBMITTED BY: Ohio Chapter
Pennsylvania College of Emergency Physicians
West Virginia College of Emergency Physicians

SUBJECT: In Memory of Neal F. Aulick, II, MD, FACEP

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Neal Aulick, II, MD, FACEP, passed away surrounded by his family and loved ones on May 9, 2024, at the age of 55; and

WHEREAS, Dr. Aulick completed his undergraduate studies at Northern Kentucky University in 1991 and while there met his future wife, and they were united in marriage one week following their graduation by their college biology professor and ordained minister, Dr. Thomas Rambo; and

WHEREAS, Dr. Aulick completed his medical school training at the University of Kentucky in 1995; and

WHEREAS, He completed his residency at the WVU School of Medicine in Morgantown in 1998; and

WHEREAS, Dr. Aulick was a fellow of the American College of Emergency Physicians; and

WHEREAS, Dr. Aulick spent his emergency career working in emergency departments throughout West Virginia, Ohio, and Pennsylvania; and

WHEREAS, He was an emergency physician at United Hospital Center in West Virginia from 1997 to 2005 and he served there as the director since 1999; and

WHEREAS, He worked at Ohio Valley Medical Center in West Virginia and East Ohio Regional Hospital in Ohio from 2005 until their closures in 2019 and he served as their director since 2007; and

WHEREAS, He worked at Cannonsburg General Hospital in Pennsylvania from 2014 to 2017; and

WHEREAS, His final employment was at WVU Medicine Reynolds Memorial Hospital in West Virginia; and

WHEREAS, Dr. Aulick was also involved in educating future emergency physicians as a lecturer and instructor to the Ohio Valley Medical Center Emergency Medicine Residency Program and Wilderness Medicine Rotation; and

WHEREAS, He was a clinical assistant professor at the West Virginia School of Osteopathic Medicine, the Department of Emergency Medicine at West Virginia University, and the Ohio University Heritage College of Osteopathic Medicine; and

WHEREAS, Dr. Aulick was also a certified Black Lung Examiner for the Respiratory & Occupational Lung Disease Clinic through the Department of Labor; and

WHEREAS, Dr. Aulick served on numerous committees and boards including national ACEP's Emergency Medicine Practice Committee, Membership Committee, and the Section Affairs Committee; and

WHEREAS, He was involved at the state level with the West Virginia College of Emergency Physicians and served on their Board of Directors and held multiple leadership roles including president; and

WHEREAS, Dr. Aulick's other interests included playing guitar for Al Buterol and the Inhalers, a charity cover band of local physicians and health care professionals; and

WHEREAS, He was a champion Texas Hold 'Em poker player; and

WHEREAS, He also enjoyed reading, heavy metal music, racquetball, pickleball, golfing, and deer hunting; and

WHEREAS, Dr. Aulick was in two episodes of Untold Stories of the ER: "Secrets and Hives" 2013 Season 8, Episode 6 and "Better to be Lucky" 2014 Season 9, Episode 6; and

WHEREAS, Dr. Aulick had a huge heart, was a great mentor, loved without limits, and his family and friends were everything to him; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Neal Aulick, II, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians, the Ohio Chapter, the Pennsylvania College of Emergency Physicians, and the West Virginia College of Emergency Physicians extends to his wife Ginger of 33 years, and his daughters Afton and Harper Aulick, gratitude for his service as an emergency physician at multiple hospitals in Ohio, Pennsylvania, and West Virginia, as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 8(24)

SUBMITTED BY: Douglas Hill, DO, FACEP
Carla Murphy, DO, FACEP
Colorado Chapter

SUBJECT: In Memory of Marilyn J. Gifford, MD

WHEREAS, Emergency medicine lost a longtime champion and advocate when Marilyn J. Gifford, MD, passed away at the age of 80 on January 16, 2024; and

WHEREAS, Dr. Gifford was a military veteran and served in the United States Navy as a Lieutenant (LT MC 0-3) at the United States Naval Training Center, Bainbridge, Maryland, from 1970 through 1972 while continuing her medical training; and

WHEREAS, Dr. Gifford served as the 8th President of the Colorado Chapter of the American College of Emergency Physicians in 1979; and

WHEREAS, Dr. Gifford was on staff in the emergency department at Memorial Hospital of Colorado Springs from 1980 to 2013, and despite very few women in emergency medicine, she became their Medical Director of Emergency Medical Services (EMS); and

WHEREAS, While Dr. Gifford was at Memorial Hospital, she became Medical Director of the Emergency Department, earning a reputation as a staunch advocate for her colleagues, staff, patients, EMS personnel, and the community at large and during her directorship, Memorial Hospital had the highest volume of any emergency department in the State of Colorado; and

WHEREAS, Dr. Gifford authored protocols used by ambulance and fire services to assist first responders in helping patients in Colorado; and

WHEREAS, Dr. Gifford served the El Paso County Medical Society of Colorado on many committees and in many capacities from 1982-1996 including Council on Legislation, Pre-Hospital Care Physician Advisory Committee, and Board President from 1993-1994; and

WHEREAS, Dr. Gifford served as a delegate to the Colorado Medical Society (CMS) House of Delegates for several terms from 1984-2015, as well as on the CMS Board of Directors from 1996-1998; and

WHEREAS, Dr. Gifford served as Board Chair of the National Registry of EMTs from 1992-1993 and again from 1998-1999, and was the first woman to hold that position; and

WHEREAS, Dr. Gifford, during her tenure with the National Registry of EMTs Board of Directors, endorsed the EMS Education and Practice Blueprint and pledged support to the Commission on Accreditation of Allied Health Education Programs (CAAHEP) as the accrediting body; and

WHEREAS, During her second term at CAAHEP, Dr. Gifford spearheaded substantial revisions to the practical examinations for EMT-I/85, EMT-I/99, and EMT-Paramedic; and

WHEREAS, Dr. Gifford received national ACEP's Award for Outstanding Contribution in EMS in Chicago on October 17, 2001, at the Scientific Assembly held just 5 weeks after 9/11, and in her acceptance remarks she praised and honored the many first responders who gave their lives in the line of duty on that fateful day; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Colorado Chapter extend to Marilyn J. Gifford, MD's son, Eric Caplan, MD, and his wife Melissa Ewer, MD, son Brian Caplan, JD, and his wife Christina, brother Steve Gifford, and his wife Mimi, her five grandchildren Connor, Carson, Alaina, Piper, and Relic, other family members, friends and colleagues, condolences and profound gratitude for her advocacy to Emergency Medical Services and her commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 9(24)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Veronica Greer, MD

WHEREAS, With the untimely death of Veronica Greer, MD, on May 26, 2024, Texas lost a devoted emergency physician and educator; and

WHEREAS, Dr. Greer was a distinguished alumnus of McGovern Medical School at UT Houston, furthering her training in family medicine at John Peter Smith Hospital in Fort Worth and subsequently in emergency medicine at Texas Tech Health Science Center in El Paso; and

WHEREAS , Dr. Greer dedicated many years of her career to Texas Tech, serving as the Emergency Medicine Residency Director, where she guided and mentored countless aspiring emergency physicians with clinical expertise, empathy, and integrity; and

WHEREAS, Dr. Greer served with distinction as Chief of Staff at University Medical Center from 2016-18, ensuring that University Medical Center's medical staff adhered to the highest standards of compliance and ethical practice, providing exceptional care to patients; and

WHEREAS, Dr. Greer most recently contributed as Physician Advisor of the Clinical Documentation Integrity Department since 2020, further enhancing the quality and accuracy of medical records; and

WHEREAS, Dr. Greer was renowned for her unwavering commitment to education, excellence, compassion, and quality, impacting the lives of rotating residents, students, hospital staff, and patients alike; and

WHEREAS, Dr. Greer's legacy of humility, dedication, and kindness will forever endure in the hearts of her colleagues, friends, and the broader emergency medicine community; therefore be it

RESOLVED, That the American College of Emergency Physicians hereby honors the memory of Veronica Greer, MD, for her exceptional contributions to the field of emergency medicine, her inspiring leadership, and her unwavering dedication to education and patient care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Veronica Greer, MD, acknowledging that though she may be gone, her legacy as a friend, mentor, and role model will live on in perpetuity.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 10(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Christopher H. Linden, MD, FACEP

WHEREAS**,** Dr. Christopher Linden, renowned for his groundbreaking contributions in the fields of emergency medicine and medical toxicology, died on August 26, 2023, leaving an indelible mark on the medical community, his peers, colleagues, and students; and

WHEREAS, Dr. Linden studied psychology at Amherst College before completing his medical degree at the University of Massachusetts Medical School in 1979, demonstrating his commitment to academic excellence and the pursuit of medical knowledge; and

WHEREAS**,** After residency training in emergency medicine at the Milton Hershey Medical Center, Dr. Linden pursued his medical toxicology fellowship at the Rocky Mountain Poison Control Center, where he developed lasting friendships and conducted seminal research with Barry Rumack, MD, and Kenneth Kulig, MD, on acetaminophen poisoning and other toxicological emergencies; and

WHEREAS**,** Dr. Linden published practice-changing papers on the use of physostigmine, MAOI toxicity, and cyanide poisoning, significantly advancing the field of medical toxicology and improving patient care globally; and

WHEREAS**,** After his fellowship, Dr. Linden became the founding director of the Division of Medical Toxicology at the University of Massachusetts, where he developed a robust fellowship program that attracted fellows from around the world and mentored a generation of toxicologists from 1986 to 1997; and

WHEREAS**,** Dr. Linden served as Chair of the Toxicology Section of the American College of Emergency Physicians from 1995 to 1997, and as the Medical Toxicology sub-board director for the American Board of Emergency Medicine from 1992 to 1997, further contributing to the governance and advancement of the field; and

WHEREAS, Dr. Linden was a member of American College of Emergency Physicians for over 40 years and a longstanding member of the American Academy of Clinical Toxicologists, demonstrating his commitment to professional development and the dissemination of emergency medicine and toxicological knowledge; and

WHEREAS**,** In 1997, Dr. Linden joined the staff of Milford-Whitinsville Regional Hospital, where he was beloved by colleagues and patients alike for his fearless approach to medicine, his encyclopedic knowledge, humility, sense of humor, and his dedication to challenging conventional wisdom and inspiring innovation; and

WHEREAS, Dr. Linden's legendary incident of consulting on a case of methemoglobinemia from his own ICU bed exemplifies his unwavering dedication to patient care and his exceptional clinical expertise; and

WHEREAS**,** Dr. Linden served as the Chair of the Pharmacy and Therapeutics Committee at Milford-Whitinsville Regional Hospital for over two decades, leaving a lasting legacy of leadership and excellence in clinical practice; and

WHEREAS, Outside the realm of medicine, Dr. Linden was known for his joy of life, maintaining extraordinary collections of toxicologic images, vintage poison bottles, and a Harley-Davidson motorcycle, becoming an accomplished, self-taught stonemason, and engaging in big mountain skiing; and

WHEREAS, Dr. Linden's social gatherings, including discussions on dram shop laws and Daubert proceedings over dinner or late-night poker sessions, exemplified his generosity in sharing knowledge and fostering camaraderie among colleagues; and

WHEREAS Dr. Linden's contributions to academia, medicine, and humanity as a whole will continue to resonate through the generations of emergency physicians and medical toxicologists he mentored and inspired; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the life and legacy of Christopher H. Linden, MD, FACEP, expressing our deepest condolences to his family and all who loved him and acknowledging his remarkable achievements and the profound impact he had on the fields of emergency medicine and medical toxicology and the lives of those fortunate enough to have known him.

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 11(24)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Gregory L. Walker, MD, FACEP

WHEREAS, With the passing of Gregory L. Walker, MD, FACEP, on March 26, 2024, emergency medicine lost a champion for the Michigan College of Emergency Physicians (MCEP), the American College of Emergency Physicians (ACEP), a longtime leader and teacher in the field, and a beloved friend in emergency medicine; and

WHEREAS, Dr. Walker received his bachelor's and medical degrees from Michigan State University (MSU), completed his residency at the Michigan State University Sparrow Emergency Medicine residency program in Lansing, Michigan, and will forever be a Spartan; and

WHEREAS, Dr. Walker was board certified in emergency medicine by the American Board of Emergency Medicine (ABEM) and the National Board of Medical Examiners, was sub-specialty boarded in pediatric emergency medicine by ABEM, and was a Fellow of ACEP; and

WHEREAS, Dr. Walker worked tirelessly as an attending physician at Sparrow Hospital in Lansing, Michigan starting in 1991 as an early partner of Emergency Medical Associates, PLLC, and in 2014 earned the ACEP Tenure Award for having the longest active career in the same emergency department, continuing to work for a total of 30 years; and

WHEREAS, Dr. Walker demonstrated exceptional leadership skills as he led Emergency Medical Associates, PLLC as an executive leader and staunch advocate for emergency medicine for over 15 years; and

WHEREAS, Dr. Walker was a committed and dedicated faculty member, serving as core faculty, including Program Director, for the MSU EM Sparrow Lansing Residency for over 12 years, receiving the program's Resident Advocate and the Faculty Recognition awards; and

WHEREAS, Dr. Walker believed everyone who worked in the emergency department should be adequately trained and prepared, and as such, he developed and directed the Sparrow Hospital Emergency Medicine Physician's Assistant program from 1994-2004; and

WHEREAS, Dr. Walker never stopped representing and advocating for the specialty of emergency medicine, serving on multiple hospital committees over the years at Sparrow Hospital; and

WHEREAS, Dr. Walker in 1988 embarked on advocacy for emergency medicine early in his career by becoming a resident member of both MCEP and ACEP, serving on multiple state committees, and becoming the founding president of the Emergency Medicine Residents' Association of Michigan in 1990; and

WHEREAS, Dr. Walker served as an MCEP Board member, including as an Executive Board member, and served as President of MCEP in 1998; and

WHEREAS, Dr. Walker was passionate about teaching and served as the Program Director for the MCEP Resident's Assembly for 25 years, educating countless EM residents, and serving as an ABEM Oral Board examiner for over 20 years; and

WHEREAS, Dr. Walker used his voice, knowledge, and vote to represent MCEP at the ACEP Council starting in 1991, serving over 30 years; and

WHEREAS, Dr. Walker was recognized for his outstanding service and dedication to EM and received the MCEP Ronald L. Krome Meritorious Service Award in 2001, the MCEP Legacy Award in 2009, and the MCEP Significant Contribution Award in 2020; and

WHEREAS, Dr. Walker believed emergency medicine should be represented broadly in the house of medicine, serving as a member and president of the Michigan Trauma Coalition and in the Michigan State Medical Society (MSMS) as an executive leader and Chair of the Young Physicians Section and earning recognition as a leader on the cover of the MSMS May 1996 Michigan Medicine Journal as a physician "Taking charge in an era of change;" and

WHEREAS, Dr. Walker believed that the only thing better than being an emergency nedicine doctor was raising his two exceptional children, Andy and Sam, spending time with his lifetime partner, Jamie, and playing hockey, which he did as much as possible; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the outstanding dedication and contribution of Gregory L. Walker, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Walker, MD, FACEP, especially his sons Andy and Sam, his colleagues, partners, former residents, and all friends, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, where his impact will be felt for generations to come.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 12(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory Jesse A. Weigel, MD, FACEP

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Jesse A. Weigel, MD, FACEP, passed away on December 12, 2023, at the age of 90; and

WHEREAS, Dr. Weigel completed his undergraduate studies at the University of Pittsburgh; and

WHEREAS, He also completed his medical school training at the University of Pittsburgh in 1960; and

WHEREAS, He initially began his career in family medicine, but soon found his passion in emergency medicine; and

WHEREAS, Dr. Weigel was a pioneer in the field of emergency medicine and was instrumental in establishing it as a specialty; and

WHEREAS, He was a founding member of the American College of Emergency Physicians and started the Pennsylvania Chapter; and

WHEREAS, Dr. Weigel was a fellow of the American College of Emergency Physicians; and

WHEREAS, Dr. Weigel was the first Director of Emergency Medicine at Passavant Hospital in Pittsburgh, PA; and

WHEREAS, He helped create three emergency medical service organizations and then united the area's diverse services into a cohesive system; and

WHEREAS, He was the Director of the Pennsylvania Medical Services Council and was a national speaker; and

WHEREAS, Dr. Weigel was involved in the startup of the Pittsburgh Paramedic Program and served as its Medical Operations Director; and

WHEREAS, Dr. Weigel became the Director of Emergency Medical Service at Harrisburg Hospital in 1979; and

WHEREAS, He later became the Senior Vice President and Chief Medical Officer of Pinnacle Health System in 1984 until his retirement in 2000; and

WHEREAS, He developed the paramedic program at the Harrisburg Area Community College; and

WHEREAS, Throughout his career and into retirement, Dr. Weigel continued to be a leader in emergency medicine by serving in many leadership roles, on various boards, establishing new programs, and sharing his knowledge with others across various organization; and

WHEREAS, His passion for cooking family dinners led him to his second career as a sous chef at the Kitchen Shoppe Cooking School in Carlisle, PA; and

WHEREAS, He also enjoyed traveling, gardening, anything Snoopy, and rooting for his Pittsburgh Panthers; and

WHEREAS, Dr. Weigel was active in his church and in the Scottish Society of Central Pennsylvania; and

WHEREAS, He was married for 53 years to Janet Kay (McMeans) Weigel, who preceded him in death, and together they built a life centered on family and service to others; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jesse A. Weigel, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his children Karen Weigel, Kevin Weigel, and Jennifer Hudson gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 13-23

Larisa M. Traill, MD, FACEP (MI) – Chair
Laurel Barr, MD, FACEP (OH)
Amanda Irish, MD, MPH (IA)
Catherine A. Marco, MD, FACEP (PA)
Emily Mills, MD, FACEP (MI)
Aine Yore, MD, FACEP (WA)

Amanda Pairitz-Campo
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 13(24)

SUBMITTED BY: Colorado Chapter
Louisiana Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Allocation of Councillors

PURPOSE: Amend the Bylaws to determine councillor allocation for the annual Council meeting by using the average number of members during the calendar year instead of the actual number of members as of December 31 of the preceding year.

FISCAL IMPACT: Budgeted staff resources to assess the number of members of each component body for councillor allocation based on the requirements in the Bylaws.

WHEREAS, The ACEP Council consists of members representing ACEP's 53 chartered chapters (50 states, Puerto Rico, the District of Columbia, and Government Services), its sections of membership, the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), the Emergency Medicine Residents' Association (EMRA) and the Society for Academic Emergency Medicine (SAEM); and

WHEREAS, The Council elects the president-elect and four members to the Board of Directors each year and the Council Speaker and Vice Speaker every two years; and

WHEREAS, The Council votes on resolutions, including changes to the Bylaws, College Manual, and the Council Standing Rules; and

WHEREAS, The Council ensures "grassroots" involvement in ACEP's democratic decision-making process; and

WHEREAS, The current ACEP Bylaws specify each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter; and

WHEREAS, There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year; and

WHEREAS, ACEP membership renewal options are yearly, quarterly, or monthly and payment options include phone, mail, or online and auto-renewal is not required; and

WHEREAS, Membership rolls fluctuate throughout the year due to variable membership renewal options, delayed renewals, variable payment options, inaccurate credit/debit card/bank draft information leading to failures, etc.; and

WHEREAS, If membership rolls are below threshold on December 31, then chapters lose a councillor; and

WHEREAS, Several chapters have lost members due to current Bylaws but would have met the threshold at other times of the year; and

WHEREAS, Using the average membership number over the calendar year more accurately reflects each

chapter's membership totals given that this number can change daily due to new enrollments and drops; and

WHEREAS, In 2018 there was a resolution concerning the growth of the Council, however comparing 2021 when there were 407 total chapter councillors to 2024 when there are 382 total chapter councillors, there are now 25 less councillors; and

WHEREAS, Loss of councillors leads to less grassroots involvement; and

WHEREAS, ACEP should support efforts to increase member engagement and trust and grassroots involvement in decision-making processes in line with ACEP's strategic plan and Council goals; therefore be it

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

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

Background

This resolution seeks to amend the Bylaws to determine councillor allocation for the annual Council meeting by using the average number of members during the calendar year instead of the actual number of members as of December 31 of the preceding year.

December 31 has been used as the date to determine councillor allocation since 1987. The date for determining councillor allocation before 1987 was 45 days prior to the annual meeting.

Councillor distribution can change each year as members move among different chapters, particularly when candidate members graduate residency and move to another chapter. Chapters receive monthly membership reports and have access to their membership reports through the chapter portal. Additionally, chapters are sent reports every month providing a list of members that will be cancelled. Cancellations typically occur the third Friday of the third month following the membership expiration date. The grace period to renew membership allows graduating residents an opportunity to become settled in their new location. Multiple reminders are sent to chapters to remind them of the councillor allocation deadline and to follow up with any lapsed members.

ACEP membership was at an all-time high in 2020 and councillor allocation reached a peak of 446 for the 2021 Council meeting. Membership declined in 2021, 2022, and 2023 and the number of councillors for 2024 is 422 based on the total membership as of December 31, 2023, which is a decline of 24 councillors over the past 4 years.

Based on the December 31, 2023, date, the following chapters gained one councillor for the 2024 Council meeting: Connecticut, Idaho, and Kentucky. Using the average number of members would not have changed their councillor allocation for 2024.

The following chapters each lost one councillor for the 2024 Council meeting using the December 31, 2023, date: Alaska, California, Colorado, Government Services, Kansas, Louisiana, Missouri, South Carolina, Washington, and West Virginia. Using the average number of members would have resulted in California gaining one councillor compared to 2023 and Alaska and Colorado still losing one councillor. Government Services, Kansas, Louisiana, Missouri, South Carolina, Washington, and West Virginia would have maintained the same number of councillors as were allocated for 2023. Additionally, Florida, Michigan, New York, Ohio, Oklahoma, Pennsylvania, and Texas would have gained one councillor compared to the 2023 allocation. The total councillor allocation for chapters would have increased by 16 based on the average number of members, bringing the overall total councillor allocation,

including AACEM, CORD, EMRA, SAEM, and sections to 438 for a net gain of 11 compared to the total 2023 councillor allocation.

Attachment A provides an analysis of the councillor allocations for 2024 by chapter based on the membership as of December 31, 2023, compared to the average number of members by chapter for the 2023 calendar year. Councillor allocations for 2023 are also included in the chart.

ACEP Strategic Plan Reference

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

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.

Fiscal Impact

Budgeted staff resources to assess the number of members of each component body for councillor allocation based on the requirements in the Bylaws.

Prior Council Action

Resolution 4(86) Councillor Allocation adopted. Amended the Constitution to change the timing of councillor allocation determination based on the number of members of a chapter as shown by the membership rolls from 45 days prior to the annual meeting to December 31 each year.

Prior Board Action

Resolution 4(86) Councillor Allocation adopted.

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

Mollie Pillman, MS, MBA, CAE
Associate Executive Director, Member Experience

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

Chapter	2023 Councillor Allocation	Membership as of 12/31/23	2024 Councillor Allocation	Average 2023 Membership	Councillor Allocation Based on Average Membership	Plus/Minus average 2023 vs. 12/31/23
Alabama	4	312	4	328	4	
Alaska	2	89	1	95	1	
Arizona	8	722	8	754	8	
Arkansas	2	194	2	196	2	
California	34	3254	33	3429	35	2
Colorado	7	594	6	596	6	
Connecticut	5	513	6	506	6	
Delaware	2	194	2	190	2	
District of Columbia	3	254	3	268	3	
Florida	21	2094	21	2118	22	1
Georgia	9	850	9	899	9	
Government Services	11	999	10	1037	11	1
Hawaii	2	168	2	166	2	
Idaho	2	207	3	206	3	
Illinois	13	1230	13	1284	13	
Indiana	6	558	6	541	6	
Iowa	2	181	2	189	2	
Kansas	3	194	2	210	3	1
Kentucky	3	313	4	321	4	
Louisiana	5	370	4	420	5	1
Maine	3	220	3	225	3	
Maryland	7	619	7	623	7	
Massachusetts	10	905	10	941	10	
Michigan	20	1905	20	2002	21	1
Minnesota	8	711	8	720	8	
Mississippi	3	242	3	252	3	
Missouri	7	583	6	621	7	1
Montana	1	88	1	88	1	
Nebraska	2	144	2	154	2	
Nevada	4	322	4	341	4	
New Hampshire	2	162	2	160	2	
New Jersey	10	991	10	959	10	
New Mexico	3	215	3	207	3	
New York	30	2920	30	3038	31	1
North Carolina	11	1048	11	1067	11	
North Dakota	1	52	1	54	1	
Ohio	15	1468	15	1534	16	1
Oklahoma	3	272	3	303	4	1
Oregon	5	475	5	440	5	
Pennsylvania	18	1784	18	1824	19	1
Puerto Rico	2	148	2	140	2	

Chapter	2023 Councillor Allocation	Membership as of 12/31/23	2024 Councillor Allocation	Average 2023 Membership	Councillor Allocation Based on Average Membership	Plus/Minus average 2023 vs. 12/31/23
Rhode Island	3	219	3	240	3	
South Carolina	6	489	5	532	6	**1**
South Dakota	1	56	1	60	1	
Tennessee	5	413	5	439	5	
Texas	21	2000	21	2103	22	**1**
Utah	4	349	4	357	4	
Vermont	2	117	2	117	2	
Virginia	9	875	9	891	9	
Washington	8	689	7	716	8	**1**
West Virginia	3	195	2	211	3	**1**
Wisconsin	6	500	6	517	6	
Wyoming	1	39	1	40	1	
Chapter Totals	**378**		**371**		**387**	**16**
AACEM	1		1		1	
CORD	1		1		1	
EMRA	8		8		8	
SAEM	1		1		1	
Sections	38		40		40	
Total Councillors	**427**		**422**		**438**	**16**

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 14(24)

SUBMITTED BY: Bylaws Committee
Board of Directors
Council Steering Committee

SUBJECT: College Parliamentary Authority

PURPOSE: Amends the Bylaws to update ACEP's parliamentary authority.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, The College's current parliamentary authority, *The Standard Code of Parliamentary Procedure (Sturgis)* is no longer updated; therefore be it

RESOLVED, That the ACEP Bylaws, Article XIV –Miscellaneous, Section 3 – Parliamentary Authority, be amended to read:

The parliamentary authority for meetings of the College shall be **the most recent edition** of ~~*The Standard Code of Parliamentary Procedure (Sturgis)*~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure***, except when in conflict with the Bylaws of the College or the Council Standing Rules.

Background

This resolution amends the Bylaws to update ACEP's parliamentary authority from *The Standard Code of Parliamentary Procedure (4th Edition)* to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure.* There is also a companion Council Standing Rules resolution.

ACEP has used *The Standard Code of Parliamentary Procedure* and its subsequent updates as the parliamentary authority since 1975. The American Institute of Parliamentarians (AIP) published *The Standard Code of Parliamentary Procedure, Fourth Edition* (TSC) in 2001. ACEP has been aware since 2012, when AIP published the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIPSC), that a change to the parliamentary authority would eventually be necessary. The changes to the 2012 edition compared to the 4th edition released in 2001 were quite minor. Past Council officers and past members of the Bylaws Committee have consulted with ACEP's parliamentarian, Jim Slaughter, JD, over the past few years about the advisability of updating the parliamentary authority and when that should occur since TSC continues to be available for purchase and as a publish-on-demand book. Mr. Slaughter advised in 2022 that a new edition of the AIPSC was forthcoming and it was determined that considering a change to the parliamentary authority should be delayed until the new edition was released. The AIPSC 2nd edition was finally released in Fall 2023. Mr. Slaughter prepared a brief article about the book's purpose and updates: https://blog.lawfirmcarolinas.com/newly-released-aip-standard-code-of-parliamentary-procedure-second-edition/.

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the Council Standing Rules. Additional changes to the Council Standing Rules beyond updating the name of the parliamentary authority, are not required since the Council Standing Rules override the parliamentary authority as the higher authority, i.e., the Bylaws and the Council Standing Rules are higher authority governing documents.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 9(75) Rules of Order adopted. Amended the Bylaws to change the parliamentary authority from *Robert's Rules of Order* to *The Standard Code of Parliamentary Procedure.*

Prior Board Action

June 2024, approved cosponsoring the resolution with the Council Steering Committee and the Bylaws Committee to update ACEP's parliamentary authority and submit it to the 2024 Council for consideration.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules Amendment

RESOLUTION: 15(24)

SUBMITTED BY: Council Steering Committee

SUBJECT: College Parliamentary Authority

PURPOSE: Amends the Council Standing Rules to update ACEP's parliamentary authority with a proviso that the changes become effective after the 2024 Council meeting and only upon adoption of the companion Bylaws amendment.

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

WHEREAS, The College's current parliamentary authority, *The Standard Code of Parliamentary Procedure (aka "Sturgis")* is no longer updated; therefore be it

RESOLVED, That the ACEP Council Standing Rules, Parliamentary Procedure (paragraph one) be amended to read as follows with the proviso that the changes will become effective after the 2024 Council meeting and only upon adoption of the companion resolution College Parliamentary Authority – Bylaws Amendment:

Parliamentary Procedure

The ~~current~~ **most recent** edition of ~~*Sturgis, Standard Code of Parliamentary Procedure*~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*** will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately.***

Background

This resolution amends the Council Standing Rules to update ACEP's parliamentary authority from *The Standard Code of Parliamentary Procedure (4th Edition)* to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* with a proviso that the changes become effective after the 2024 Council meeting and only upon adoption of the companion Bylaws amendment.

ACEP has used *The Standard Code of Parliamentary Procedure* and its subsequent updates as the parliamentary authority since 1975. The American Institute of Parliamentarians (AIP) published *The Standard Code of Parliamentary Procedure, Fourth Edition* (TSC) in 2001. ACEP has been aware since 2012, when AIP published the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIPSC), that a change to the parliamentary authority would eventually be necessary. The changes to the 2012 edition compared to the 4th edition released in 2001 were quite minor. Past Council officers and past members of the Bylaws Committee have consulted with ACEP's parliamentarian, Jim Slaughter, JD, over the past few years about the advisability of updating the parliamentary authority and when that should occur since TSC continues to be available for purchase and as a publish-on-demand book. Mr. Slaughter advised in 2022 that a new edition of the AIPSC was forthcoming and it was determined that considering a change to the parliamentary authority should be delayed until the new edition was released. The AIPSC 2nd edition was finally released in Fall 2023. Mr. Slaughter prepared a brief article about the book's purpose and updates: https://blog.lawfirmcarolinas.com/newly-released-aip-standard-code-of-parliamentary-procedure-second-edition/.

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the

Updating ACEP's parliamentary authority from TSC to the AIPSC requires amendments to the Bylaws and the Council Standing Rules. Additional changes to the Council Standing Rules beyond updating the name of the parliamentary authority, are not required since the Council Standing Rules override the parliamentary authority as the higher authority, i.e., the Bylaws and the Council Standing Rules are higher authority governing documents.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 9(75) Rules of Order adopted. Amended the Bylaws to change the parliamentary authority from *Robert's Rules of Order* to *The Standard Code of Parliamentary Procedure.*

Prior Board Action

June 2024, approved cosponsoring the Bylaws resolution with the Council Steering Committee and the Bylaws Committee to update ACEP's parliamentary authority and submit it to the 2024 Council for consideration. The Board and the Bylaws Committee were not requested to cosponsor the Council Standing Rules amendment since this is a governing document of the Council.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 16(24)

SUBMITTED BY: Bylaws Committee
Board of Directors
Cruise Ship Medicine Section
International Emergency Medicine Section

SUBJECT: International Members Serving as Section Officers

PURPOSE: Amends the Bylaws to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, Section officers must be elected by members of the section per the terms outlined in each section's operational guidelines; and

WHEREAS, Section officers, as defined in section operational guidelines, typically include the positions of chair, chair-elect or vice chair, immediate past chair, secretary or secretary/newsletter editor, and website editor and some section operational guidelines include the councillor and alternate councillor positions; and

WHEREAS, International members of the College cannot currently serve as section officers based on the restriction in the Bylaws that international members "may not hold office;" and

WHEREAS, "Holding office" is interpreted as having been elected to a position; and

WHEREAS, Some sections have international members and have expressed interest in serving as section officers; and

WHEREAS, It is desirable to continue to the requirement that international members may not serve on the Council; and

WHEREAS, It is desirable to continue to allow international members to vote in committees on which they serve and participate as voting members in sections of membership; therefore be it

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.4 – International Members, be amended to read:

Any physician interested in emergency medicine who is not a resident of the United States or a possession thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides and practices, shall be eligible for international membership. All international members will be assigned by the Board of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.

International members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Any international member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain

life status.

~~International members may not hold office and may not serve on the Council. International members, with the exception of those in inactive status, may vote in committees on which they serve.~~

International members may not seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor.

Background

This resolution amends the Bylaws to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor.

Some international members of sections have expressed a desire to serve as section officers. Section officers must be elected per the terms outlined in each section's operational guidelines. Section officers, as defined in section operational guidelines, typically include the positions of chair, chair-elect or vice chair, immediate past chair, secretary or secretary/newsletter editor, and website editor and some section operational guidelines include the councillor and alternate councillor positions as officer positions.

The current language in the Bylaws regarding "holding office" has been interpreted to exclude international members from serving as section officers because the positions are elected by the section and elected individuals are "holding office." ACEP's "Conflict of Interest" policy statement includes section chairs as key leaders having a fiduciary duty to the College.

The Bylaws Committee was assigned an objective to define "holding office" and determine whether a Bylaws amendment should be developed to provide clarification in the Bylaws regarding international members eligibility to serve as section chairs. Given that most sections would want a potential section chair to have served in other section leadership roles prior to being elected as chair-elect, it is desirable to expand the ability of international members to serve in those other leadership roles.

After careful review of the Bylaws and after researching various definitions of "holding office" the Bylaws Committee concluded that the term is overly broad and is difficult to define in a manner that fully resolves the potential conflict in the Bylaws. The proposed language in this Bylaws amendment specifically delineates the privileges the College extends or does not extend to international members, particularly regarding positions of leadership. The prior restrictions applied to international members who are in inactive status has been retained.

International membership in ACEP was added to the Bylaws in 1975. A Bylaws amendment was adopted in 1986 clarifying the voting rights for all classes of membership and specifically stated that international members cannot vote. In 1988, Bylaws language regarding the inability of inactive and international members to vote was amended to include "or hold office." Subsequent changes to the Bylaws have occurred over the years and have always maintained that international members cannot vote or hold office. A provision was added in 2014 allowing international members to vote in committees on which they serve.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Amended Resolution 9(14) Membership Classification Restructure adopted. Changes to Article IV – Membership, Section 2.4 – International Members, explicitly defined the rights of international members and included language allowing international members the ability to "vote in committees in which they serve."

Amended Resolution 21(88) Housecleaning Changes to Constitution and Bylaws adopted. Several non-substantive and clarifying language changes were made to the Constitution and Bylaws. The "Voting Members and Holding Office" section was amended to include that inactive and international members shall not be entitled to vote **or hold office**.

Substitute Resolution 9(86) Voting Rights for Members adopted. The Bylaws amendment clarified the voting rights for all classes of membership and specifically stated that international members cannot vote.

Resolution 7(75) International Membership adopted. This Bylaws amendment created an international membership category.

Prior Board Action

June 2024, approved cosponsoring the Bylaws resolution with the Bylaws Committee to clarify the voting rights of international members and allows international members to serve as section officers except for the positions of councillor and alternate councillor and submit it to the 2024 Council for consideration.

Amended Resolution 9(14) Membership Classification Restructure adopted.

The Board did not adopt Bylaws resolutions prior to 1991.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 17(24)

SUBMITTED BY: Jacob Altholz, MD
Scott Pasichow, MD, MPH, FACEP

SUBJECT: Removing Gendered Pronouns from ACEP's Bylaws

PURPOSE: Amends the Bylaws to remove gendered pronouns.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, ACEP's policy on Caring for Transgender and Gender Diverse Patients in the Emergency Department states: "EDs should foster and develop practices, policies, and accessible resources that provide a supportive and inclusive environment for TGD patients."[1]; and

WHEREAS, ACEP's values state: "The best interests of patients are served when emergency physicians practice in a fair, equitable, and supportive environment."[1]; and

WHEREAS, Our Bylaws are the legal foundation of the function of our College and its chapters, and that legal foundation should uphold the values and policies of the organization; and

WHEREAS, The U.S. Department of Commerce has issued a guide to gender inclusive language that includes not assuming the gender of another individual and avoid gendered nouns or pronouns[2]; and

WHEREAS, The European Union has published gender pronoun language that includes the use of "they" as a singular pronoun[3]; and

WHEREAS, ACEP's College and chapter bylaws have varying levels of adherence to the avoidance of gendered pronouns and nouns, including some chapters that simply state that using gendered pronouns is not intended to imply a gender bias or preference; and

WHEREAS, It would be clearer for ACEP to avoid the use of pronouns in bylaws to the individual and positions being referred to in a statement were clear and consistent; therefore be it

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 3 – Qualifications be amended to read:

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who retires from medical practice regardless of membership class and changes ~~his/her~~ state of residence may retain membership in a chapter of prior professional practice/residence.; and be it further

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election be amended to read:

Election of Directors shall be by majority vote of the Councillors present and voting at the annual meeting of the Council.

The Board shall consist of 12 elected directors, plus the president, president-elect, immediate past president, and chair if any of these officers is serving following the conclusion of ~~his or her~~ **an** elected term as director. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council. In no instance may a member of the Board of Directors sit as a member of the Council.; and be it further

RESOLVED, That the ACEP Bylaws Article X– Officers/Executive Director, Section 7 – Vice President be amended to read:

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

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 9 – Secretary-Treasurer be amended to read:

A director shall be eligible for election to the position of secretary-treasurer if ~~he or she has~~ at least one year ~~remaining~~ **remains** on the Board as an elected director and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The secretary-treasurer's term of office shall begin at the conclusion of the meeting at which the election as secretary-treasurer occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No secretary-treasurer may serve more than two consecutive terms.; and be it further

RESOLVED That the ACEP Bylaws Article XI – Committees, Section 5 – Finance Committee be amended to read:

The Finance Committee shall be appointed by the president. The committee shall be composed of the president-elect, secretary-treasurer, speaker of the Council or ~~his/her~~ **the speaker's** designee, and at least eight members at large. The chair shall be one of the members at large. The Finance Committee is charged with an audit oversight function and a policy advisory function and may be assigned additional objectives by the president. As audit overseers, the committee performs detailed analysis of the College budget and other financial reports ensuring due diligence and proper accounting principles are followed. In addition, expenses incurred in attending official meetings of the Board, shall be reimbursed consistent with amounts fixed by the Finance Committee and with the policies approved by the Board.; and be it further

RESOLVED, That the ACEP Bylaws Article XV – Mandatory Indemnification, Section 3 – Non-Exclusive; Continuation) be amended to read:

The indemnification provided by this Article XV shall not be deemed exclusive of any other rights to which the person claiming indemnification may be entitled under any agreement or otherwise both as to any action in ~~his or her~~ **the individual's** official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

References
1. "Caring for Transgender and Gender Diverse Patients in the Emergency Department."
2. ACEP's Values Statements
3. "PROMISING PRACTICE GUIDE ON HOW TO USE GENDER-INCLUSIVE LANGUAGE AT THE U.S. DEPARTMENT OF COMMERCE." *US Departement of Commerece*. June 2024. Online.
4. *Gender Neutral Language in European Parliament.* 2018. Online.

Background

This resolution amends the Bylaws to remove gendered pronouns.

ACEP is committed to fostering diversity, equity, and inclusion in emergency medicine. This commitment is evidenced by the policy statements and Council resolutions that have been adopted as well as the creation of awards to recognize and honor individuals for their efforts to advance diversity, equity, and inclusion. Additionally, ACEP participated with nine other emergency medicine organizations to create the All EM DEI Vision Statement. Removing gendered pronouns and using gender-neutral or gender-inclusive in the Bylaws is consistent with ACEP's commitment.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

None pertaining to removing gendered pronouns from the Bylaws.

Prior Board Action

None pertaining to removing gendered pronouns from the Bylaws.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 18(24)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Aimee Moulin, MD, FACEP
David Terca, MD, FACEP
Randall Young, MD, FACEP
California Chapter
Nevada Chapter
New York Chapter

SUBJECT: ACEP Council and Scientific Assembly Meeting Location

PURPOSE: Survey members to obtain feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on other factors to consider when designating a conference location.

FISCAL IMPACT: Programs are budgeted so that net revenue exceeds expense. ACEP would incur significant fees to cancel meetings that are contracted through 2025. Potential estimated cost of $10,000 to conduct an all-member survey.

WHEREAS, Members of ACEP reside in all 50 states, which requires the majority of members to travel annually to attend the Scientific Assembly and Council meeting; and

WHEREAS, Longer distance travel leads to higher costs incurred by the member/attendee; and

WHEREAS, Scientific Assembly locations located closer to the East or West coast impose significantly increased cost and time associated with travel to members on the opposite coast, which can lead to decreased attendance from those members; and

WHEREAS, Scientific Assembly meetings hosted in locations with multiple direct flight options, more central location, and without significant weather-related travel disruptions, such as Las Vegas, can attract higher member attendance for the Scientific Assembly and Council meetings; and

WHEREAS, Attendance at Scientific Assembly is an important fiscal as well as culture-building priority for ACEP and having a single conference site could save money for the organization and be logistically simpler; therefore be it

RESOLVED, That ACEP survey the membership to obtain robust, direct member feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on the other factors that the College should consider when designating a conference location.

Background

This resolution calls for ACEP to survey the members to obtain feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on other factors to consider when designating a conference location.

Scientific Assembly is the second largest single source of revenue for ACEP after membership dues and is approximately 38% of ACEP's overall budget. It is critically important that the annual meeting be held in locations

that maximize the likelihood of large attendance and financial success while providing all attendees with an exceptional experience.

The location of Scientific Assembly is traditionally placed in the most recognized first-tier cities such as Chicago, San Francisco, San Diego, Las Vegas, and Boston because of the size of the meeting and the rate of constant growth. In recent years, ACEP has been able to branch out into other lower cost cities such as Salt Lake City, Denver, and Dallas that may not be as recognized but offer ACEP financial incentives and lower costs to meet in those cities. The demand across all sectors for business meetings in these cities continues to increase as they prove to be extremely popular and have the capacity to accommodate large meetings and are attractive to registrants. Some cities will offer incentives to return to that location within a given time period, which can save ACEP significant costs.

Staff continue to explore all possibilities for cities that have the needed hotel rooms, meetings space, and easy flights to ensure ACEP is receiving the most beneficial financial package for the annual meeting, which is critical to the College's financial success each year. We must also select venues that ensure member/customer satisfaction and provide an exhilarating experience for attendees, attract exhibitors, and physically accommodate the large amount of function space ACEP requires at a reasonable cost. Data is gathered annually from the Scientific Assembly attendees about cities they would like to return to and potential new venues of interest from the overall evaluation sent to all attendees. Surveying attendees provides better data since all member surveys typically yield about a 2% response rate.

Given the continued growth of our meeting, accelerating competition for our preferred dates each year, a strong economy, and the loss of some previous options based on the growth in the size of our annual meeting, ACEP has been challenged with identifying venues that offer desirable dates, adequate function space, and hotel inventory. The competition for desirable dates in the most popular venues has increased, which makes it more challenging to find favorable date patterns with the required meeting space, reasonable hotel room rates, and availability, especially in the popular fall meeting timeframe.

Las Vegas is an attractive city for conventions but it is also known for having higher costs to host a meeting. Additionally, Las Vegas labor costs are higher because of union rules that govern labor usage. ACEP24 expenses in Las Vegas are significantly more than the previous meeting held in Las Vegas in 2016. The building rental has increased $100,000 and the food and beverage minimum has increased from $350,000 to $1 million. Our typical food and beverage minimum is around $500,000 and we have been successful in negotiating low or free building rentals for Philadelphia, Salt Lake City, and Dallas.

The history of attendance for Scientific Assembly the last ten years:

Year	Location	Final 4-day Registration
2023	Philadelphia, PA	4,780
2022	San Francisco, CA	4,791
2021	Boston, MA	3,022
2020	Virtual	4,811
2019	Denver, CO	6,644
2018	San Diego, CA	7,479
2017	Washington, DC	6,154
2016	Las Vegas, NV	7,461
2015	Boston, MA	6,508
2014	Chicago, IL	6,535

Future cities contracted for Scientific Assembly:

Year	Location	Amount to Cancel Contracted Meeting
2025	Salt Lake City, UT	100% of anticipated expenses at the convention center, hotel blocks total of 13,494 room nights, and vendor expenses incurred to date

2026	Chicago, IL	$82,500 center rental, hotel blocks currently contracted – total of 18,618 room nights
2027	Boston, MA	$284,700 center rental, hotel blocks currently contracted – total of 5,316 room nights
2028	Las Vegas, NV	n/a
2029	Philadelphia, PA	Hotel blocks currently contracted – total of 5,655 room nights
2030	San Francisco, CA	$198,540 center rental
2031	Chicago, IL	$50,000 center rental
2032	Dallas, TX	$25,000 center rental

ACEP Strategic Plan Reference

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

Fiscal Impact

Programs are budgeted so that net revenue exceeds expense. ACEP would incur significant fees to cancel meetings that are contracted through 2025. Potential estimated cost of $10,000 to conduct an all-member survey.

Prior Council Action

Substitute Resolution 17(22) Criteria for the Location of Future National ACEP Events adopted. Directed ACEP to consider whether the location of future national level ACEP events restricts access to reproductive health care.

Prior Board Action

The Board approves the dates and location of Scientific Assembly.

Substitute Resolution 17(22) Criteria for the Location of Future National ACEP Events adopted.

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

Toni McElhinney, CMP
Director, Conventions and Meetings

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 19(24)

SUBMITTED BY: Diversity, Inclusion, Health Equity Section
Social Emergency Medicine Section

SUBJECT: Vetting Intended Speakers with Divisive Language or Ideologies for ACEP Events

PURPOSE: 1) Create and enforce guidelines to avoid selecting speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion; 2) Develop a vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards; and 3) Provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

FISCAL IMPACT: Budgeted committee and staff resources to develop guidelines and educational resources for speaker vetting processes.

WHEREAS, ACEP is deeply committed to fostering a professional, respectful, and inclusive environment for all its members and attendees of its events, valuing diversity, equity, and inclusion as fundamental principles

WHEREAS, Understanding that the use of divisive language or the promotion of divisive ideologies may undermine the principles of diversity, equity, and inclusion, but also has the potential to create a hostile or unwelcoming atmosphere; and

WHEREAS, ACEP is resolute in its stance against such practices setting precedence in the past with such actions as the disinvite of Deepak Chopra; and

WHEREAS, ACEP has a firm commitment to upholding the highest standards of professionalism and respect in all its activities, including its educational and professional development events; and

WHEREAS, ACEP takes a proactive approach in ensuring these standards are met; therefore be it

RESOLVED, That ACEP:

1. Establish, enforce, and periodically update guidelines that avoid the selection of speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion.
2. Develop a thorough vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards.
3. Provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

Background

This resolution calls for the College to create and enforce guidelines to avoid selecting speakers who use or promote divisive language or ideologies that conflict with ACEP's commitment to diversity, equity, and inclusion; develop a vetting process for potential speakers to ensure their current language and ideologies align with ACEP's values and standards; and provide resources and education for members and event organizers on the importance of maintaining a professional and inclusive environment emphasizing the impact of divisive language and ideologies.

The planning and execution of ACEP's educational meetings are managed by the member-led Education Committee and various subcommittees. The committee is appointed by the ACEP president to ensure leadership and strategic direction align with ACEP's goals and priorities. Each committee is structured with three chairs, serving two-year terms across incoming, current, and outgoing roles. This structure allows for continuity and experienced leadership in the development and delivery of the educational programs. The General Session keynote speakers are recommended and vetted by the incoming ACEP president to ensure the speaker, and their message, align with ACEP's core values and the General Session annual theme.

The Education Committee has the following objective:

- Purposefully increase diversity, equity, inclusion, and belonging within ACEP education.
  - Recruit leading Under-Represented in Medicine (URM) educators to the Education Committee, subcommittees, and advisory group.

The Education Committee's *Scientific Assembly* Planning Subcommittee has the following objective:

- Increase diversity, equity, and inclusion within *Scientific Assembly*.
  - Recruit leading URM educators to the ACEP Scientific Assembly Planning.

In the ongoing commitment to enhance the diversity and inclusivity of educational offerings, ACEP has recently implemented a new speaker portal designed to improve the accuracy and reliability of data collection regarding speaker demographics. Historically, the process of tracking speaker ethnicity and gender involved assumptions, which often led to unreliable and inconsistent data. The new speaker portal facilitates self-reporting by speakers, allowing them to provide their own demographic information. This advancement in data collection provides the ability to track and analyze speaker diversity with greater precision and fostering a more inclusive and representative educational environment. The transition to self-reported data through the speaker portal marks a significant step towards improving transparency and inclusivity in our educational initiatives. Additionally, the transition to established term-limits for the Education Committee supports consistent and knowledgeable leadership in the planning and execution of educational programs while also ensuring there is a pipeline to new leadership with fresh perspectives.

Beginning with ACEP22, learning objectives pertaining to diversity, inclusion, and/or health care disparities have been added where appropriate. Each track for *Scientific Assembly* includes at least one didactic session with a learning objective related to systemic racism and social determinants of health. The annual "Leon L Haley, Jr Lecture" focuses on diversity, equity, and inclusion as well as professionalism, humanitarianism, and advocacy for the elimination of health care disparities.

In January 2025, a workgroup of the Board of Directors and staff was appointed to review and codify the process for planning the annual Leadership & Advocacy Conference (LAC) including the process for identification and approval of the educational program and speakers. A LAC Planning Workgroup will be appointed each year by the president and will be responsible, in collaboration with ACEP staff, for the overall planning of the LAC meeting. The keynote political speaker will be selected by the president. Staff will solicit input on potential administration speakers from the Board of Directors and the LAC Planning Workgroup and select the speakers based on the input from stakeholders and the availability of administration officials.

Rigorous guidelines and educational resources for speaker vetting processes are not currently developed. Completion of speaker/course evaluations from attendees is extremely helpful to the Education Committee, its subcommittees, and staff to help determine the effectiveness of speakers and usefulness of the topics presented. Additionally, the evaluations provide an opportunity for feedback about the presenters use of language or any controversial ideologies that may be mentioned.

This year ACEP24 features "off-track" (non-CME) courses that include innovative content beyond traditional CME and features fresh perspectives from new speakers and unique, thought-provoking topics, designed to challenge and expand knowledge outside of clinical topics. The speakers for the off-track courses feature the individual(s) that submitted the course proposal and, therefore, do not go through the usual *Scientific Assembly* Planning Subcommittee process.

All ACEP meeting attendees, including faculty, guests, and staff, are expected to adhere to ACEP's "Non-Discrimination and Harassment" policy statement and the "Meeting Conduct Policy" policy statement.

ACEP's "Non-Discrimination and Harassment" and policy statement includes the following information:

> "…ACEP acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions."
>
> "ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices protected by local, state, or federal law. Discrimination and harassment may be based on, but are not limited to, 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, or sexual orientation."

ACEP's "Meeting Conduct Policy" policy statement includes the following information:

> "ACEP promotes equal opportunities and treatment for all participants. All participants are expected to treat others with respect and consideration, follow venue rules, and alert staff or security when they have knowledge of dangerous situations, violations of this Meeting Conduct Policy, or individuals in distress."

Attendees can report harassment or other violations of the "Meeting Conduct Policy" to ACEP Meetings staff either in person or by email at conduct@acep.org or other means of reporting. ACEP may involve event security and/or local law enforcement, as appropriate based on the specific circumstances. Event attendees and participants must also cooperate with any ACEP investigation into reports of a violation of the "Meeting Conduct Policy" by providing all relevant information requested by ACEP.

ACEP Strategic Plan Reference

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

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

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

Fiscal Impact

Budgeted committee and staff resources to develop guidelines and educational resources for speaker vetting processes.

Prior Council Action

Resolution 81(21) Leon L. Haley, Jr., Award adopted. The resolution directed ACEP to create a national award to or champions of diversity, inclusion, and health equity in honor of one of the emergency medicine leaders who promoted diversity, inclusion, health equity and eliminating health disparities throughout his career; and create the "Leon L Haley Jr Lecture" to be held at the annual *Scientific Assembly* that focuses on diversity, equity, and inclusion.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey its speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Prior Board Action

The Board has consistently supported initiatives to enhance diversity, equity, and inclusion within the organization.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

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

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

June 2018, approved the "Meeting Conduct Policy" policy statement.

Background Information Prepared by: Ansley Colbeck
Senior Manager, Conference Education

Robert Heard, MBA, CAE
Chief Operating Officer

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 20(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advisory Council for All of Emergency Medicine

PURPOSE: Work with emergency medicine organizations to develop an ongoing advisory council to address issues pertaining to the direction of emergency medicine as a specialty.

FISCAL IMPACT: Unbudgeted and unknown costs to develop a formal structure to create an ongoing advisory council comprising all emergency medicine organizations.

WHEREAS, Emergency Medicine is one of few specialties with numerous governing organizations: ACEP, AAEM, CORD, SAEM, ACOEP, EMRA, other resident/student organizations (SAEM-RAMS, AAEM-RSA);

WHEREAS, The presence of numerous organizations leads to a lack of one authority for our specialty, and occasional discord between organizations; and

WHEREAS, Other specialties may have one primary governing organization that guides major specialty-wide decisions, such as ACOG's decisions to split from the AAMC/ERAS and utilize a new application platform for all OB/Gyn residency programs for the 2024-2025 academic year[1]; and

WHEREAS, The lack of overall governance and advising for all of the specialty of emergency medicine has been demonstrated by events such as when the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee stated it is not their role to take action in preventing new EM residency programs from forming if they meet the ACGME requirements for initial accreditation[2]; therefore be it

RESOLVED, That ACEP collaborate with other stakeholder organizations in emergency medicine to develop a working advisory council to determine and adjudicate issues as they pertain to the direction of emergency medicine as a specialty, such as but not limited to, residency program growth.

References:
1. New Residency Application Platform for Obstetrics and Gynecology https://apgo.org/page/rrrapplicationplatform
2. ACGME RRC Updates, CORD Business Meeting, CORD Academic Assembly, March 2023, Las Vegas, NV

Background

This resolution requests that ACEP work with emergency medicine organizations to develop an ongoing advisory council to address issues pertaining to the direction of emergency medicine as a specialty.

ACEP routinely works with other national emergency medicine organizations to collaborate on issues of mutual interest and agreement such as the workforce study, policy statements, and most recently diversity, equity, and inclusion in emergency medicine:

- American Academy of Emergency Medicine (AAEM)
- AAEM-Resident and Student Association (AAEM-RSA)
- American Academy of Emergency Nurse Practitioners (AAENP)
- Association of Academic Chairs of Emergency Medicine (AACEM)
- American Board of Emergency Medicine (ABEM)
- American College of Osteopathic Emergency Physicians (ACOEP)

- American Osteopathic Board of Emergency Medicine (AOBEM)
- Council of Residency Directors in Emergency Medicine (CORD)
- Emergency Medicine Residents' Association (EMRA)
- Emergency Nurses Association (ENA)
- National Association of EMS Physicians (NAEMSP)
- Society for Academic Emergency Medicine (SAEM)
- SAEM-Residents and Medical Students (SAEM-RAMS)
- Society of Emergency Medicine Physician Assistants (SEMPA)

The idea of an emergency medicine advisory council is not new. Such an organization was attempted by SAEM in the late 1990s. The group had difficulties from its inception and eventually disbanded. This effort was replaced by creating the All EM Organizations group and convening regular meetings. Meetings are held during the SAEM annual meeting and ACEP's annual Scientific Assembly and are an opportunity for each organization to provide updates about their major initiatives and to identify potential areas of collaboration. The meetings are primarily for information distribution in the hopes that duplicate efforts among the organization can be recognized.

Each organization has its own strategic vision and there are often challenges for all organizations to reach consensus on issues and do so in a timely manner, particularly on social issues, social media responses, and legislative actions. Each organization serves different constituencies and has their own policies and procedures. One issue that arose over time was the definition of a stakeholder organization. The initial invitation list of organizations was limited to ACEP, SAEM, AACEM, AAEM, ABEM, ACOEP, AOBEM, CORD, EMRA and early on the group was expanded to include AAEM-RSA and SAEM-RAMS. Over time the list of organizations has grown to include 21 groups, which significantly limits time for reporting on primary projects and discussion of cooperation on projects.

While other specialties often have a single organization that represents the voice of the specialty, that is a different model where the large specialty-wide group is acknowledged as the leading voice as opposed to the collaborative model in emergency medicine where some organizations provide a unique voice for each segment of the specialty. For example AACEM, CORD, and SAEM represent the specialty at the Council of Faculty and Academic Societies, which represents academic medicine faculty and academic societies within the American Association of Medical Colleges. ACEP represents emergency medicine at the Council of Medical Specialty Societies, which is a broader group representing all 24 members of the American Board of Medical Specialties.

About 10 years ago, the All EM Organization group agreed to work together on wellness. A summit was held and ideas for many possible projects were generated. However, issues were encountered over leadership of initiatives, funding for in person meetings and resources, and organizational responsibility for action items. It became obvious that each of the organizations had different resources and interests that led to the perception that some organizations dominated and others contributed too little. When the pandemic ensued, each organization led the way.

Other mulit-organizational activities have been tried with varying levels of success. Seven emergency medicine organizations participated in the latest workforce study, with ACEP in the lead. This effort was largely effective, but we learned the need for detailed planning and handling expectations. Additionally, even when consensus/compromise was reached within the taskforce, those statements did not always coincide with the priorities of the individual organization.

The Council of Board Certified Emergency Physicians (COBCEP), led by ABEM, has worked very well in part because it has a narrow focus on merit badge requirements and also perhaps because it is led by what is perceived to be a truly neutral organization.

Ten of the above listed emergency medicine organizations developed the All EM DEI Vision Statement. Additionally, nine emergency medicine organizations issued a Joint Statement from Emergency Medicine Organizations on Efforts to Diversify Health Care Professionals in the United States was issued after the U.S. Supreme Court decisions on the consideration of an applicant's racial or ethnic background in the higher education admissions process.

Six of the organizations worked together on creating recommendations for the new Accreditation Council for Graduate Medical Education (ACGME) requirements. This was a long and difficult process of achieving consensus and approval from all constituent boards. Several areas of contention were either not addressed or left open in the recommendations because agreement could not be achieved.

ACEP Strategic Plan Reference

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

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

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

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

Fiscal Impact

Unbudgeted and unknown costs to develop a formal structure to create an ongoing advisory council comprising all emergency medicine organizations.

Prior Council Action

None

Prior Board Action

None

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

Jonathan Fisher, MD, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 21(24)

SUBMITTED BY: Alecia Gende, DO, FACEP
Sarah Hoper, MD, FACEP
AAWEP Section

SUBJECT: Printable Volunteer Recognition Certificate

PURPOSE: Develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

FISCAL IMPACT: Budgeted staff resources for some volunteer recognition during National Volunteer Appreciation Week. Unbudgeted staff resources and unknown costs depending on the scope of an expanded volunteer recognition program.

WHEREAS, The health and success of the American College of Emergency Physicians is dependent upon physician volunteers; and

WHEREAS, The retention of membership and voluntary physician leaders within ACEP is necessary for the persistence of ACEP; and

WHEREAS, Diversity amongst volunteers, and leaders will bring a larger range of lived experiences and overall strengthen ACEP; and

WHEREAS, Physician volunteers serving ACEP utilize hard-earned vacation days, personal funding, and many hours of precious free time to fulfill the responsibilities of their various leadership roles within ACEP; and

WHEREAS, Hospital administration, emergency department administration, and other organizations are likely to encourage emergency physician involvement in ACEP and recognize emergency physicians who volunteer and serve ACEP if ACEP provides an incentive certificate; and

WHEREAS, An incentive certificate recognizes the physician's volunteered time and leadership position(s) within ACEP to recognize both the employer/hospital and the physician volunteer; therefore, be it

RESOLVED, That ACEP develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

Background

This resolution asks ACEP to develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

Volunteer leadership is critical to accomplishing the work of the College and addressing issues that are important to members. ACEP has many volunteer leadership opportunities, including but not limited to:

- Board of Directors
- Chapter Board of Directors
- Council (2 Council Officers, 422 councillors, approximately 200 alternate councillors)
- 5 Council committees

- 31 ACEP committees (approximately 1,100 members)
- Task Forces (2 current task forces with 48 members)
- 40 sections of membership with volunteer section officers
- Member Interest Groups
- Emergency Medicine Foundation Board of Trustees
- *ACEP Now* Editorial Board
- *Annals of Emergency Medicine* Editorial Board
- *JACEP Open* Editorial Board
- *Critical Decisions in Emergency Medicine* Editorial Board
- PEER Editorial Board
- National Emergency Medicine Political Action Committee Board of Trustees
- Clinical Ultrasound Accreditation Program Board of Governors
- Emergency Department Accreditation Program Board of Governors
- Geriatric Emergency Department Accreditation Program Board of Governors
- Pain and Addiction Care in the ED Board of Governors
- Emergency Medicine Data Institute Board of Governors
- AMA Section Council on Emergency Medicine
- Faculty for Scientific Assembly and other ACEP meetings
- Liaison representatives to other organizations and for special projects
- International Emergency Medicine Ambassadors
- Volunteers working on grant-funded projects
- Members of the 911 Grassroots Network

Many of ACEP's volunteers are featured on the ACEP website along with the member's name, photo, and bio information, such as the *Annals of Emergency Medicine* Editorial Board.

This resolution envisions developing customized certificates of appreciation annually for each ACEP volunteer and emailing it for the member to print on demand. Many members serve in multiple leadership positions and multiple certificates would be needed for some members to include all of their volunteer leadership positions. ACEP's current membership system, i.e., Association Management System (AMS), is limited in its ease of use to accomplish what is requested in this resolution. ACEP has had a cross-functional team working on the requirements and vetting options for a new AMS system for more than a year. The cost for the new AMS is $2 – $3 million and ACEP will move forward as soon as we are able to start planning for the budgetary impact. One goal for the new AMS is the ability to create a volunteer profile as part of MyACEP that tracks each member's volunteer activity for the College, which will assist in developing a service recognition program.

The last Whereas statement mentions recognizing both the employer/hospital and the physician volunteer, however, recognition of the employer/hospital is not included in the Resolved statement. ACEP does not currently require members to provide their employer or hospital information in their membership profile and that data would need to be collected.

ACEP has participated in National Volunteer Appreciation Week the past two years to recognize and thank volunteers who lend their time, talent, voice and support to causes they care about. ACEP's campaign has focused on:

- Sending handwritten postcards to committee members, section officers, and the Board of Directors.
- Profiling some member volunteers on the ACEP website.
- Emailing a "thank you" letter to volunteers from the ACEP president.
- Using engagED communities to highlight volunteer activity with "ribbons" displaying the member's volunteer involvement.

A series of content was posted on the All Member engagED community during National Volunteer Appreciation Week:

- Sunday – Start 🌟 Happy National Volunteer Week! 🌟
- Monday – Board of Directors and Past Presidents of ACEP
- Tuesday – Chapter Leaders
- Wednesday – Committees*
- Thursday – Sections Leaders*
- Friday – Member Interest Group Leaders*
- Saturday – Close/Call to action (reminder) on how to get involved (e.g. Committee Application)

Social media posts were developed for each day and for *EM Today/Weekend Review* posts:

- Sunday – social post announcing week, celebrating volunteers
- Monday – social spotlight post on a member volunteer with link to web article/*EM Today* announcing week, celebrating volunteers, link to article
- Tuesday – social spotlight post on member volunteer with link to web article
- Wednesday – social spotlight post on member volunteer with link to web article/*EM Today* item celebrating volunteers, link to article
- Thursday – social spotlight post on member volunteer with link to web article
- Friday – social spotlight post on member volunteer h link to web article/*EM Today* item celebrating volunteers, link to article
- Saturday – social video of all member volunteer features/*Weekend Review* item celebrating volunteers, link to webpage with video and all articles

ACEP presents committee chairs with a framed certificate of appreciation for their committee service when their term is completed. Committee members receive a letter of appreciation from the ACEP president when their committee term ends. Section chairs receive a commemorative plaque when their term is completed.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources for volunteer recognition during National Volunteer Appreciation Week. Unbudgeted staff resources and unknown costs depending on the scope of an expanded volunteer recognition program.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 22(24)

SUBMITTED BY: Wellness Section
Arizona College of Emergency Physicians
Colorado Chapter
District of Columbia Chapter
South Carolina Chapter

SUBJECT: Support for the "Well Workplace" Policy Statement

PURPOSE: Promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement and develop and support a system to track adherence to the "Well Workplace" policy statement to create a wellness certification mechanism or incorporate adherence into the ED Accreditation Program.

FISCAL IMPACT: Budgeted committee, section, and staff resources for some aspects of promotion. Unbudgeted costs estimated at $73,500 – $81,000 to develop a formal compliance program with estimated ongoing costs of $81,000 – $90,500+ annually. Grant funding could potentially be secured to support the project's direct costs and additional staff time required.

WHEREAS, ACEP believes in the wellbeing of all those who work in healthcare and are supportive of efforts that result in a well workplace and has adopted a "Well Workplace" policy statement; and

WHEREAS, The evolution of health care in a post COVID 19 era has significantly affected the landscape of Emergency Departments (EDs) around the world, with an exodus of professionals who are seeking improvement in and protection of their own wellbeing; and

WHEREAS, The clinicians within the ED encounter frequent and significant challenges to the provision of care for the often-increasing volumes of patients with diminishing resources for care; and

WHEREAS, A well workplace is prioritized by organizational leaders and personnel working together to promote, build, and sustain personal and professional health and wellbeing; and

WHEREAS, ACEP recognizes that the attributes of a well workplace may vary depending on location (academic medical center, community program, urban, suburban, rural, or critical access) and regardless of the setting, it is incumbent upon individual organizations to cultivate wellness, keeping it at the forefront of every decision and initiative; and

WHEREAS, ACEP has been the leader in developing policies that set the standard for the practice of emergency medicine and support the emergency physician, emergency patients, and the entire emergency team; and

WHEREAS, A system of standards and accountability are important to ensure that a well workplace is supported across EDs; and

WHEREAS, Although the individual has responsibility for personal wellness, the primary emphasis should be on how the organization impacts the wellbeing of physicians, therefore be it

RESOLVED, That ACEP promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement; and be it further

RESOLVED, That ACEP develop and comprehensively support a system to track adherence to the "Well Workplace" policy statement in an effort to create a wellness certification mechanism or incorporate adherence to this well workplace policy into the ED Accreditation Program.

Background

This resolution calls for ACEP to promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement and develop and support a system to track adherence to the "Well Workplace" policy statement to create a wellness certification mechanism or incorporate adherence into the ED Accreditation Program

ACEP is committed to improving the well-being of emergency physicians. This work is led by the Well-Being Committee and Wellness Section and supported by the Board of Directors.

The Well-Being Committee collaborates closely with the Wellness Section. Its primary focus is to address the tough issues that hinder wellness and career satisfaction for emergency physicians using evidenced-based tactics to solve these challenges and support well workplaces for all emergency physicians. The committee's objectives for the 2024-25 committee are:

Well Workplace

1. Create a process for recognizing organizations that adhere to the ACEP "Well Workplace" policy statement.
2. Solicit nominations for the 2025 Emergency Medicine Wellness Center of Excellence Award and recommend a recipient to the Board of Directors.
3. Provide subject matter expertise in promoting ACEP's work on addressing workplace violence.

Physician Wellness

4. Partner with National Association of Mental Illness (NAMI) to pilot at least three training sessions for peer-to-peer physician wellness, report on the results and evaluate the best strategy for peer support.
5. Create and curate wellness content for emergency physicians and providers to encourage personal and professional wellness strategies to be released throughout the year. Provide subject matter experts during development of ACEP meetings and educational offerings.

The Wellness Section aims to provide a forum for ACEP members with special interests in wellness and physician well-being to develop a knowledge base, share information, receive and give counsel, and serve as a resource to others interested in this area of emergency medicine. The Wellness Section's objectives are:

- To promote wellness for physicians practicing the specialty of emergency medicine.
- To promote collegiality and cooperation among the physicians who practice emergency medicine and to foster a lexicon for personal as well as professional well-being.
- To provide an opportunity for physicians interested in well-being to meet, interact, and network.
- To develop, present, and recommend educational programs on the many facets of wellness for physicians practicing emergency medicine.
- To prepare and distribute an interesting, educational, and informative newsletter for members of the section.
- To serve as a resource to the College president, Board of Directors, College committees, and ACEP members on issues relating to the well-being of those who practice emergency medicine.
- To coordinate activities with other organizations involved in emergency medicine at the invitation of the president and/or Board of Directors.
- To provide a pathway for professional leadership development within the organization.

The section has advised on a wide array of ACEP policies and published guiding documents to empower and improve the mental health of emergency physicians in their daily practice. These include:

- Emergency Department Planning and Resource Guidelines

- Model of the Clinical Practice of Emergency Medicine
- Boarding of Admitted and Intensive Care Patients in the Emergency Department
- From Self to System: Being Well in Emergency Medicine
- Emergency Physician Rights and Responsibilities
- Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department
- Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided

The "Well Workplace" policy statement was developed by the Well-Being Committee and approved by the Board of Directors in April 2024. ACEP policy statements follow a standard process after they are approved by the Board. This ensures fair and equitable promotion of the work products of sections, committees, and other groups of ACEP volunteers. That process includes:

- Placement of the policy statement on the ACEP website and publication in *Annals of Emergency Medicine*.
- Promotion of the new policy through standard ACEP channels such as *EM Today*, *Weekend Review*, and in specialized forums such as engagED or other areas that pertain to the subject matter.

The "Well Workplace" policy statement was promoted strategically in May during Mental Health Awareness Month and leading up to Emergency Medicine Wellness Week during the first week of June 2024. It was also promoted in the June issue of *ACEP Now* as part of a summary of activities from the April 2024 Board meeting. *ACEP Now* is a print publication that is sent to all ACEP members and about 3,000 additional physicians who identify as emergency physicians to the American Medical Association (AMA) but are not currently ACEP members.

The Well-Being Committee has an objective for the coming year to create a recognition program for emergency departments / employers that adhere to the "Well Workplace" policy statement. There are a number of ways that this could be accomplished, including use of a self-reporting / attestation form or modeling after similar initiatives such as the AMA Joy in Medicine Health System Recognition Program, which is designed to guide organizations interested or already engaged in improving physician satisfaction and reducing burnout.

Another program to reference is The Charter on Physician Well-Being, which was created by the Collaborative for Healing and Renewal in Medicine (CHARM), a group of leading medical centers and organizations that includes the AMA. The Charter helps health systems, organizations and individuals advance and promote physician well-being. This project was supported by a grant from the Arnold P. Gold Foundation.

Using self-reporting and or self-attestation as the method of verifying compliance is less costly and quicker to implement than more formal mechanisms that mirror accreditation programs. However, the absence of a formal verification or follow-up process could mean that the information collected is incorrect or incomplete. Incentives might be required to encourage emergency departments to submit this information until recognition on its own becomes meaningful to physicians and administrators.

ACEP is piloting its tiered Emergency Department Accreditation Program to establish transparency by recognizing hospitals with EDs that meet several key criteria and provide the best patient care possible. The ED Accreditation Board of Governors oversees the standards for each tier of ED Accreditation, which are based on ACEP policies, and approved by the Board of Directors. The program has begun accepting pilot applications, with early pilot sites able to provide feedback of suggested improvements for future consideration.

The criteria for all ACEP accreditation programs are reviewed annually. Proposed changes to the accreditation criteria must be submitted to the ED Accreditation Board of Governors for consideration. The Board of Governors will review the request and if appropriate, submit a recommendation to the ACEP Board of Directors to revise the criteria. Once approved, a notice period of at least 120 days must be provided to accredited sites prior to action being taken to enforce the new criteria.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Recognition programs can vary widely in both the direct cost and staff labor required to implement.

- For a self-attestation program that collects information via an online form for review by ACEP volunteer leaders, with subsequent online publication of those that adhere to the policy, costs would be negligible, and the staff work required could be absorbed into current allocated time and processes.
- Adding requirements related to the "Well Workplace" policy statement to the ED Accreditation Criteria could also be low/no cost, but would have a longer time horizon to implement.
- Formal compliance programs that collect information and require verification (i.e., site visits, interviews, etc.) are more costly to implement and require dedicated staff time to operate. Grant funding could potentially be secured to support the project's direct costs and additional staff time required above what is allocated annually to support committee and section work. ACEP's grants staff team could assist with applying to the right opportunities as they are identified by ACEP leaders.
    - Several factors need to be considered to estimate the cost and targeted grant funding required to implement a formal compliance program that involves information collection and verification (e.g., site visits, interviews). These include staff salaries, operational costs, travel expenses, and any technology or resources needed for the program. Additionally, it is important to recognize that once the program is implemented, it will require continued funding. This commitment will likely grow over time as the program expands.
        - Implementing a formal compliance program is estimated to cost between $73,500 – $81,000.
            - Travel for in-person verification: 5 sites/year with two volunteers – $25,000 (this assumes we audit/verify 5, the rest would have to be Zoom interviews)
            - Program operations: Part time staff dedicated 15 hours/week – $37,500 up to 18 hours/week – $45,000 as the program is implemented
            - Software support: $1,000
            - Promotion: $10,000
        - Ongoing Costs: To ensure the program is fully supported, ongoing costs are estimated to cost between $81,000 – $90,500+* annually.
            - Travel for in-person verification: At 5 sites/year with two volunteers – $25,000 (this assumes auditing/verifying 5 and the remaining interviews conducted virtually)
                - *Up to $25,000+ if the program decides they want to visit all of the sites that apply for compliance or recognition rather than just five per year (at ~$5,000 per site visit)
            - Program operations: Increased workload may be necessary to maintain program effectiveness as the program scales; part time staff dedicated 18 hours/week – $45,000 up to 20 hours/week – $52,500 as the program scales//
            - Software support:, There may be a need for enhanced technology, which could increase costs $1,000 – $3,000 if the program grows significantly.
            - Promotion: $10,000

Prior Council Action

None

Prior Board Action

April 2024, approved the policy statement "Well Workplace."

April 2024, approved the revised ED Accreditation Program Criteria and approved the Blue Ribbon Recognition "in concept;" revised and approved January 2024; originally approved October 2023 with requests to revise Blue Ribbon category.

June 2021, approved creation of the Emergency Medicine Wellness Center of Excellence Award.

Background Information Prepared by: Amanda Pairitz-Campo
Community and Engagement Manager

Mollie Pillman, MS, MBA, CAE
Associate Executive Director, Member Engagement

Nicole Tidwell
Senior Accreditation Manager

Nancy Calaway
Managing Director, Communications

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 23(24)

SUBMITTED BY: Diversity, Inclusion & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Supporting a Statement Affirming Diversity, Equity, and Inclusion in Emergency Medicine

PURPOSE: Develop a statement affirming diversity, equity, and inclusion in emergency medicine that is specifically from ACEP.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

WHEREAS, The American College of Emergency Physicians (ACEP) is committed to fostering an inclusive and equitable healthcare environment for all individuals; and

WHEREAS, Diversity within the College is essential to reflect the varied backgrounds and experiences of the patients we serve, enhancing the cultural competence and effectiveness of our care and ACEP is already committed to a diverse workforce in healthcare settings and recognizes the shortage of minority professionals healthcare; and

WHEREAS, Emergency medicine, being at the epicenter of health equity, serves as the frontline for patients from all walks of life, including those from underserved and marginalized communities, and it underscores our commitment to ensuring equitable healthcare for all; and

WHEREAS, Embracing diversity, equity, and inclusion within the emergency medicine community will improve patient outcomes, reduce health disparities, and foster a more just health care system; and

WHEREAS, ACEP is already invested in a joint statement from emergency medicine organizations on efforts to diversify health care professionals in the United States; therefore be it

RESOLVED, That ACEP develop a statement affirming its commitment to the prioritization of diversity and inclusion, the promotion of cultural competency, the support of health equity, the promotion of transparency, and the fostering of a collaborative environment; and be it further

RESOLVED, That ACEP continue to evaluate and adapt strategies to ensure they meet the evolving needs of our diverse patient population and our commitment to excellence in emergency medicine.

Background

This resolution asks for the College to establish its own unique diversity, equity, and inclusion (DEI) statement. ACEP is a signatory to the All-EM DEI Vision Statement that outlines broad principles for diversity, equity, and inclusion within emergency medicine, however, it lacks a distinct DEI statement that reflects the specific values and commitments of ACEP as an organization. ACEP has previously addressed DEI and diversity, inclusion, and health equity (DIHE) through several policy statements (see prior Board Action).

Through affirmation by the Board of Directors, policy statements, and participation in EM-specific work, ACEP acknowledges the importance of DEI initiatives in fostering an inclusive environment within emergency medicine. This is reinforced by its participation in the all-EM organizations working group on DEI that is aimed at aligning efforts, particularly in promoting DEI across the specialty of emergency medicine and by participating in the development of the All-EM DEI Vision Statement and the joint statement from emergency medicine organizations on

efforts to diversity health care professionals in the U.S. that was issued on July 20, 2023, with nine other emergency medicine organizations following the July 2023 U.S. Supreme Court decision regarding the consideration of an applicant's racial or ethnic background in higher education admissions.

This resolution provides the framework and rationale for the College to:

- Establish a unique identity: ACEP represents emergency physicians across the United States and globally. A unique DEI statement could articulate the specific values and commitments of ACEP regarding DEI within the emergency medicine community.
- Provide members and staff guidance: A distinct ACEP DEI statement will provide clear guidance to ACEP members and staff on the organization's stance and actions regarding DEI. This will ensure alignment with organizational goals and foster a sense of ownership among stakeholders.
- Align with best practices: Many other medical specialty societies have developed their own DEI statements tailored to their unique missions and membership. These statements serve as benchmarks and demonstrate best practices in addressing DEI within their respective fields.
- Establish leadership commitment: By establishing its own DEI statement, ACEP will demonstrate leadership within emergency medicine by setting specific goals, metrics, and action plans to promote DEI within the specialty.

Examples of DEI statements from other emergency medicine organizations:

American Academy of Emergency Medicine (AAEM)
AAEM's DEI statement focuses on advocating for diversity, equity, and inclusion in emergency medicine practice, education, and policy. It highlights their dedication to addressing systemic barriers and promoting cultural competency among emergency physicians.

American Board of Emergency Medicine (ABEM)
ABEM's DEI statement outlines their commitment to diversity, equity, and inclusion in board certification processes and ongoing certification maintenance. It emphasizes efforts to ensure fairness and inclusivity in evaluating emergency medicine practitioners' qualifications and competencies.

Emergency Medicine Foundation
EMF's DEI statement emphasizes its commitment to diversity, health equity, and inclusion by increasing representation of underrepresented racial and ethnic groups in biomedical research and addressing related health inequities. EMF also promotes geographic and institutional diversity, including partnerships with historically Black colleges and Hispanic-serving institutions.

National Association of EMS Physicians (NAEMSP)
NAEMSP's DEI statement focuses on promoting diversity, equity, and inclusion within Emergency Medical Services (EMS). It outlines their commitment to supporting diversity among EMS providers, addressing disparities in prehospital care, and advocating for inclusive policies and practices.

Society for Academic Emergency Medicine (SAEM)
SAEM's DEI statement emphasizes their commitment to promoting diversity, equity, and inclusion within academic emergency medicine. It outlines principles to foster an inclusive environment for all members and support efforts to address disparities in emergency care and research.

Examples of DEI statements from other medical specialty societies:

American Academy of Pediatrics (AAP)
AAP's DEI statement emphasizes creating an inclusive environment where all children, families, and pediatricians feel valued and respected. It commits to addressing health disparities, promoting cultural competence, and advocating for policies that support diversity, equity, and inclusion in pediatric care.

American College of Surgeons (ACS)
ACS's DEI statement outlines its commitment to promoting diversity among surgeons and ensuring equitable access to surgical care for all patients. It emphasizes creating an inclusive surgical community, addressing barriers faced by underrepresented groups, and supporting diversity in surgical leadership.

American Psychiatric Association (APA)
APA's DEI statement focuses on advancing diversity, equity, and inclusion in psychiatry. It pledges to support a diverse workforce, eliminate disparities in mental health care, and foster an inclusive environment for patients and providers of diverse backgrounds.

Developing a robust DEI statement for ACEP that reflects the unique identity and values of ACEP while aligning with best practices could further formalize the commitment to diversity, equity, and inclusion within emergency medicine.

ACEP Strategic Plan Reference

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

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.
- Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.
- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future.

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

- Leverage personalization and opportunities for issue/interest-based participation to make a member's connection to ACEP more personally meaningful.
- Measure and showcase the diversity and character of ACEP leaders and members.
- Enhance ACEP's brand positioning and communication strategies.

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

- Implement a systematic program evaluation process that considers new and on-going needs, return on investment/member value and ACEP's strategic plan.
- Be more transparent and timelier in communicating College policies, processes, and initiatives.

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements.

Prior Council Action

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and

resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College (position statements, adopted resolutions, task forces) through the lens of health equity and provide a biennial assessment of the work of the College pertaining to 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.

Substitute Resolution 41(05) Sexual Orientation 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

June 2023, approved the policy statement "Appropriate Use of Race in Research."

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2023, reviewed the Policy Resource & Education Paper "Caring for Transfer and Gender Diverse Patients in the Emergency Department."

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

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

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted.

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

October 2017, reviewed the information paper "Disparities in Emergency Care."

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

Background Information Prepared by: Tony Vellucci
Director of Advancement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-42

Torree M. McGowan, MD, FACEP (GS) – Chair
Blake Bailey, DO, MBA, FACEP (PA)
Lisa M. Bundy, MD, FACEP (MS)
Joshua R. Frank, MD, FACEP (WA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchner, MD, MPH, FACEP (MI)

Erin Grossmann
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 24(24)

SUBMITTED BY: James Humble, MD
Virginia College of Emergency Physicians
Dual Training Section
Observation Medicine Section
Young Physicians Section

SUBJECT: Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation

PURPOSE: Prioritize advocacy to remove the 3-midnight rule for skilled nursing placement.

FISCAL IMPACT: Budgeted staff resources as this is already an ongoing initiative of the College.

WHEREAS, Emergency Department boarding (ED Boarding) is an ongoing and serious issue[1,2]; and

WHEREAS, The boarding crisis is a major issue for ACEP at this time[1,2]; and

WHEREAS, This rule adversely affects patient care and physician wellness[3]; and

WHEREAS, The Medicare three-midnight rule (3MN rule) is outdated and unnecessary[4]; and

WHEREAS, Waiving the 3MN rule led to shorter hospital lengths of stay and was specifically implemented to prevent hospital crowding and ED boarding[5,6]; therefore be it

RESOLVED, That the American College of Emergency Physicians prioritize advocacy to have the Medicare three-midnight rule for skilled nursing placement removed.

References

1. https://www.acep.org/news/acep-newsroom-articles/acep-to-cms-consider-the-boarding-crisis-in-reporting-measures
2. https://www.acep.org/news/acep-newsroom-articles/new-poll-alarming-number-of-patients-would-avoid-emergency-care-because-of-boarding-concerns
3. https://www.jointcommission.org/resources/news-and-multimedia/news/2023/11/ed-boarding-impact-on-patient-care-and-clinician-well-being/
4. Halawi MJ, Vovos TJ, Green CL, Wellman SS, Attarian DE, Bolognesi MP. Medicare's 3-Day Rule: Time for a Rethink. J Arthroplasty. 2015 Sep;30(9):1483-4. doi: 10.1016/j.arth.2015.03.038. Epub 2015 Apr 8. PMID: 25922314.
5. Sheehy AM, Locke CF, Kaiksow FA, Powell WR, Bykovskyi AG, Kind AJ. Improving Healthcare Value: COVID-19 Emergency Regulatory Relief and Implications for Post-Acute Skilled Nursing Facility Care. J Hosp Med. 2020 Aug;15(8):495-497. doi: 10.12788/jhm.3482. PMID: 32804613; PMCID: PMC7518138.
6. https://www.mcknights.com/news/waiver-of-3-day-stay-didnt-increase-costs-or-lower-outcomes-in-cms-study/#:~:text=center%20published%20the-,February%20analysis,-%2C%20which%20showed%20that

Background

This resolution calls for the College to prioritize advocacy for the removal of the three-midnight rule (or 3-Day Rule), a Medicare policy that requires a Medicare approved 3-day hospital stay before a patient is eligible for Medicare coverage in a skilled nursing facility (SNF), due because of the compounding effects on the boarding crisis and its obsolescence.

The requirement for a Medicare approved 3-day hospital stay before a patient is eligible for Medicare coverage in a SNF has been part of Medicare since its inception. Since Medicare only covers “skilled nursing care,” the intent of Congress was to allow ongoing acute medical care in a less expensive setting limited to 120 days. However, since

Medicare's inception in 1965, medical care of the elderly, as well as treatment centers, have changed significantly. Acute and chronic medical care previously rendered almost exclusively in the inpatient hospital setting is now often being delivered in SNFs, rehabilitation hospitals, or even at home.

The Centers for Medicare & Medicaid Services (CMS) already provides 3-Day Rule waivers for certain Accountable Care Organizations (ACOs) that participate in or have applied to certain Shared Savings Program performance-based risk tracks, wherein health care providers can admit a beneficiary to a SNF directly from the community or after only 1-2 days in a hospital. A Center for Medicare & Medicaid Innovation Center (CMMI)-published report found that average SNF length of stay for direct and 1-2-day stays was consistently lower than non-waiver SNF stays, and that adverse outcome rates for direct waiver stays and 1-2-day stays were consistently lower than or similar to 3-day non-waiver stays and non-waiver stays overall.

Elimination of the 3-Day Rule has been a priority on ACEP's legislative and regulatory agenda for about 20 years. ACEP has supported every Congressional proposal and related regulatory action or proposal to rescind or ameliorate the rule's effects by at least counting time in observation toward the 3-day requirement. During the COVID-19 public health emergency, CMS provided a temporary waiver for the three-day stay rule. Legislators and advocates had hoped that CMS would make this waiver permanent and could potentially obviate the need for a legislative fix, but CMS indicated they did not have the authority to make the policy permanent and the waiver expired with the end of the public health emergency declaration in May 2023.

Specifically, ACEP supports the Improving Access to Medicare Coverage Act (H.R. 5138/S. 4137) to count time spent under observation status towards the three-day hospital stay for coverage of skilled nursing care, and establish a 90-day appeal period following passage for those that have a qualifying hospital stay and have been denied skilled nursing care after January 1, 2024. This bipartisan, bicameral legislation was introduced in the current 118th Congress by U.S. Representatives Joe Courtney (D-CT), Glenn Thompson (R-PA), and others, and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), and Sheldon Whitehouse (D-RI). The legislation remains a priority for ACEP's federal advocacy. ACEP is also a member of a larger coalition solely focused on addressing this issue. While there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. However, as there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to take up and pass this legislation.

Regulatory Activity
ACEP has also advocated for rescission and/or counting observation in countless regulatory comments, including in response to the "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success" proposed rule, the 2021 Outpatient Prospective Payment System (OPPS) proposed rule, and the 2023 OPPS.

ACEP also identified removal of the three-midnight rule as a key policy solution for addressing ED boarding in the Policy Solutions to ED Boarding document, a document that guides ACEP advocacy strategies.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources as this is already an ongoing initiative of the College.

Prior Council Action

Resolution 25(15) Medicare 3-Day Rule not adopted. Requested that ACEP develop a paper describing the barriers of

the Medical 3- Day Rule, the costs it creates for the health care system and costs that are often transferred to patients; partner with the AMA and other organizations to develop the paper and work together to eliminate the rule and make elimination of the rule a top legislative priority.

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

Prior Board Action

The Board of Directors approves the legislative and regulatory priorities each year.

March 2024, February 2023, January 2022, and January 2021, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services and encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.

February 2020, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services and encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule.

January 2019, approved supporting waivers to the 3-day Skilled Nursing Facility (SNF) rule that are included in Medicare payment models.

February 2018, January 2017, and February 2016, approved supporting expanded exemption for integrated payment models regarding Medicare policy that requires 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services.

January 2015, January 2014, and February 2013, approved supporting legislation to rescind the Medicare 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2012, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule, and/or waiving the rule for ACOs.

January 2011, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule.

September 2008, approved continuing efforts with key stakeholders, such as AARP, nursing homes, and beneficiary groups to advocate for a change in the Medicare 3-day rule.

August 2007, supported continuing state and federal advocacy efforts to rescind the Medicare 3-day stay rule.

Background Information Prepared by: Erin Grossmann
Regulatory and External Affairs Manager

Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 25(24)

SUBMITTED BY: John Bibb, MD, FACEP
Fred Dennis, MD, FACEP
New Mexico Chapter
Exploring Retirement Section

SUBJECT: Boarding – Follow the Money

PURPOSE: Collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the ED to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the ED.

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

WHEREAS, President George W. Bush said in 2007, "I mean, people have access to health care in America. After all, you just go to an emergency room."; and

WHEREAS, There have been 69 billion ACEP resolutions about boarding over the last several decades and the problem has only gotten worse; and

WHEREAS, The adverse outcomes of boarding have been documented ad nauseam; and

WHEREAS, Boarding has forced the development of new subspecialties of emergency medicine including Hallway Medicine, Waiting Room Medicine, and Tent/Parking Lot Medicine that patients are forced to endure; and

WHEREAS, When they say it is not about the money, it is always about the money; and

WHEREAS, It is, at best, partially effective, in our capitalist system, to force businesses to engage in nonprofitable lines of work through regulation, legislation, bureaucracy begging, pleading, and accusations; and

WHEREAS, When admitting sick patients to the hospital from all economic strata is profitable (economically viable?), this business line will be pursued fervently, and many of our problems with boarding will be ameliorated; therefore be it

RESOLVED, That ACEP collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the emergency department.

Background

The resolution calls for ACEP to collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the ED.

The resolution aims to address the foundational economic incentives that have led to the current emergency

department boarding crisis. Emergency department boarding is a scenario where patients are kept in the ED for extended periods of time because of a lack of available inpatient beds or space in other facilities where they could be transferred. Shortages of physicians, nurses, and other health care providers across the health care continuum have significantly contributed to the growing issue of boarding.

Recent reports, including a May 2024 report issued by the American Hospital Association, suggest that hospitals and health systems throughout the country are facing dire financial outlooks, despite the stabilization of operating costs and margins as the COVID-19 pandemic subsided. The AHA report states that increasing demand for higher acuity care, persistent workforce shortages, supply chain issues for drugs and supplies, and high levels of inflation, are contributing to growing costs while reimbursement rates from government payers and bad commercial insurer practices are exacerbating the financial distress facing hospitals. As the resolution notes, given our current system of health care financing, regulatory and legislative environments, and growing administrative and bureaucratic burdens, hospitals and health systems are required to provide nonprofitable lines of business and are thus incentivized to pursue lines of business that are profitable, often at the expense of efficiencies or most appropriate care for patients.

Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic. Boarding and ED crowding are not caused by ED operational issues or inefficiency; rather, they stem from misaligned economic drivers and broader health system dysfunction.

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). Preliminary results of this 2022 EDBA performance measures survey "…found a significant deterioration in patient processing due to inpatient boarding." ACEP issued a report in 2016, developed by the Emergency Medicine Practice Committee, "Emergency Department Crowding: High Impact Solutions." The report was developed to identify and disseminate proven ways to decrease input, as well as novel approaches to increase throughput and increase output. This document is available on ACEP's resource page, "Crowding & Boarding," along with links to other relevant information papers, policy statements, resources regarding state approaches, and others.

Overall, addressing boarding and crowding have been longstanding priorities of the College There is active policy development, committee work, liaison work, and media outreach that is ongoing on this issue. Federal legislative and regulatory advocacy efforts continue as well. ACEP federal advocacy has focused on raising awareness of the ED boarding crisis and developing both legislative and regulatory solutions to help ease this multifactorial challenge. In November 2022, ACEP led a coalition letter to President Biden, laying out the ED boarding crisis as a public health emergency and asking the Administration to establish an ED Boarding Task Force. Then, in May 2023, ACEP developed and helped secure signatories during the 2023 Leadership and Advocacy Conference (LAC) for a bipartisan "Dear Colleague" letter led by Representatives Debbie Dingell (D-MI) and Brian Fitzpatrick (R-PA), along with 42 other Representatives, urging U.S. Department of Health and Human Services Secretary Xavier Becerra to convene a stakeholder task force to address the boarding crisis and develop and implement immediate and long-term solutions.

As part of this continued initiative, in September 2023, ACEP organized and led a summit of stakeholders across health care to discuss the factors contributing to the boarding crisis and strategies to pursue collaborative solutions. Participating medical societies, state and federal government leaders, hospital, nursing home, and patient group representatives came to the ACEP DC office for a candid and crucial conversation, including the Agency for Healthcare Research and Quality (AHRQ), the American Hospital Association, American Nurses Association, America's Essential Hospitals, among others. A full report of the Summit's proceedings was published on October 20, 2023. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. And in December 2023, Secretary Becerra responded to the Dingell-Fitzpatrick Dear Colleague letter and announced the convening of stakeholders through AHRQ to address ED boarding. ACEP has worked closely with AHRQ since this announcement to help inform the AHRQ Directors' Roundtable and its continued efforts on the topic.

Additionally, the Centers for Medicare and Medicaid Services (CMS) finalized the adoption of the Age-Friendly Hospital Measure as part of the Hospital IQR Program. The measure, developed by ACEP in partnership with the American College of Surgeons (ACS) and Institute for Healthcare Improvement, seeks to enhance care for older patients by focusing on key areas like medication management and frailty screening. This measure aims to redefine how hospital systems approach geriatric care, calling for hospitals to have protocols in place to move older patients out of the emergency department within eight hours of arrival or three hours of the decision to admit. ACEP encouraged CMS to include attestations to reduce boarding in the emergency department and screen for risk factors related to social determinants of health, among others. The inclusion of the measure in the hospital IQR program gives hospitals a financial incentive to address boarding in geriatric populations.

In July 2024, ACEP leadership and staff met with CMS asking them to potentially modify the Emergency Services Condition of Participation (CoP) as a lever to help address boarding. There is a recent precedence for this, as in the Calendar Year 2025 Outpatient Prospective Payment System (OPPS) proposed rule, CMS proposes to revise the Emergency Services CoP related to emergency readiness for hospitals and CAHs that provide emergency services and create a new CoP for obstetrical services.

Addressing boarding and crowding have also been key priorities for federal advocacy during the 118th Congress. ACEP helped develop and supports the bipartisan Improving Mental Health Access from the Emergency Department Act (S.1346), which creates a grant program aimed at assisting emergency departments and communities in implementing innovative strategies to ensure continuity of care for patients who have presented with acute mental health conditions.

ACEP also supports:

- The bipartisan Helping Kids Cope Act (H.R. 2412), introduced by Representatives Lisa Blunt Rochester (D-DE) and Brian Fitzpatrick (R-PA) which would provide funding to support necessary staffing, capacity increases, and infrastructure adjustments needed to alleviate pediatric boarding; maintaining initiatives to allow more children to access care outside of emergency departments; and addressing gaps in the continuum of care for children.
- The Mental Health Infrastructure Improvement Act (H.R. 5804), introduced by Representatives Derek Kilmer (D-WA) and Don Bacon (R-NE). Helps expand mental health infrastructure by establishing a new loan and loan guarantee program to fund the construction or renovation of mental health or SUD treatment facilities that provide inpatient care, partial hospitalization, intensive outpatient, and/or crisis stabilization; sets aside at least 25% of the funding for pediatric-serving facilities; provides priority for facilities that are located in high-need, underserved, or rural areas, are able to provide integrated care for complex patients, and will provide multiple services along the continuum of care.
- The Providing Access to Treatment and Housing (PATH) Act (H.R. 4941) introduced by Representatives Adam Schiff (D-CA), Nancy Pelosi (D-CA), Yvette Clarke (D-NY), and others. Expands access to mental health and behavioral health services, including substance use disorder treatment, for individuals experiencing homelessness or housing insecurity. Establishes a $2 billion grant program to expand access to services, overdose prevention, workforce training, care coordination, housing programs, and training for non-health care professionals interacting with those experiencing homelessness or housing insecurity.

ACEP staff continue to discuss potential solutions with legislators in both chambers and inform additional legislative efforts in development, including legislation to help improve bed tracking and capacity management systems that is expected to be introduced in the near future. Additionally, ED boarding, ED crowding, and mental health have been the central themes of the face-to-face advocacy efforts by our members who attend the ACEP Annual Leadership and Advocacy Conference for the last several years.

Emergency Department Boarding and Crowding resources are available on the ACEP website, including Policy Solutions to Emergency Department Boarding. These policy solutions point to some of these financial drivers and potential ways to realign financial incentives, such as establishing reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding, tying additional financial incentive es and penalties to measures of crowding and boarding, developing incentives to enable skilled nursing facilities and long-term care facilities to expand capacity and accept patients from the ED outside of core business hours (as well as

possible penalties for refusing patients without documentation of legitimate reasons for doing so), among others.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Directed ACEP to work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and, support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed ACEP to use legislative venues and lobbying efforts, focus regulatory bodies to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve ED capacity; and define criteria to determine when an ED is considered over capacity and hospital action plans are triggered to activate

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce Boarding of admitted patients in the emergency department.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend

discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Amended Resolution 50(88) Hospital Bed Availability and Methodology adopted. It called for ACEP to develop policies to ensure that emergency patients receive the highest priority in hospital admission systems.

Prior Board Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

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

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

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

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

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

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper "Emergency Department Crowding High-Impact Solutions"

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Amended Resolution 50(88) Hospital Bed Availability and Methodology adopted.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 26(24)

SUBMITTED BY: Erik Blutinger MD FACEP
Elaine Rabin MD FACEP
Nicholas Stark, MD, MBA
Arjun Venkatesh, MD, FACEP
New York Chapter
Quality Improvement & Patient Safety Section
Young Physicians Section

SUBJECT: Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events

PURPOSE: 1) Advocate for and support the development of policies that take ED boarding and overcrowding into consideration when analyzing adverse patient safety events and patient safety procedures; 2) Commit resources for establishing best practices for hospitals to consider ED boarding/overcrowding in developing corrective action plans in response to medical errors; 3) Work with stakeholders to require that Root Cause Analyses performed in response to adverse patient safety events specifically list boarding and/or overcrowding as benchmarks in analysis questions and root cause types.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives and potential unbudgeted expenses of $5,000-$10,000 if an in-person meeting (depending on the number of participants) is necessary or for third-party development and dissemination of best practices materials.

WHEREAS, Inpatient boarding in emergency departments and hospital crowding was declared a national epidemic in 2007 by the Institute of Medicine[1]; and

WHEREAS, The issue has not been resolved and likely worsened after COVID[2]; and

WHEREAS, Boarding and crowding have been demonstrated to compromise patient safety, with dire effects on morbidity and mortality[3]; and

WHEREAS, The Joint Commission mandates that hospitals employ a Root Cause Analysis (RCA) process or similar activity to identify and address systemic contributors to patient safety issues[4]; and

WHEREAS, RCAs often deliberately focus only on the care of one patient without consideration of other activity in a department at the time, thus by design not necessarily accounting for contributions of boarding and crowding to any adverse events; and

WHEREAS, There is no widely accepted, universal approach to performing an RCA used by health systems to account for boarding in Emergency Departments and hospital crowding; and

WHEREAS, Federal data often fails to capture a comprehensive review of resource limitations inclusive of ED strain, staffing variability, and local outbreak burden; therefore be it

RESOLVED, That ACEP advocate for and support the development of policies that will ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; and be it further

RESOLVED, That ACEP commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and be it further

RESOLVED, That ACEP work with other organizations to require that Root Cause Analysis and corrective actions include hospital capacity constraints and overcrowding as benchmarks in "analysis questions" and "root cause types" when analyzing an event and organizing next steps.

References

1. Institute of Medicine. 2007. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11621.
2. Janke AT, Melnick ER, Venkatesh AK. Hospital Occupancy and Emergency Department Boarding During the COVID-19 Pandemic. JAMA Netw Open. 2022 Sep 1;5(9):e2233964. doi: 10.1001/jamanetworkopen.2022.33964. PMID: 36178691; PMCID: PMC9526134
3. Kelen GD, Wolfe R, D'Onofrio G, et al. Emergency Department Crowding: the canary in the healthcare system. NEJM Catalyst. September 28, 2021.
4. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/camh_se_20230906_155314.pdf. Accessed June 24, 2024.

Background

This resolution calls for the College to work with other organizations to add emergency department (ED) boarding and crowding as a factor when conducting Root Causes Analysis (RCA) and determining corrective action plans in response to medical errors and adverse patient safety events. Additionally, the resolution asks the College to create resources to establish best practices in engaging and assisting hospitals in consideration of ED boarding and crowding when those hospitals conduct analyses of such incidents.

The resolution also asks the College to advocate for requiring that RCA include ED boarding and/or overcrowding as benchmarks in "analysis questions" and "root cause types" but does not specifically mention TJC. the College would need to engage with TJC, state regulatory bodies, the Centers for Medicare & Medicaid Services (CMS), and/or other appropriate policymaking bodies that can enforce a requirement to include these benchmarks,

RCA is a structured method used to analyze serious adverse events and is the method mandated by The Joint Commission (TJC) when hospitals experience and report a sentinel event. Though hospitals and accredited organizations are not required to report sentinel events – a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm) – TJC encourages self-reporting of such events for health care organizations. Self-reporting allows hospitals and health care organizations to identify opportunities to change their culture, systems, and processes to prevent unintended harm; help health care organizations that have experienced a sentinel event determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and develop strategies to prevent or reduce such events in the future; and maintain the confidence of the public, clinical staff, and health care organizations in the priority of patient safety in TJC–accredited health care organizations. Though specifically mandated by TJC in response to a sentinel event, RCA is also widely used internally as a response to medical errors and adverse patient safety incidents.

In TJC's Framework for Root Cause Analysis and Action Plan, which provides a template for analyzing an event and helps to organize the steps and information in an RCA in preparation for submitting an analysis to TJC (but can be used to guide analysis of non-TJC-reported events), boarding and/or overcrowding is not listed as one of the root cause types or referenced as a causal factor. However, multiple studies have shown that boarding and/or overcrowding is associated with a reduction in quality of care, resulting in unfavorable clinical outcomes and adverse events (Rocha et al.; Loke et al.).

In June 2024, ACEP leadership and staff engaged in a discussion with TJC in which we advocated for the consideration of boarding and/or overcrowding-related adverse incidents as sentinel events. Further, in July 2024, ACEP leadership and staff met with CMS asking them to potentially modify the Emergency Services Condition of Participation (CoP) as a lever to help address boarding. There is a recent precedence for this, as in the Calendar Year 2025 Outpatient Prospective Payment System (OPPS) proposed rule, CMS proposes to revise the Emergency Services CoP related to emergency readiness for hospitals and CAHs that provide emergency services and create a new CoP for obstetrical services.

Addressing boarding and crowding has been a longstanding priority of the College, with continuing federal legislative and regulatory advocacy efforts. In September 2023, ACEP organized and led a summit of stakeholders across health care to discuss the factors contributing to the boarding crisis and strategies to pursue collaborative solutions. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding has also been key priorities in ACEP's advocacy to Congress. Specifically, ACEP's Boarding Policy Recommendations include several recommendations for hospital contributions:

- Creation of reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding.
- Tie additional financial incentives and penalties to measures of crowding and boarding such as CMS measure OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) and ED-2 (Admit Decision Time to ED Departure Time for Admitted Patients).
- Creation of "holding for discharge rooms" elsewhere in hospital that allow patients who are near discharge to receive final discharge instructions—thereby freeing up ED beds.
- New CMS Condition of Participation requiring hospitals to develop contingency plans when inpatient occupancy exceeds 85 percent [or similar threshold], including a load balancing plan and an identification and utilization plan of alternative space and staffing for inpatients when greater than a certain percentage of ED licensed bed capacity is occupied.
- Expansion of surgical and procedural schedules to seven days, thereby spreading out elective procedures and smoothing out the availability of inpatient beds within hospitals.

Boarding was a key issue that ACEP member advocates brought to Congressional offices during the last two Leadership & Advocacy Conferences. ACEP staff continue to work on developing legislative proposals and it is hoped the proposals will be introduced this fall in both chambers of Congress. Lastly, boarding is also part of ACEP's recess toolkit for ACEP members to advocate to their Congressional leaders during the August break while legislators are back in their home districts.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted staff resources for advocacy initiatives and potential unbudgeted expenses of $5,000-$10,000 if an in-person meeting (depending on the number of participants) is necessary or for third-party development and dissemination of best practices materials.

Prior Council Action

The Council has discussed and adopted many resolutions related to boarding in the ED, but none that are specific to adding ED boarding and crowding as a factor when conducting Root Causes Analysis (RCA) and determining corrective action plans in response to medical errors and adverse patient safety events.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. It directed the College to use legislative and regulatory venues to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Amended Resolution 13(16) ED Boarding and Overcrowding is a Public Health Emergency adopted. It directed the College to work with regulatory agencies and the Joint Commission to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council's next scheduled meeting.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. The resolution directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce ED crowding by placing the burden on hospitals to manage their resources more effectively.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department."

Prior Board Action

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

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

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

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

April 2017, approved the revised policy statement "Disclosure of Medical Errors;" revised and approved April 2010; originally approved September 2003.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Erin Grossmann
Regulatory and External Affairs Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(24)

SUBMITTED BY: Rural Emergency Medicine Section
Social Emergency Medicine Section
Oklahoma Chapter
Michigan College of Emergency Physicians
Virginia College of Emergency Physicians

SUBJECT: Continuous Physician Staffing for Rural Emergency Departments

PURPOSE: Collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

WHEREAS, Rural emergency department patients deserve access to physician-led teams to the same degree as their urban counterparts; and

WHEREAS, There is variability in the required training and supervision of non-physician practitioners (NPs, PAs,) working in emergency departments which can lead to a lower degree or complete absence of physician involvement in emergency care; and

WHEREAS, The states of Virginia and Indiana have set a precedent with legislation requiring continuous on-site physician staffing in all emergency departments; and

WHEREAS, The ACEP Council adopted Amended Resolution 42(23) which resolved to "encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments"; and

WHEREAS, The American Medical Association (AMA) in 2024 adopted resolution 204 that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician; therefore be it

RESOLVED, That ACEP collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

Background

This resolution requests ACEP to collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

ACEP has consistently advocated for physician-led care teams in the emergency department at both the national and state level. The Advocacy and Practice Affairs Division has also advocated for this standard to the Centers for

Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

Indiana ACEP successfully passed legislation in 2023 (HOUSE BILL No. 1199) that requires a physician be on-site, on-duty, and responsible for the emergency department at all times. This new legislation complements state regulations in place in California and New Jersey that also require a physician on-site in a hospital emergency department.

The State Legislative/Regulatory Committee (SLRC) developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit was distributed to ACEP chapters in time for the 2023-24 state legislative season.

Virginia ACEP used the model legislation developed by ACEP to pass legislation (HB 392) updating an existing law to include a requirement for a physician to be on site and responsible for the emergency department at all times. Nearly a dozen other states are considering introducing the ACEP model legislation in their 2025 legislative session.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet to begin and continue participating in Medicare and Medicaid. This action would have the effect of creating a federal mandate that EDs in Critical Access Hospitals (CAH) and Rural Emergency Hospitals (REH) be staffed 24/7 by a qualified physician. This would parallel the requirement in Indiana, Virginia, and ACEP's model legislation, but does not require a board certified emergency physician in the rural setting.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP has continually promoted the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and advocated for this standard to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the U.S. Congress.

ACEP Strategic Plan Reference

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

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

- Expand and strengthen the role, approach, and impact of state-level advocacy.

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

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the

independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

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

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

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

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

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

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

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

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

Jonathan Fisher, MD, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 28(24)

SUBMITTED BY: Utah Chapter

SUBJECT: Data Gathering on Free Standing EDs: Examining Regulations, Services Offered, and Staffing Policies

PURPOSE: Collect data on free standing emergency department-type facilities at the national and state level, including current services and equipment offered at FSEDs, state regulations, and other policies that might assist chapters addressing issues with FSEDs.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Significant staff resources would be required to identify existing FSEDs and the contact information for each one. An outside consultant would likely be necessary and the cost is estimated at $250,000 or more. As the possible use of the data is unknown, this estimate could increase depending on the amount of detail required and the analysis needed. A data system would require ongoing staff resources to ensure the data remains current. This project would require diverting budgeted staff resources from other initiatives to support this effort.

WHEREAS, Across the nation there is significant variation both in number and location of free standing emergency departments (FSEDs) as well as regulation of staffing or clinical capabilities at these facilities; and

WHEREAS, One study demonstrated that state requirements for FSEDs vary from "thorough and well defined to vague or non-existent, a range that likely contributes to the wide variation in the services available at FSEDs"[1]; and

WHEREAS**,** ACEP has recommended core policies that FSEDs should adopt, as well as a formal accreditation process for FSEDs,[2] but that has not come to fruition and this has allowed hospital corporations and individuals to open and operate FSEDs without nationally standardized, formal safety regulations related to staffing, equipment, or capabilities; and

WHEREAS**,** Patients may be likely to assume that a FSED can provide the same services as a hospital-based ED and seek care from a facility that may not be capable of adequately providing definitive care and this could result in treatment delays or inability to prevent death or severe disability; and

WHEREAS, In addition, patients may confuse FSEDs for urgent care centers, receiving evaluation and treatment for lower acuity issues, but receiving a bill on par with that of a hospital-based emergency department due to similar facility fees[3]; therefore be it

RESOLVED**,** That ACEP collect data on free standing emergency department-type facilities (FSEDs) nationally, and any state regulations specifically pertaining to them, and this may include a survey of current services and equipment offered at FSEDs in each state as well as staffing and other pertinent policies that might be helpful to ACEP chapters who may be addressing issues with these facilities.

References

1. Gutierrez, C et al. State Regulation of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, and Services Provided. *Health Affairs* 35, No. 10 (2016): 1857-1866.
2. Dayton, J et al. Freestanding Emergency Center Accreditation Task Force Recommendations. ACEP 2018.
3. Alexander, A and Dark, C. Freestanding Emergency Departments: What is Their Role in Emergency Care? *Annals of Emergency Medicine.* Volume 74, No. 3: September 2019. 325-330.

Background

This resolution requests ACEP to gather data on free standing emergency department-type facilities (FSEDs) at the national and state level to assist ACEP chapters addressing issues with FSEDs.

The number and location of FSEDs, and regulation of these facilities vary greatly. Patients might confuse am FSED with a hospital ED and seek care from a facility that is not equipped to provide definitive care, potentially causing treatment delays or exacerbating the patient's condition. Conversely, patients might confuse a FSED with an urgent care center and could lead to unexpected medical bill totals.

The ability to gather sufficient data about FSEDs will first require a determination about the purpose and possible uses of the data. It will also be necessary to determine contact information for each FSED. There is no repository that identifies FSEDs in the U.S. or the contact information for each one. Additionally, there will need to be an incentive for an FSED to complete a survey to provide the information.

ACEP's "Freestanding Emergency Departments" policy statement maintains that states are encouraged to develop regulations regarding FSEDs in partnership with the applicable ACEP state chapter. The policy statement addresses appropriate staffing by qualified emergency physician and adequate medical and nursing personnel, and affirms that FSEDs should receive the same level of reimbursement for physician and technical component services as a hospital-based ED.

ACEP endorses the Center for Improvement in Healthcare Quality Free-Standing Emergency Center Accreditation Program. The accreditation survey process includes a review of facility policies and procedures, a tour of the facility and care areas, review of physician credentials and medical records, and observation of care services. This is a voluntary program that facilities can choose to utilize for accreditation.

ACEP's Freestanding Emergency Centers Section has an objective focused on collaborating with ACEP leadership to establish a national set of standards that could be referred to as a unified national resource for legislatures, physicians, and the medical community.

ACEP Strategic Plan Reference

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

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

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

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Significant staff resources would be required to identify existing FSEDs and the contact information for each one. An outside consultant would likely be necessary and the cost is estimated at $250,000 or more. As the possible use of the data is unknown, this estimate could increase depending on the amount of detail required and the analysis needed. A data system would require ongoing staff resources to ensure the data remains current. This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency

Care in Underserved and Rural Areas of the U.S. adopted. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Called for ACEP to explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers and the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where allowed by state law.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted. Called for ACEP to encourage physicians and health care providers and health care facilities to emphasize in advertising their own positive attributes rather than to denigrate the capabilities of other providers or facilities.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. Instructed ACEP to reaffirm the Emergency Care Guidelines and develop definitions of various forms of ambulatory care facilities and emergency care facilities to be included in future Emergency Care Guidelines.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

April 2020, approved the revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

April 2019, approved partnering with the Center of Improvement in Healthcare Quality (CIHQ) to provide accreditation services for freestanding emergency centers.

September 2018, directed the Freestanding Emergency Centers Task Force to explore models and develop a business plan to develop for freestanding emergency center accreditation.

May 2018, reviewed the Freestanding Emergency Centers Task Force report.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2016 and April 2016, discussed a certification program for Freestanding Emergency Centers created by the Society of Cardiovascular Patient Care (SCPC), which merged with the American College of Cardiology (ACC), and offers certification in Freestanding ED cardiac care. ACEP notified SCPC that it does not support certification of this type. SCPC formally launched the certification program in May 2016.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper Freestanding Emergency Departments and Urgent Care Centers.

June 2014, approved the policy statement, "Freestanding Emergency Departments."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Resolution 15(98) Certifying Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted.

Background Information Prepared by: Jessica Adams
Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 29(24)

SUBMITTED BY: Utah Chapter

SUBJECT: Minimum Standards for Freestanding Emergency Departments

PURPOSE: Promote and advocate that all FSEDs meet minimum standards of: 24/7 staffing by a board-certified/board-eligible emergency physician; x-ray, CT, and ultrasound capabilities at all times, trained technicians dedicated to those tasks; two registered nurses experienced in emergency medicine onsite at all times; laboratory services capable of performing low and moderate complexity tests available at all times; a certified respiratory therapist onsite at all times; a trained security officer present at all hours of operation; at least two units of packed red blood cells at all times.

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

WHEREAS**,** Freestanding emergency departments (FSEDs) were created in the 1970s in the hopes they would provide high-quality emergency care to people in medically underserved areas, provide convenient services and treatments with shorter wait times, and relieve overburdened hospital emergency departments (EDs); and

WHEREAS, FSEDs are a rapidly expanding alternative to traditional hospital-based EDs. However, when advertised as an emergency center/department/room, the general public may reasonably expect that a FSED will be able to provide emergency services on par with that of a hospital ED, including care for strokes, heart attacks, and traumatic injuries, when the reality is that some FSEDs may not be capable of providing all of these services; and

WHEREAS**,** FSEDs should provide services that reflect the current evidence-based standard of emergency medical care as well as provide adequate staffing and capabilities to ensure patient safety and to reduce physician and other provider liability; therefore be it

RESOLVED**:** That ACEP promote and advocate that all free standing emergency departments (FSEDs) maintain the following minimum standards:

1. All facilities advertised or promoted as free standing emergency departments (FSEDs) or similar titles implying services comparable to a hospital-based emergency department should be staffed by at least one board-certified or board-eligible emergency physician 24 hours a day, 7 days a week. All FSEDs should be physician-led. Nurse practitioners and physician assistants providers may be allowed to supplement staff at FSEDs, but a physician must be present on site at all times.
2. FSEDs must have x-ray, CT, and ultrasound capabilities at all times with trained technicians dedicated to those tasks. Ultrasound technicians may be on call if they can arrive within 30 minutes when needed.
3. There should be at least two registered nurses with experience in emergency medicine services with the ability to flex up nursing staff as needed if--in the opinion of the on-duty physician-- patient census, acuity level, or length of stay requires more nursing staff for safe and optimal patient care.
4. All FSEDs must maintain on the premises during all hours of operation laboratory services capable of performing low and moderate complexity laboratory tests that can be completed in a timely manner so that results are readily available for the on-site physician to make decisions regarding appropriate patient care and disposition. This may include but not be limited to only use of point of care tests at any hour of operation. The facility must be staffed by a certified technician or dedicated staff member for laboratory services who is trained to process labs on site. Facility lab capability should include, at a minimum, tests such as CBC, CMP and BMP, troponins (preferably high sensitivity), d-dimers, pregnancy tests including a Beta-hCG quantitative level, and basic toxicology screens.

5. A trained and certified respiratory therapist (RT) should be on site at all times of operation. The RT can be trained to do additional tasks including ECGs, IV access, clerical duties, and other tasks as needed.
6. The FSED should have a trained security officer present at all hours of operation. The security guard may also be assigned clerical duties or other tasks as needed.
7. FSEDs should have at least two units of packed red blood cells on site and immediately available for emergency use at all times.

Background

This resolution asks the College to promote and advocate that all freestanding emergency departments meet minimum standards of: 24/7 staffing by a board-certified/board-eligible emergency physician; x-ray, CT, and ultrasound capabilities at all times, trained technicians dedicated to those tasks; two registered nurses experienced in emergency medicine onsite at all times; laboratory services capable of performing low and moderate complexity tests available at all times; a certified respiratory therapist onsite at all times; a trained security officer present at all hours of operation; at least two units of packed red blood cells at all times.

ACEP's "Freestanding Emergency Departments" policy statement addresses some of the standards requested in this resolution, including staffing by appropriately qualified emergency physicians, adequate medical and nursing personnel, and provision of stabilizing treatment by any FSED that presents itself as an ED. The policy statement could be updated to include the minimum standards requested in this resolution. ACEP has resources available on FECs on the web site, including an information paper and the Freestanding Emergency Centers Section newsroom.

ACEP created, in response to Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers, and now endorses the Center for Improvement in Healthcare Quality Free-Standing Emergency Center Accreditation Program. The accreditation survey process includes a review of facility policies and procedures, a tour of the facility and care areas, review of physician credentials and medical records, and observation of care services. This is a voluntary program that facilities can choose to utilize for accreditation.

ACEP's Freestanding Emergency Centers Section has an objective focused on collaborating with ACEP leadership to establish a national set of standards that could be referred to as a unified national resource for legislatures, physicians, and the medical community.

ACEP Strategic Plan Reference

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

- Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

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

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers and the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where allowed by state law.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Instructed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to membership.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. Instructed ACEP to reaffirm the Emergency Care Guidelines and develop definitions of various forms of ambulatory care facilities and emergency care facilities to be included in future Emergency Care Guidelines.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted. Called for ACEP to encourage physicians and health care providers and health care facilities to emphasize in advertising their own positive attributes rather than to denigrate the capabilities of other providers or facilities.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

September 2020, approved revised policy statement "Freestanding Emergency Departments" with the current title; originally approved June 2014.

October 2016, Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper Freestanding Emergency Departments and Urgent Care Centers.

June 2014, approved the policy statement, "Freestanding Emergency Departments."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed in August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free-standing Facilities adopted.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted.

Background Information Prepared by: Jessica Adams, Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(24)

SUBMITTED BY: Elisabeth Giblin, MD
Paul Kivela, MD, FACEP
Bing Pao, MD, FACEP
Thomas Sugarman, MD, FACEP
California Chapter

SUBJECT: Hospital Network Requirements for Emergency Physicians

PURPOSE: ACEP to formally request appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians be in-network as a condition for an emergency professional service contract.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS**,** The American College of Emergency Physicians (ACEP) is committed to ensuring that patients have access to high-quality emergency care; and

WHEREAS**,** Emergency physician practices provide professional services to hospitals through service agreements; and

WHEREAS**,** Hospitals and health systems may require emergency physicians to be in-network with specified health insurers as a condition of a professional service contract; and

WHEREAS**,** Hospitals may receive financial inducements from health insurers to force emergency physicians into accepting in-network contracts with unfavorable terms or below-market rates; and

WHEREAS**,** Following the passage of the No Surprises Act, several health insurers have demanded drastic reductions in long standing contracted emergency physician in network rates; and

WHEREAS**,** These practices reduce the ability of emergency physicians to adequately staff emergency departments with high quality emergency physicians, particularly in underserved areas, and compromise the ability of emergency physicians to provide necessary care; and

WHEREAS**,** There is concern that such contractual practices by health insurers and hospitals may violate antitrust laws and result in monopolistic practices that harm both healthcare providers and patients; therefore be it

RESOLVED, That ACEP formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians to be in-network as a condition for an emergency professional service contract.

Background

This resolution seeks for ACEP to formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians be in-network as a condition for an emergency professional service contract.

Emergency physician service agreements with hospitals that require physicians to contract with insurer networks are

not uncommon. In the past decade, roughly 90% of emergency physician groups have reported insurers deliberately selling policies to patients that cover very little while forcing hospitals to ensure all physicians in their facilities join their network.

The No Surprises Act (NSA) limited out-of-network for physician groups and requiring insurers and physicians to abide by an independent dispute resolution process. While the result of the NSA was largely positive for patients, taking them out of the middle of disputes, physician groups have felt pressure to join insurer networks. Insurer consolidation and narrowing of networks has increasingly forced hospitals to agree to in-network demands by insurers.[1]

Federal and state antitrust agencies play a role in challenging anticompetitive practices of health care providers and other businesses. At the federal level, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) share responsibility for enforcing federal antitrust laws, including the Sherman Act, the Clayton Act, and the FTC Act. State attorneys general (AG) offices also have the authority to bring action under federal antitrust law, as well as under state statutes, which sometimes expand upon federal law.[2]

While hospitals cannot force physicians to be in network with insurers because hospitals and physicians negotiate contracts with insurers independently, there are some exceptions, such as Health Maintenance Organizations (HMOs), which require patients to use physician groups in their network. Physician groups negotiating directly with hospital administration for a contract are at a disadvantage if they do not contract with the major health insurers in the local area. As physician groups find themselves at a disadvantage, hospitals also risk their reputation if physicians accept a lower rate of reimbursement which does not meet the financial needs of the group.

Insurer anticompetitive behavior has made a significant impact on competition and physician groups. There have been very few settlements after a federal investigation. Recently, in a class-action suit, plaintiffs successfully alleged that Blue Cross Blue Shield "violated antitrust laws by entering into an agreement not to compete with each other and to limit competition among themselves in selling health insurance and administrative services for health insurance." The plaintiffs argued that Blue Cross was able to charge higher rates for plans through the practice of limiting competition. Despite these serious charges and the resulting settlement, neither federal antitrust agency has given any indication that it intends to investigate or take any action to deal with the lack of competition and increase in prices.

ACEP supported the bipartisan 2021 Competitive Health Insurance Reform Act (CHIRA), which protects consumers and physicians by repealing a long-outdated antitrust exemption for the health insurance industry. To date, neither the FTC nor the DOJ has announced major steps to exercise their expanded antitrust enforcement authority under the new law. ACEP has called on the agencies to provide information on any enforcement actions, guidelines, rulemaking, or other actions taken to extend antitrust enforcement to the health insurance industry.

In December 2023, ACEP leaders and staff met with Jonathan Kanter, the United States Assistant Attorney General for Antitrust and other key Department of Justice (DOJ) staff to discuss the growing negative impact of insurer consolidation on emergency physicians and the patients seeking care in the ED. In the meeting, ACEP raised concerns about the impact on clinical decision making and physician autonomy that vertical consolidation by insurers who directly employ physicians can bring. Also on the agenda was the rapidly diminishing leverage that emergency physician groups have during contract negotiations as insurance companies are acquiring more and more market share via consolidation. ACEP continues to work with the DOJ on these and other related issues.

Background References

[1] Anticompetitive Conduct by Commercial Health Insurance Companies, American Hospital Association, 2023.
[2] Issue Brief: Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices Of Hospitals and Other Health Care Providers, Kaiser Family Foundation, 2023.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 25(20): Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage. Directed 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.

Resolution 26(13) Repeal of McCarran-Ferguson Act referred to the Board of Directors. Requested that ACEP support the repeal of the McCarran-Ferguson Act of 1945 and ask the American Medical Association via resolution to work legislatively for the repeal of the McCarran-Ferguson Act of 1945. The AMA did not take action to pursue repeal of the McCarran-Ferguson Act.

Prior Board Action

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

October 2013 referred to the Board Council Resolution 26(13): Repeal of McCarran-Ferguson Act which asks ACEP to work with the American Medical Association in pursuit of legislation to repeal the 1945 McCarran-Ferguson Act. The resolution states that repeal would lead to substantial savings to insurance consumers.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 31(24)

SUBMITTED BY: Diversity, Inclusion & Health Equity Section
Social Emergency Medicine Section

SUBJECT: NEMPAC Contributions Transparency and Ethical Standards

PURPOSE: Asks NEMPAC to implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed and ensure easy access and understanding by members; discourage supporting candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion; and encourage the support of policies, candidates, and initiatives that are grounded in evidence-based practices further suggesting that decisions to support will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

FISCAL IMPACT: Budgeted resources for ongoing management and administration of NEMPAC.

WHEREAS, ACEP is committed to transparency, ethical standards, and evidence-based practices in all its endeavors; and

WHEREAS, The National Emergency Medicine Political Action Committee (NEMPAC) plays a pivotal and indispensable role in advocating for policies and candidates that support emergency medicine and the patients we serve; and

WHEEREAS, NEMPAC's contributions must be distributed in a manner that aligns with ACEP's values and commitment to diversity, equity, inclusion, and evidence-based medicine; therefore, be it.

RESOLVED, That ACEP:

1. Create expectations that NEMPAC implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed, ensuring that ACEP members can easily access and understand this information.
2. Discourage NEMPAC to support candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion, thereby maintaining the integrity and inclusiveness of ACEP's mission.
3. Encourage NEMPAC to support policies, candidates, and initiatives that are grounded in evidence-based practices. This will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

Background

This resolution asks the National Emergency Medicine PAC (NEMPAC) to implement measures to provide clear and detailed reports on how NEMPAC contributions are distributed and ensure easy access and understanding by members; discourage supporting candidates who discriminate or promote discrimination based on race, gender, sexual orientation, age, disability, nationality, or religion, thereby maintaining the integrity and inclusiveness of ACEP's mission; and encourage the support of policies, candidates, and initiatives that are grounded in evidence-based practices further suggesting that decisions to support will be achieved through rigorous vetting processes and consultations with medical experts, devaluing non-evidence-based ideologies that could undermine the quality of emergency care.

NEMPAC Organization, Purpose, and Governance:
The ACEP Board of Directors initially approved the National Emergency Medicine Political Action Committee (NEMPAC) Articles of Association on November 5, 1987. The Articles of Association were last approved by the ACEP Board of Directors in January 2023.

The NEMPAC Articles of Association Article IV – Purposes and Powers, Section 1 states:

> "The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office."

Article VIII – Trustees, Section 1 states:

> "Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of the ACEP Immediate Past President, ACEP President-elect, fourteen (14) individuals, and one ACEP Resident."

Article VIII – Trustees, Section 2 states:

> "Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations."

NEMPAC has served a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress since its inception in 1987. NEMPAC raised $1.75 million and contributed $1.6 million to candidates, party committees, leadership PACs, and independent expenditure campaigns during the 2022 election cycle. Approximately 19% of ACEP members donate to NEMPAC.

The NEMPAC Board of Trustees, composed of the ACEP Immediate Past President, ACEP President-Elect, fourteen (14) individual ACEP members, and one Resident Liaison, develops the NEMPAC Contribution Guidelines and budget at the beginning of each two-year election cycle. The 2024 Election Cycle Guidelines are modified throughout the election cycle per majority vote of the NEMPAC Board of Trustees. The Guidelines were last amended on March 7, 2024, are provided as Attachment A. The NEMPAC Board of Trustees meets in person or virtually each month and the minutes of these meetings are available upon request.

The NEMPAC website is updated continually to reflect any changes to the guidelines established by the NEMPAC Board of Trustees. All active ACEP members can access the NEMPAC website. The website also includes a list of all candidates supported in the current election as well as election reports from prior election cycles. Criteria for support is clearly outlined. The 2024 Election Cycle Guidelines follow past NEMPAC practice of focusing on a candidate's support and co-sponsorship of ACEP's key legislative and regulatory initiatives, committee assignments, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. Incumbents and new candidates seeking NEMPAC support that meet criteria in several categories are eligible for more support. Additionally, a list of NEMPAC Champions and Investment candidates are identified by the NEMPAC Board and staff. The Champions receive maximum financial support and additional resources from NEMPAC as determined by the NEMPAC Board. NEMPAC produces an Election Report at the end of each cycle that contains this information. In 2022, the report was included as an insert with the March 2023 issue of ACEPNow.

An internal spreadsheet is maintained by NEMPAC staff and tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislation considered by Congress, campaign activity, election ratings, and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs (FGA) Committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and the ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

The votes and co-sponsorships records of all members of Congress are available to the public on https://www.congress.gov/ and disbursement information from federally registered PACs to federal candidates is available to the public on www.Fec.gov.

The 2024 NEMPAC Contribution Guidelines include the following language:

> "Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. We believe NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.
>
> The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise.
>
> NEMPAC will also continue our commitment to inclusiveness and respect for diversity."

The guidelines also state: "Each legislator and candidate will be looked at individually for their past and current conduct and actions and none of the metrics outlined are meant to be a litmus test."

NEMPAC tracks our federal expenditures by diversification (Attachment B). In the 2024 election cycle, our donation percentage to diverse candidates stands at 47.4 percent. In the 2022 election cycle, NEMPAC's diversity percentage was 45.66 while the make-up of Congress was 43.33 percent.

ACEP Strategic Plan Reference

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

- Identify, test, and adopt new fundraising strategies to support advocacy initiatives.

Fiscal Impact

Budgeted resources for ongoing management and administration of NEMPAC.

Prior Council Action

Resolution 15(19) Increased Transparency in NEMPAC contributions not adopted. Requested the College to support increased NEMPAC transparency by making available online to ACEP members the voting/sponsorship record of key ACEP legislation for federal candidates supported by NEMPAC.

Prior Board Action

January 2024, , approved the amended NEMPAC Articles of Association; amended and approved October 2020 and April 2008; originally approved November 1987.

Background Information Prepared by: Jeanne Slade
Senior Director, Political Affairs and Grassroots Advocacy

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

NEMPAC Contribution Guidelines/Strategic Plan and Budget for 2024 Cycle

(last revised and approved by the NEMPAC BOT on March 7, 2024)

Background

NEMPAC serves a vital role in advancing ACEP's legislative agenda and in broadening emergency medicine's visibility with Congress. In the 2022 election cycle, despite the challenges of emerging from a global pandemic, national political unrest and divisiveness, and economic and professional concerns unique to emergency medicine, NEMPAC raised $1,751,328 and contributed more than $1.6 million to candidates, party committees, leadership PACs, and independent expenditure campaigns.

In the 2024 election cycle, the NEMPAC Board of Trustees adopted the following strategies which are to be continued from the 2022 cycle:

- Identify and assist candidates and incumbents who support ACEP's mission, vision, and values.
- Support candidates in both major political parties who will work to advance ACEP's issues or can influence positions important to the specialty of emergency medicine.
- Identify "Champions" of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits identified below.
- Continue to fund independent expenditure campaigns as warranted with hard dollars.
- Authorize a minimum contribution ($1000) to Senators and Representatives from the states and districts of members of the ACEP Board of Directors and the NEMPAC Board of Trustees. This strategy is designed to enhance the contacts between these two Boards and their Congressional representatives by giving the Board members the opportunity to attend virtual and local events for their Members of Congress.

The following strategies will be continued from the 2022 cycle with stronger emphasis in the 2024 cycle:

- Prioritize checking deliveries and attendance in person by ACEP members ACEP leaders, Chapter leaders, and NEMPAC VIP Donors.
- Prioritize contribution to members of key congressional committees (House Ways and Means, House Energy and Commerce, Senate Finance and Senate HELP) utilizing NEMPAC donations and interactions due to NEMPAC to educate committee members, particularly those new to the committees.

The NEMPAC budget will guide NEMPAC's contributions through the election cycle and will be subject to modification as the election cycle progresses and the congressional agenda takes shape. The budget may be amended to reflect projections of NEMPAC fundraising efforts in 2023 and 2024.

Evaluation Criteria

Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our democratic process and orderly governance. We believe NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.

The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate's behavior arise.

NEMPAC will also continue our commitment to inclusiveness and respect for diversity.

2024 evaluation criteria follow past NEMPAC practice of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignments (with an emphasis as noted above), leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions.

As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support.

Although a candidate may be budgeted a specific amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A notable change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments will enable us to determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

Each legislator and candidate will be looked at individually for their past and current conduct and actions and none of the metrics outlined below are meant to be a litmus test.

2024 Senate Budget Spreadsheet Categories (as of March 1, 2024)

- Committee Assignments and Leadership Positions
  - Finance, HELP, Appropriations Health Subcommittee
- Emergency Department Visit back home, or district meeting with Senator or staff
- Dine-around participant at Leadership and Advocacy Conference in DC
- Senator or staff participated in meeting with ACEP members during the Hill Days at LAC in 2023/2024

Workplace Violence

- Co-sponsor of S.1176, Workplace Violence Prevention for Health Care and Social Service Workers Act (OSHA)
- Co-sponsor of S.2768, Safety from Violence for Healthcare Employees (SAVE) Act

Boarding

- Co-sponsor of S.1346, Improving Mental Health Access from the Emergency Department Act (MH Boarding)

Firearm Safety and Research

- Co-sponsor of S. 494, Background Check Expansion Act

SUD

- Co-sponsor of S.1080, Opioid Reporting - establishes requirements for electronic communication service providers and remote computing service providers to report knowledge of various drug-related offenses to the DEA.

Other

- Co-sponsor of S. 220 to ban non-compete clauses.
- Co-sponsor of S.1653, Prevent Bleeding Act - grants to make available anti-blood loss supplies (e.g., tourniquets, wound-packing materials, and gloves) in high-traffic and other specified areas for use in medical emergencies.
- Co-sponsor of S.1447, Bipartisan Solution to Cyclical Violence Act of 2023
- Co-sponsor S.704, REDI Act – allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs.
- Co-sponsor S. 2364 MAPS Act to provide a mapping system for essential drugs and an FDA essential drugs list (Peters, Lankford, Braun)
- Co-sponsor S. 3765 to reauthorize the Emergency Medical Services for Children (EMSC) program.
- Co-sponsor of S. 3679, the Dr. Lorna Breen Health Care Provider Protection Act Reauthorization
- Co-signed Boozman/Welch Medicare Cuts letter (2/23/2024)
- Support of efforts to fund appropriations requests for trauma programs, EMSC, Dr. Lorna Breen Act, grants for programs to assist with OUD and mental health disorders in the ED, etc.
- Signing on to letters asking for Congress to act on pending Medicare cuts.
- Historical and ongoing support for fair and reasonable implementation of the No Surprises Act, and other legislation impacting physician payment.
- Support of peaceful democracy and election certification.

Overall background/knowledge in health care with emphasis on physician candidates.

2024 House Budget Spreadsheet Categories (as of March 1, 2024)

- Committee Assignments and Leadership Positions
  - Ways and Means, Energy and Commerce, Education and Labor, Appropriations including health subcmt assignments.
- Attended district meeting, Emergency Department Visit or fundraiser with ACEP member back home.
- Met with ACEP members during 2024 LAC Hill Days (not including 2023 because House not in session)
- Dine-around participant at LAC meetings in Washington DC

Workplace Violence

- Co-sponsor of H.R. 2584, Safety from Violence for Healthcare Employees (SAVE) Act
- Co-sponsor of or vote for H.R. 2663, Workplace Violence Prevention for Health Care and Social Service Workers (OSHA)

Boarding

- Co-signed letter asking Administration to convene a boarding summit
- Co-sponsor of and/or vote for H.R. 5414, Improving Mental Health Access from the Emergency Department Act (to assist with mental health patient boarding)
- Co-sponsor of H.R. 2412, Helping Kids Cope Act (Blunt Rochester, Fitzpatrick)
- Co-sponsor of H.R. 5804, The Mental Health Infrastructure Improvement Act (Kilmer, Bacon)

Medicare Payment Reform

- Co-sponsor for H.R. 6683, to prevent across-the-board Medicare spending cuts
- Co-sponsor H.R. 2474, Strengthening Medicare for Patients and Providers Act (MEI update for Medicare physician reimbursements)
- Co-sponsor H.R. 6371, Provider Reimbursement Stability Act (Doc Caucus budget neutrality proposal)
- Co-sponsor H.R. 6545, Physician Fee Schedule Update and Improvements Act (GPCI work floor extension, 1.25% fix for PFS, APM bonus extension, budget neutrality threshold update, etc.)
- Stop Medicare cuts "Dear Colleague" letter signer (12/13/23)
- Bera/Bucshon Stop Medicare Cuts letter signer.

Other Issues

- Co-sponsor of H.R.731 to ban non-compete clauses.
- Co-sponsor H.R. 1694 to provide Medicare payments to freestanding EDs.
- Co-sponsor H.R. 2416, the Mission Zero Act - reauthorize a military and civilian partnership for trauma readiness grant program.
- Co-sponsor H.R. 1202, REDI Act – allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs
- H.R. 5506, HANDS Act to support the distribution of naloxone (Pettersen)
- H.R. 6251, Helping Educators Respond to Overdoses Act (HERO) (Schiff, Ruiz, Kuster, Sanchez, Tokuda, Trone, Watson Coleman)
- H.R. 7251, To amend the Public Health Service Act to reauthorize certain poison control programs (Reps. Chavez-DeRemer, D. Joyce, Davis, and Cherfilus-McCormick)
- H.R. 7153, To reauthorize the Dr. Lorna Breen Health Care Provider Protection Act, and for other purposes (Reps. Wild and Kiggans)
- H.R. 6960, Emergency Medical Services for Children Reauthorization Act of 2024 (Reps. Carter and Castor)
- Cosponsor H.R 6992, MAPS Act to provide a mapping system for essential drugs and an FDA essential drugs list. (Matsui, Bucshon)
- Support of efforts to fund appropriations requests for trauma programs, EMSC, Dr. Lorna Breen Act, grants for programs to assist with OUD and mental health disorders in the ED, etc.
- Historical and ongoing support for fair and reasonable implementation of the No Surprises Act, and other legislation impacting physician payment.
- Support of peaceful democracy and election certification.
- Background/knowledge in health care with emphasis on physician candidates

The Board will maintain flexibility throughout the election cycle in assessing the importance of these issues. All will be considered when determining a candidate's level of support from NEMPAC without assigning a score or weight to each one.

Committee Assignments

As stated earlier, NEMPAC contributions should be directed to those candidates who serve on committees with jurisdiction over healthcare issues. Contribution amounts are based on which committee a Member serves, his or her leadership position on the committee, and whether the Member also serves on the healthcare subcommittee of the committee.

Key committees in the House are:

- Ways and Means
- Energy and Commerce
- Appropriations

Key committees in the Senate are:

- Finance
- Health, Education, Labor, and Pensions (HELP)
- Appropriations

Members of Congress on a key committee are eligible to receive a minimum of $2500 and/or $5000 if on the health subcommittee without Board approval. Additional funds for these members would require Board approval.

Relationship to ACEP

The relationship that a candidate (Member of Congress) has with ACEP leadership, ACEP Advocacy Leaders and 911 members, staff and other ACEP members is another factor to consider when evaluating contribution requests. If a candidate has a good working relationship with someone associated with ACEP, he or she is more likely to take the time to listen to ACEP's position on an issue. Although NEMPAC will direct most contributions to members of Congress who have shown concrete support for ACEP's priorities, a special relationship with ACEP can be a key factor in considering a contribution request.

Co-Sponsorship of ACEP Legislation

Members of Congress who do not serve on a key or secondary committee but who support ACEP's legislative agenda by co-sponsoring key legislation would be eligible for $2,500 - $5,000 during the election cycle. Also, Members of Congress who participate in press conferences, co-sign letters of support for an ACEP legislative priority, or host meetings for ACEP members, etc., would be considered for a NEMPAC contribution on a case-by-case basis in the same contribution range.

Difficulty of Race

As we move through the election cycle, the difficulty of a candidate's race or Members re-election campaign will become a key factor in determining if NEMPAC contributes to or increases the amount budgeted to a candidate. NEMPAC can have a greater impact by making contributions to candidates who face a difficult election.

"Friendly Incumbent" Guidelines

NEMPAC will continue to follow "friendly incumbent" guidelines for contributions used in past election cycles. These guidelines recommend that NEMPAC should not contribute campaign funds to a candidate running against an incumbent determined to be friendly or supportive to ACEP. In situations where physicians, members of ACEP, or other candidates strongly supported by an ACEP state chapter run against a "friendly incumbent," the NEMPAC Board may vote to modify this guideline after careful consideration of factors such as electability, support of ACEP's legislative and regulatory agenda and relationship to ACEP members in the district or state.

In an "open seat" situation, where neither candidate is an incumbent, each candidate will be evaluated to determine if the candidates' positions on important healthcare issues are consistent with ACEP policy.
Responses to the NEMPAC Candidate Questionnaire, input from the state chapters, local ACEP leaders, and 911 Network members will also be considered. All open seat and challenger candidate contributions must be approved by the NEMPAC Board of Trustees or the NEMPAC Executive Committee if time is of the essence.

Endorsement Requests by Candidates

NEMPAC/ACEP does not endorse candidates for office outside of or in addition to our financial contributions to federal campaigns. A NEMPAC contribution or financial expenditure through other means such as a SuperPAC or independent expenditure serves as our means for "supporting" candidates and under no circumstances do we permit the name of our PAC (NEMPAC) or supporting organization (ACEP) to be listed as an "endorsing" organization on a candidate's campaign materials and website.

NEMPAC Candidate Questionnaire

For each election cycle, NEMPAC will develop a candidate questionnaire that highlights ACEP core legislative and regulatory principles and requests information from the candidate about their background and campaign operation. Open

seat and challenger candidates will be strongly urged to complete and return the survey for consideration of NEMPAC support. Exceptions may be permitted if time constraints are present if the NEMPAC Board of Trustees or Executive Committee are made aware of the circumstances, and they are documented, as to why the survey was not completed prior to making and/or approving a donation.

Contributing to Two Candidates Running for the Same Congressional or Senate Seat

NEMPAC will maintain the practice of supporting only one candidate in a race. In instances where the candidate supported by NEMPAC loses a primary election, the NEMPAC Board may consider supporting another candidate in the general election since the original candidate supported would be out of the race.
In rare circumstances and after careful consideration by the NEMPAC Board of Trustees, there may be flexibility in this practice so that an exception could be made for NEMPAC to donate to two different candidates running for the same office.

Independent Expenditures

NEMPAC will continue to consider independent expenditures as an option for support of candidates in key races if funds are available for this allocation. Independent expenditure can be made for communications expressly advocating the election or defeat of a candidate that are not made in cooperation or consultation with or at the request or suggestion of, a candidate's campaign or representatives. These expenditures allow NEMPAC to go beyond the limits of $5,000 per primary and $5,000 per general to individual candidates' campaigns and can provide significant and much appreciated campaign support to candidates while enhancing ACEP's and NEMPAC's political influence.

National Party Committees

Prior to 2015, the maximum allowable annual donation from a PAC to a party committee was $15,000. NEMPAC consistently donated $15,000 to the NRSC, NRCC, DSCC and DCCC over the years to maintain parity and bipartisanship in our giving strategy.
In 2015, three new types of political funds for national party committees went into effect.

- A **party convention fund** for the Republican National Committee and Democratic National Committee that may accept up to $45,000 per year from a multicandidate PAC.
- A **building fund** that may accept up to $45,000 per year from a multicandidate PAC. The RNC, NRSC, NRCC, DNC, DSCC and DCCC are eligible to accept these funds.
- A **recount & legal proceedings fund** that may accept up to $45,000 per year from a multicandidate PAC. The above committees are also eligible for these types of funds.

Contributing to these Committees allows ACEP leadership (i.e., Board members, FGA Committee members, etc.) and staff to participate in special briefings, roundtables and out of town events throughout the year held specifically for donors to the campaign committees. These events allow for greater access to Congressional leaders and will help establish ACEP as an important player on the political scene, and the travel expenses for ACEP members and staff participating in these and other candidate-related activities can be reimbursed by NEMPAC's administrative fund or hard dollars if needed.

Going forward in the 2024 cycle, it is recommended that NEMPAC continue to make a minimum $15,000 annual contribution to each of these four committees. Because the amount allowable from PACs to these committees has dramatically increased, the possibility of exceeding the status quo should be considered by the NEMPAC Board on a case-by-case basis. The contribution amount should be maintained consistent over all four committees with no preference to any of the four.

This committee also allow PACs to "tally" their contributions to specific members of congress which is another way to increase support to NEMPAC champions. The decisions to tally will be made on a case-by-case basis by ACEP staff in consultation with the NEMPAC Board of Trustees.

Leadership PACs

Leadership PACs (LPACs) are separate funds established by Members of Congress that have separate and distinct limits from their campaign committees. Leadership PACs can accept up to $5,000 per year from other PACs. Legislators often use their leadership PACs to support the campaigns of other federal candidates who may not have the ability to raise

significant or adequate funds on their own. When considering a contribution to a Member's leadership PAC, NEMPAC will observe the same criteria as for contributions to that member's campaign committee.

NEMPAC will budget $5,000 annually to the leadership PACs of NEMPAC "Champions" and consider other requests on an ad hoc basis, prioritizing the LPACs of members on key committees. Leadership PAC contributions should be looked at carefully and not be given if there is the potential to reduce the amount available for other approved candidate's re-election campaigns. Priority should be given to re-election committees contributions first since NEMPAC cannot control where/how a contribution to a Leadership PAC is used and may not agree with or be aware of other members of congress that the LPAC is supporting.

Post Election/Debt Retirement

Some Members of Congress request contributions following a general election to help retire debts from the previous campaign. Debt retirement can offer ACEP the opportunity to establish relationships with Members of Congress that NEMPAC did not contribute to in the general election, to forge relationships with newly elected Members of Congress, and to maintain strong relationships with Members of Congress who have been supportive of ACEP's legislative agenda.

NEMPAC will continue its policy of contributing to Members' debt retirement account on a case-by-case basis. These contributions will be considered only to victorious candidates, will not count towards a Member's total NEMPAC eligibility for the upcoming election cycle, and will not exceed the contribution level the candidate was eligible for under NEMPAC criteria in the just completed election cycle.

NEMPAC also reserves the right to request a refund of a contribution made to a candidate in good faith, if immediately or soon after requesting and receiving support from NEMPAC, the candidate decides to retire or leave congress for other reasons.

NEMPAC "Champions"

The NEMPAC Board with the consultation of ACEP staff will develop a list of "NEMPAC Champions" not to exceed a total of 20 incumbent Senators or Representatives and candidates. These champions would be eligible to receive the following financial support and other benefits from NEMPAC if available:

- Maximum donation to primary and general election campaign ($5K to each)
- Maximum donation to leadership PAC if applicable ($5K)
- Campaign highlighted in NEMPAC newsletter during the cycle with link to campaign website.
- Campaign highlighted on NEMPAC website.
- NEMPAC would host or co-host a MADPAC event for the Member during the election cycle.
- NEMPAC staff or ACEP members would attend one out of town event for the Member per cycle.
- NEMPAC staff would serve on the Member's fundraising steering committee.
- NEMPAC would "tally" part of our party committee donation to that member.
- NEMPAC would conduct a dine-around event for the members during LAC or invite to participate in a Virtual Happy Hour.
- NEMPAC would fund or co-fund an independent expenditure for the members.
- NEMPAC would contribute to a "SuperPAC" formed to positively support the member or candidate.

Delivery of NEMPAC Contributions

When delivering contributions, we will give priority to participating in smaller healthcare-specific meetings and fundraisers. The smaller events allow the candidates to focus solely on healthcare issues and to hear ACEP's concerns and priorities in the current Congress.

Funds will also be set aside for "dine-around" at future Leadership and Advocacy Conferences and virtual happy hour events for targeted members.

In the 2024 cycle as most legislators and candidates have fully returned to in-person events, NEMPAC will place emphasis on events and meetings back home in the state and district where ACEP members can deliver a NEMPAC check personally to their Member of Congress. NEMPAC will attempt to target contributions to Members of Congress who

represent the states and congressional districts of ACEP Board of Directors members and members of the NEMPAC Board of Trustees. This strategy will enhance the contacts between these ACEP leaders and their federal legislators.

The NEMPAC Board, ACEP Board and Council will be provided with regular updates of check deliveries and fundraisers attended by ACEP members.

NEMPAC Board and ACEP Board Involvement

To show ACEP members the strength of support for NEMPAC and its activities by the leadership of ACEP, all members of both the ACEP Board of Directors and the NEMPAC Board of Directors should make significant contributions to NEMPAC each year.

Members of both Boards will be encouraged to "Give-a-Shift" ($1,200) each year to NEMPAC and maintain this giving level throughout their tenures. They will also be encouraged to attend and contribute to NEMPAC dine-around events at LAC annually.

Members of both Boards will be encouraged to attend at least one fundraiser or other event for their Representative and Senators in the next two years to enhance contacts between these ACEP leaders and their Members of Congress. NEMPAC will contribute to the federal representatives of Board members to allow those Board members to attend the event. A minimum amount will be contributed to each Board member' Representative and Senators, even if that Representative or Senator is not a strong supporter of ACEP's legislative priorities. This minimum contribution is simply designed to foster improved contacts between Board members and their Members of Congress.

Attachment B

Federal Expenditure Diversification Breakdown
All PACs

Election Year	Net Contribution Amount*	Funds Given to Diverse** Candidates	% of Funds Given to Diverse Candidates	% of Diversity in Congress
2014	$1,618,582	$406,000	25.08%	31.10%
2015	$2,500		0.00%	
2016	$1,506,900	$397,500	26.38%	32.00%
2017	$1,000		0.00%	
2018	$1,652,187	$472,188	28.58%	34.90%
2019	$3,000	$1,000	33.33%	
2020	$1,227,000	$513,500	41.85%	38.80%
2021	$4,500	$4,500	100.00%	
2022	$1,187,891	$542,391	45.66%	43.30%
2024	$1,157,000	$548,500	47.41%	
2026	$5,500	$2,500	45.45%	
2028	$2,500		0.00%	

*Federal candidates/leadership PACS only

**Diverse candidates are defined as women and non-white/Caucasian

Election Year	Net Contribution Amount*	Male	Female	% of Women in Congress
2014	$1,618,582	86.72%	13.28%	19.00%
2015	$2,500	100.00%	0.00%	
2016	$1,506,900	85.04%	14.96%	20.00%
2017	$1,000	100.00%	0.00%	
2018	$1,652,187	81.35%	18.53%	21.30%
2019	$3,000	100.00%	0.00%	
2020	$1,227,000	75.14%	24.74%	24.20%
2021	$4,500	44.44%	55.56%	
2022	$1,187,891	68.22%	31.78%	27.50%
2024	$1,157,000	67.42%	32.58%	
2026	$5,500	100.00%	0.00%	
2028	$2,500	100.00%	0.00%	

*Federal candidates/leadership PACS only

Election Year	% Given to Asian / Pacific American	% Given to Black / African American	% Given to Hawaiian / Pac. Islander	% Given to Hispanic / Latino	% Given to Indian / Native American	% Given to Other	% Given to Two or More Ethnicities	Total % Given to Minorities	% Given to White / Caucasian	% of Minorities in Congress
2014	1.05%	1.33%	0.00%	6.83%	0.31%	4.82%	0.00%	14.33%	85.67%	17.90%
2015	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	
2016	0.83%	1.56%	0.00%	6.27%	0.23%	4.05%	0.33%	13.27%	86.73%	18.90%
2017	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	
2018	1.82%	1.57%	0.00%	4.75%	0.67%	3.42%	0.48%	12.71%	87.29%	21.80%
2019	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	0.00%	33.33%	66.67%	
2020	1.59%	4.93%	0.00%	5.91%	0.73%	9.70%	1.34%	24.21%	75.79%	24.20%
2021	0.00%	44.44%	0.00%	0.00%	0.00%	0.00%	0.00%	44.44%	55.56%	
2022	1.85%	3.03%	0.00%	6.52%	1.14%	8.75%	0.84%	22.13%	77.87%	25.90%
2024	1.90%	5.66%	0.00%	5.79%	0.13%	8.99%	1.08%	23.55%	76.45%	
2026	0.00%	0.00%	0.00%	0.00%	45.45%	0.00%	0.00%	45.45%	54.55%	
2028	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 32(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Preventing Harmful Health Care Deals

PURPOSE: Advocate for legislation to require health systems to notify regulatory agencies prior to entering into an agreement or transaction that reduces competition or increases costs for health care consumers to help maintain competitive markets.

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

WHEREAS, The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have shown increased interest in scrutinizing private equity firms' acquisitions in the health care sector due to concerns about the negative impact on competition and the value of health systems[1,2]; and

WHEREAS, Transactions such as sale-leaseback agreements, purchases or sales of health system facilities or real estate, dividend recapitalization, private practice roll-ups, and changes in majority owner equity stakes have been identified as contributing factors to these concerns; and

WHEREAS, Many of these harmful health care deals drain value from health systems and often portend hospital closures and a loss of health care access to communities; and

WHEREAS, Pennsylvania Senate Bill 548, introduced by Senator Tim Kearney (D-Delaware County), is model legislation that aims to address these issues by requiring health systems to file notice and documentation to the Office of the Attorney General before completing critical transactions[3]; and

WHEREAS, Similar legislative measures have been considered or implemented in other states to ensure transparency and oversight of such transactions, including but not limited to Massachusetts, New York, and California[4]; and

WHEREAS, It is essential for the ACEP to advocate for its members by supporting national legislation that aligns with the objectives of Pennsylvania Senate Bill 548; therefore be it

RESOLVED, That ACEP advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions, to protect the integrity of health systems and maintain competitive markets.

References

1. FTC News Release https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government
2. DOJ Polsinelli Publication https://www.polsinelli.com/publications/ftc-and-doj-signal-greatly-increased-scrutiny-of-private-equity-firms-acquisitions-in-health-care
3. Pennsylvania Senate Bill 548, introduced by Sen. Tim Kearney (D-Delaware). https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2023&sInd=0&body=S&type=B&bn=0548
4. Massachusetts legislation: https://malegislature.gov/PressRoom/Detail?pressReleaseId=84

Background

This resolution asks ACEP to advocate for legislation to require health systems to file notice with regulatory agencies

prior to entering into an agreement or transaction that reduces competition or increases costs for health care consumers to help protect the integrity of health systems and maintain competitive markets.

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have shown increased interest in scrutinizing private equity firms' acquisitions in the health care sector due to concerns about the negative impact on competition and the value of health systems. The agencies jointly launched a cross-government public inquiry into private-equity and other corporations' increasing control over health care in March 2024. The agencies wish to understand how specific transactions may increase consolidation and generate profits for firms and pose potential risks to quality of care and affordable health care for patients and taxpayers. Officials at Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services share these concerns.

There is increased interest in these purchases at the state level, as well. New York state passed a law in August 2023 requiring health care entities involved in material transaction(s) to provide written notice to the state Department of Health a minimum of 30 days prior to the closing of the transaction. Material transactions include mergers, acquisitions, affiliation agreements, and partnerships that increase a healthcare entity's total gross in-state revenues by $25 million.

In Pennsylvania, Senator Tim Kearney (D-Delaware County) introduced Senate Bill 548 that would allow for intervention in large financial transaction involving health systems that could pose a threat to public. The bill would require for-profit health systems to file notice and documentation with the Office of the Attorney General before completing transactions such as, sale-leaseback agreements, purchase or sale of health system facilities or real estate, private practice roll-ups, and changes in majority owner equity stakes. The Office of the Attorney General could then challenge those transactions that threaten patient access to care for violating the defined public interest.

The Massachusetts House of Representatives recently passed legislation intended to increase accountability across the healthcare industry and curb healthcare spending to ensure patient access to quality, affordable healthcare. The Bill empowers the Massachusetts Health Policy Commission to scrutinize transactions for anti-competitive effects, such as equity investments that would result in a change of hospital or practice ownership, conversion of a hospital to a for-profit entity, and significant transfer of a hospital's assets.

ACEP carefully monitors how increased acquisitions of emergency medicine practices have affected emergency physicians and the patients they serve. There have been numerous assessments conducted across the house of medicine to determine the effect consolidation on both health care costs and quality of patient care. In 2022, ACEP utilized the opportunity of the FTC and DOJ's request for information to ask members a series of structured and open-ended questions about their experiences with mergers and acquisitions in emergency medicine. Responses indicated that consolidation in EM detrimentally affects physicians' interests and well-being, and therefore, might impact their ability to serve their patients. ACEP shared our findings with the FTC and DOJ and called upon the agencies to address potentially anti-competitive labor-related effects of mergers and acquisitions.

Based upon feedback from ACEP and other stakeholders, the FTC and DOJ issued Draft Merger Guidelines in July 2023. The Draft Guidelines included thirteen principles that the agencies determine whether a merger is unlawfully anticompetitive under antitrust laws. ACEP sent a formal letter commenting on the proposed updates to guidelines used to assess health care mergers. ACEP supported the proposal to more closely examine the labor impacts of health care mergers as well as lowered thresholds for identifying potentially monopolistic market share. In December, ACEP leaders met with Jonathan Kanter, the U.S. Assistant Attorney General for Antitrust, and other key Department of Justice staff to discuss the growing negative impact of insurer consolidation on emergency physicians and the patients they care for.

ACEP remains committed to our overall goal of supporting emergency physicians and ensuring that they are treated fairly by their employer and practice in an environment where they can serve their patients to the best of their abilities. This resolution asks for investment of ACEP resources in advocating for national legislation that requires health systems to provide regulatory agencies with notice before completing acquisition or merger transactions to preserve health systems and competitive markets. There is not a specific ask related to emergency medicine.

ACEP Strategic Plan Reference

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

Fiscal Impact

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

Prior Council Action

Resolution 23(23) Opposing Sale-Leaseback Transactions by Health Systems referred to the Board of Directors. The resolution asked ACEP to advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

Amended Resolution 56(22) Policy Statement on the Corporate Practice of Medicine. "ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine." The resolution directed ACEP to work with relevant experts to develop a policy statement opposing the corporate practice of medicine.

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; 2) adopt as policy: "ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services."; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted. The resolution called for ACEP to study and report annually the market penetration of non-physician ownership of emergency medicine groups and the effects that these groups have on physicians and ACEP advocacy efforts. It further directed the College to advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcies, or other adverse events of their employer/management company. Additionally, ACEP was directed to partner with other medical societies to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur.

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.

Prior Board Action

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

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

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

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

Background Information Prepared by: Jessica Adams
Reimbursement Director

Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 33(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Promotion of Nursing in Emergency Medicine

PURPOSE: Collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with ACEP's beliefs and policies, to maintain a safe standard of care for patients.

FISCAL IMPACT: Budgeted staff resources for some components of advocacy work. Studying models to alleviate the nursing shortage is not a current initiative of the College, is unbudgeted, and would require diverting current budgeted staff resources from other advocacy work to support this effort.

WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and Resource Guidelines" states that "Appropriately educated and qualified emergency physicians, NPs, PAs, registered nurses and ancillary staff should staff the ED during all hours of operation"[1]" and

WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and Resource Guidelines" states that, "Each nurse working in the ED should: Provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark. Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice"[1]; and

WHEREAS, The April 2022 ACEP-approved policy statement "Emergency Department Nurse Staffing" states that "The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of emergency nursing"[2]; and

WHEREAS, The January 2024 ACEP-approved policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine" states that "The American College of Emergency Physicians supports the efforts of the Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN) regarding defining standards of emergency nursing care and the provision of resources, support, and incentives for emergency nurses to be able to readily attain Certified Emergency Nurses (CEN) certification"[3]; and

WHEREAS, The Nursing Community Coalition provided testimony to both the U.S. House and U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) & National Institutes of Health (NIH), requesting support for, "at least $530 million for the Nursing Workforce Development programs (authorized under Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] and administered by HRSA)"[4,5]; and

WHEREAS, Emergency departments have always served as the "safety net" of the health care system; and

WHEREAS, The ED nursing shortage is not a new phenomenon and it has affected care delivery in emergency departments for most of the 21st century and the COVID-19 pandemic, however, has dramatically increased nursing turnover rates[6]; and

WHEREAS, The exodus of health care staff continues despite the resolution of the COVID-19 pandemic and multiple studies have demonstrated an increased prevalence of anxiety, depression, and insomnia during the pandemic,

and nursing burnout can be traced to "occupational psychological trauma;" and

WHEREAS, Many nurses report the emergence of new sleep disturbances and decreased quality of life; and

WHEREAS, Psychological trauma combined with the current pressures of working through the pandemic have contributed significantly to workforce shortages as nurses leave the emergency department and/or field altogether and in addition, a large cohort of aging "baby boomer" nurses are now retiring, thus adding to the problem[6]; therefore be it

RESOLVED, That ACEP collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with our organization's beliefs and policies, to maintain a safe standard of care for our patients.

References

1. https://www.acep.org/siteassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-department-nurse-staffing/
3. https://www.acep.org/siteassets/new-pdfs/policy-statements/advocating-for-certified-emergency-nurses-cens-in-departments-of-emergency-medicine.pdf
4. https://www.ena.org/docs/default-source/government-relations/federal-news/2-fy2025-senate-appropriations-committee-coalition-testimony.pdf?sfvrsn=b553ee5c_1
5. https://www.ena.org/docs/default-source/government-relations/federal-news/3-fy-2025-house-appropriations-committee-coalition-testimony.pdf?sfvrsn=d670e59_1
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10116161/..

Background

This resolution calls for the College to collaborate with relevant organizations and stakeholders to look at models, such as incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with ACEP's beliefs and policies, to maintain a safe standard of care for patients. Essentially, the resolution asks for ACEP to develop a plan for identifying appropriate emergency department staffing levels for nursing and support personnel and to identify alternative staffing patterns for a variety of emergency departments.

Emergency departments (EDs) are facing challenges related to staffing, which impacts the quality of care provided to patients. The health care workforce, particularly in emergency medicine, continues to experience high levels of burnout, workplace violence, mental health challenges, and emergency department boarding. According to a 2020 survey by the American Nurses Association (ANA), almost two-thirds of nurses (62%) experience burnout, with this rate being even higher (69%) among nurses under 25. Burnout is driven by several factors, including the inherent demands of nursing, such as providing compassionate care, working long hours, changing shift schedules, and the physical strain of being on one's feet for extended periods. Systemic challenges, such as the increasing demand for nursing professionals due to an aging population and the COVID-19 pandemic, have exacerbated these issues. The pandemic also added emotional stress, with nurses often providing moral and emotional support for patients dying without their families and dealing with public skepticism about the pandemic's severity. A study published in the *Journal of Nursing Management* found that burnout and turnover rates among emergency nurses are alarmingly high, driven by factors such as workload, emotional demands, and workplace violence. In May 2022, the Center for American Progress published a report on the nursing shortage, recommending policy efforts to enhance recruitment and retention, improve workplace conditions, and collect data on staffing levels, nurse interventions, and patient outcomes. A Government Accountability Office (GAO) report highlighted emerging nurse shortages and the need for better data to describe nurse workforce availability. The American Hospital Association (AHA) has published reports addressing strategies for increasing recruitment, retention, and development of hospital caregivers. These reports include fostering educational opportunities, broadening the applicant pool, and reviewing compensation strategies.

ACEP submitted a statement for the record for an Energy and Commerce Health Subcommittee hearing in May 2023 on the health care workforce where ACEP noted the importance of addressing the ongoing nursing shortage. ACEP partnered with EMRA in 2022 to submit a statement for the record for a Senate HELP Committee hearing on workforce shortages. The statement highlighted how ongoing workforce shortages affect emergency care, reiterating the importance of maintaining the physician-led, team-based emergency care model, while also raising the persistent

issues of providing emergency care in rural and underserved areas, nurse staffing firm practices during the COVID-19 pandemic, and how these workforce shortages contribute to ED boarding.

Regarding the issue of mental health, depression, and burnout in emergency medicine, nursing, and other health care professions, ACEP developed and led the efforts to enact the Dr. Lorna Breen Health Care Provider Protection Act that was signed into law on March 18, 2022. This landmark first-of-its-kind law includes provisions that have supported increased access to mental health services and supports for health care workers, research into the mental health challenges faced by health care workers, and initiatives to reduce stigma and encourage health care workers to seek mental health support, among other things. ACEP is currently working to reauthorize this critical law through fiscal year 2029 and secure continued federal appropriations to fully fund its programs. ACEP also continues to partner with the Emergency Nurses Association (ENA) and ANA on legislation to address and reduce workplace violence as part of the effort to help reduce burnout, in addition to both psychological and physical harm.

ACEP's September 2023 Summit on ED Boarding, among numerous factors, identified inadequate nurse staffing ratios as a contributing factor to boarding and overcrowding. A range of strategies, including data collection, surveys, legislative and regulatory advocacy have been initiated to address these issues. In February 2022, ACEP submitted a response to a request for information (RFI) to the US Department of Health and Human Services on preparedness and response that highlighted efforts to reduce nursing burnout such as regulatory waivers and flexibility around documentation requirements. Several states, including CT, IL, NV, NY, OH, OR, TX, WA, and MN, participate in Hospital-Based Staffing Committees, where a team of hospital stakeholders collaborates to review staffing challenges. CA and MA are the two states that have a limit for nurses to one patient in the intensive care unit. ACEP does not support mandated staffing ratios out of concern that these policies would not allow flexibility during mass trauma or other common occurrences in busy suburban and urban EDs. If hospitals lack enough nurses to comply with a mandated ratio in an inpatient unit, they may keep additional patients in the ED to comply with the law, contributing to ED crowding. ACEP supports hospitals staffing more nurses on inpatient units to alleviate ED boarding but has strong concerns that mandated staffing ratios could worsen the situation.

An ACEP article published in *Annals of Emergency Medicine* in December 2023 studied the deteriorating conditions at Ascension Via Christi St. Francis Hospital in Wichita where staffing shortages and cost-cutting measures have led to high nurse-to-patient ratios and long wait times. This situation prompted 66% of the staff to unionize with the National Nurses United (NNU). The article references a University of Pennsylvania survey that attributes high nurse turnover rates to poor working conditions rather than a shortage of nurses. The study noted that financially-driven understaffing, especially in emergency departments, has worsened the crisis.

The American Nurses Association (ANA) has also been involved in legislative initiatives to address nurse shortages, including funding for nursing education and restricting mandatory overtime. The Emergency Nurses Association (ENA) has developed position statements on staffing and productivity in emergency care settings. Americans for Nursing Shortage Relief (ANSR) Alliance, comprising 29 nursing organizations, advocates for increased funding for nursing education and comprehensive initiatives to address nurse shortages. Nurses for a Healthier Tomorrow (NHT), a coalition of 43 nursing and health care organizations, initiated a national campaign to attract people to the nursing profession.

ACEP worked with leaders of ENA during the pandemic (2022) to identify traditional nursing tasks that could be performed by other health care professionals. In these discussions, our nursing colleagues identified the nursing assessment as the primary task that required an individual with nursing training and experience. Many other tasks could be completed by alternative staff including preclinical medical students, nursing students, LPNs, paramedics, pharmacists and even specially trained volunteers. It was suggested that locally a team of nurses, physicians, and others in health care should meet to identify the appropriate tasks and available staff as these vary by location. It was also suggested to initiate team nursing and additional training sessions, especially for less experienced nurses. Nursing documentation is time consuming, just as it is with physicians, and the use of scribes, dictation, and perhaps AI in the near future, should be extended to nurses as well. Finally, they identified that care of boarders as their major pain point and suggested the use of floor nurses or LPNs for the care of these patients when possible.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted staff resources for some components of advocacy work. Studying models to alleviate the nursing shortage is not a current initiative of the College, is unbudgeted, and would require diverting current budgeted staff resources from other advocacy work to support this effort.

Prior Council Action

Resolution 17(01) Staffing Levels not adopted. It directed ACEP to identify appropriate staffing levels in the ED.

Amended Resolution 38(00) Professional Staffing adopted. It called for ACEP to investigate optimal staffing models for emergency department professional nurses with appropriate entities such as the Emergency Nurses Association, American Hospital Association, and the American Nurses Association, develop specific recommendations to address the manpower needs that exist and that are anticipated in the future to ensure continued access to quality emergency care, and submit a resolution to the AMA House of Delegates to investigate hospital wide staffing shortages.

Prior Board Action

January 2024, reaffirmed the policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine;" reaffirmed February 2018 and April 2012; originally approved October 2006.

April 2022, approved the revised policy statement "Emergency Department Nurse Staffing;" revised and approved October 2005; reaffirmed September 2005; originally approved June 1999.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

Amended Resolution 38(00) Professional Staffing adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 34(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Reimbursement for Emergency Physician Services Provided Out-of-Hospital

PURPOSE: Collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Emergency Medical Services (EMS) is the largest and a rapidly growing board certified sub-specialty of emergency medicine; and

WHEREAS, EMS Physicians have a specialized skill set that can improve patient outcomes in the out-of-hospital environment, both in the emergent and non-emergent settings; and

WHEREAS, EMS Physicians currently are unable to bill for clinical services provided in the out-of-hospital environment, limiting the expansion of the specialty; therefore be it

RESOLVED, That ACEP collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

Resolution References

1. Medical Claims processing manual: Chapter 15 Ambulance https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c15.pdf

Background

This resolution directs ACEP to collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

Emergency medicine and EMS have grown immensely in the past 50 years; however, EMS medicine only recently became a subspecialty of emergency medicine in 2010 (2006 by the AOA).[1] EMS fellowships were established to give emergency physicians the knowledge and experience to provide, oversee, and improve prehospital care. These programs have evolved to include 80 fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME). Many physicians interested in EMS complete a fellowship to gain experience and engage in their field of interest. Historically, EMS fellowships have varied widely in terms of the experiences for individual fellows. However, with the arrival of subspecialty certification and ACGME accreditation, there is now a standard core curriculum for EMS fellowships. As of today, the subspecialty of EMS is over 800 strong and is the largest subspecialty under the American Board of Emergency Medicine umbrella.

Funding for EMS physician reimbursement pathways has largely depended on local, state, federal, and private positions. Many states and larger EMS systems have dedicated full-time medical directors. Tactical teams and local law enforcement, large event organizations, sporting arenas, and international medical groups may employ the services of an EMS medical director or physician.

Currently, CPT code 99288, Under Other Emergency Services, is described as giving medical direction for a patient's care via a two-way radio with EMS personnel in the field, or during transport to or from the emergency department. Medical direction includes trauma patients or patients who require advanced life support. While limited use of other

CPT codes is possible for EMS directors, additional reimbursement mechanisms should be identified.

The CMS Innovation Center announced in 2019 the Emergency Triage, Treat, and Transport (ET3) voluntary, five-year payment model intended to increase flexibility for ambulance care teams addressing emergency health care needs of Medicare patients after a 911 call. Under the model, Medicare paid Medicare-enrolled ambulance suppliers and hospital-owned ambulance providers to transport patients to Alternative Destination Partners, such as a primary care doctor's office or an urgent care clinic, providing additional options to the hospital ED or other destinations traditionally covered by Medicare. The ET3 Model ended two years early on December 31, 2023, due to low participation.

CMS created new codes in the 2024 Medicare Physician Fee Schedule Final Rule to identify and value the work involved in helping Medicare patients with serious, high-risk illnesses navigate their care (pages 121-123). This includes helping patients understand and implement their specific plan of care and contacting the necessary providers for follow-up care.

- G0023: Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:
  - Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home- and community-based care communication
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
    - Communicating with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable
    - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
    - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals

        - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- G0024: Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)
- G0140: Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
    - Person-centered interview, performed to better understand the individual context of the serious, high-risk condition
        - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that aren't billed separately)
        - Facilitating patient-driven goal setting and establishing an action plan
        - Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan
    - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
    - Practitioner, home, and community-based care communication
        - Assisting the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors
        - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
    - Health education
        - Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
        - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
        - Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals
        - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals
        - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- G0146: Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

HCPCS codes G0023, G0024, G0140, and G0146 identify services furnished after an initiating E/M visit to provide navigation of a high-risk illness or condition, such as cancer, COPD, congestive heart failure, dementia, HIV/AIDS, etc. These services may be provided by auxiliary personnel, such as patient navigators, under the general supervision of a physician. However, CMS specifies that certain types of E/M visits, including, ED visits, do not serve as initiating visits, "because the practitioner providing the E/M visit wouldn't typically provide continuing care to the patient, including providing necessary PIN services in subsequent months."

ACEP's policy statement "The Role of the Physician Medical Director in Emergency Medical Services Leadership" states: "EMS systems have ethical responsibilities to provide EMS physician medical directors with the tangible resources and remuneration commensurate with the responsibilities and authorities fulfilled by EMS physician medical directors."

ACEP's policy statement "Salary and Benefits Considerations for Emergency Medical Services Professionals" states: "Given the important responsibilities and roles fulfilled by EMS professionals, these healthcare providers should be fairly compensated with salary and benefits commensurate with such responsibilities and roles…"

Background Reference

[1]A Brief History of Emergency Medical Services in the United States, EMRA 2023.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 30(23) Advocating for Increased Funding for EMS not adopted. The resolution called for ACEP to advocate for: 1) increased funding for EMS services to address inadequacies in reimbursement rates; 2) increased funding for EMS services; 3) a premium rate for EMS reimbursement in rural areas; 4) EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the consumer price index (CPI); 5) reimbursement of EMS based on the value of the care provided; and 6) reimbursement models that allow for "treatment-in-place" health care delivery

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

Resolution 35(20): Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care adopted. Directed 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.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed the College to champion the principle that emergency care is an essential public service and make it a key concept in advocacy efforts on behalf of America's emergency medical services safety net.

Prior Board Action

June 2023, approved the revised policy statement "The Role of the Physician Medical Director in Emergency Medical Services Leadership;" originally approved October 2017, 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); Professional Liability Insurance for EMS Medical Control Activities (1985-2017).

Amended Resolution 36(22) Emergency Medical Services Are Essential Services adopted.

Resolution 35(20) Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care adopted.

April 2019, approved the policy statement "Salary and Benefits Considerations for Emergency Medical Services Professionals."

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems."

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

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

Jessica Adams
Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 35(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians
New York Chapter

SUBJECT: Sharing of Protected Health Information

PURPOSE: Provide guidance to members on legally and operationally sound practices for sharing of protected health information and encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of sharing protected health information with emergency physicians actively engaged in patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency departments operate 24/7 but medical records offices typically do not; and

WHEREAS, Emergency physicians frequently care for patients who have also received care at other emergency departments, hospitals, urgent care centers, and medical offices; and

WHEREAS, Formal mechanisms for securely sending/receiving written medical records are often incompatible with the exigent needs of emergency physicians seeking protected health information (PHI) for real-time medical decision making; and

WHEREAS, The HIPAA establishes PHI stewardship responsibilities which may be incompletely understood by emergency department and hospital clinicians and staff; therefore be it

RESOLVED, That ACEP provide guidance to members on legally and operationally sound practices for sharing of protected health information; and be it further

RESOLVED, That ACEP encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of accessing and/or sharing protected health information with emergency physicians actively engaged in patient care.

Background

This resolution calls for the College to provide guidance to members on legally and operationally sound practices for sharing of protected health information and to encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of sharing protected health information with emergency physicians actively engaged in patient care.

The resolution notes the challenges of sharing patients' protected health information (PHI), including that existing formal mechanisms for securely sending or receiving written medical records are incompatible with the exigent needs of emergency physicians seeking PHI for real-time medical decision making, in addition to a lack of clarity or incomplete understanding of legally established PHI stewardship responsibilities under the Health Insurance Portability and Accountability Act (HIPAA).

The issues related to the dramatic expansion and increased utilization of electronic health records (EHRs) and ensuing complexities of safeguarding PHI have been and remain a top priority for the College. While intended to streamline patient records and improve patient care and outcomes, the burdens associated with EHRs have significantly increased the amount of time health care providers spend on administrative tasks, which contributes to growing frustration and

job dissatisfaction for emergency physicians. And in addition to federal laws and regulations governing PHI and patient privacy, health care providers and facilities may also be subject to additional requirements imposed by various state laws, and health care facilities or systems may establish stricter policies themselves.

Broadly, one of the primary challenges in the effort to standardize any processes or develop best practices in the health information technology (HIT) ecosystem is that there are several commercial vendors of EHR solutions, all of which provide products that are configurable and customizable for the particular use cases and needs of each individual customer and can range from individual small practices to large national health systems, and even parts of the federal government (e.g., the U.S. Department of Defense or Department of Veterans Affairs). Protocols and guidelines may vary by department even within a single hospital, adding to the already substantial complexity. As noted in a 2012 Institute of Medicine report, "Health IT and Patient Safety: Building Safer Systems for Better Care," HIT "…is not a single product; it encompasses a technical system of computers and software that operates in the context of a larger sociotechnical system – a collection of hardware and software working in concert within an organization that includes people, processes, and technology."

Existing ACEP policy addresses the concepts of high-quality emergency department medical records ("Patient Medical Records in the Emergency Department") and the responsibility of physicians to protect the confidentiality of their patients' personal health information ("Confidentiality of Patient Information"). As an adjunct to the latter policy statement, ACEP developed a two-part Policy Resource Education Papers (PREPs): "From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine – Part I: Conceptual, Moral, and Legal Foundations" and "From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine – Part II: Challenges in the Emergency Department." Part I reviews the concepts of privacy and confidentiality and also details the moral and legal foundations and limits of these values in health care. Part II addresses emergency medicine-specific privacy and confidentiality issues, including a summary listing of practical ways to protect privacy and confidentiality in the emergency department.

The College also provides several additional resources and summaries of ongoing advocacy related to the ever-growing complexities of HIT and EHRs, including a Health Information Technology landing page and an ACEP4U overview of federal advocacy on Electronic Health Records. Also among these resources is a lesson *from Criticial Decision in Emergency Medicine* (CDEM), Online Relationship: Electronic Health Records for Patient Safety. In this article, the authors address the question of "What steps can be taken to protect patient privacy when using EHRs?" The authors note:

> "Although there are limits to what emergency physicians can change regarding federal and state privacy laws, they can protect themselves from violations when using the EHR. Additional safeguards can be implemented by working with department, hospital, and IT leadership. Examples include limiting information on electronic display boards in public view, providing privacy screens for outward-facing computer monitors, allowing patients to safely opt out of tracking board screens, and creating policies regarding printed documents.
>
> Many EHR systems still rely on paper printouts for outside providers, for use in another location, or for the patient's own records. The user who printed the information should be identified on the paperwork. Staff should protect all materials printed from the EHR by avoiding transporting PHI outside the workplace and shredding documents no longer needed. As more mobile technology is implemented to complement the traditional desktop EHR, the need to print will hopefully diminish."

ACEP Strategic Plan Reference

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

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

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 36(21) Mitigating the Unintended Consequences of the CURES Act adopted. Directed ACEP to work with stakeholders to highlight patient safety issues affecting emergency department patients related to the CURES Act implementation and develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity to review results and discuss with the patient.

Amended Resolution 21(15) Healthcare Information Exchanges adopted. Directed ACEP to create a minimum standard of information to be contained in Healthcare Information Exchanges (HIE), promote standardized requirements in development, identify recommended standards for ED summaries, and work with stakeholders to identify and promote standards that allow for notification in the ED EHR of applicable HIE data.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. The resolution directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians work with stakeholders to mitigate patients' risk of self-directed or interpersonal harm, and investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

Amended Resolution 29(13) Support of Health Information Exchanges adopted. Directed ACEP to investigate and support health information exchanges, work with stakeholders to promote the development, implementation, and utilization of a national HIE, and develop an information paper exploring a national HIE.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted. Directed ACEP to update and establish policies regarding the need and utility of information systems for emergency care and produce a paper on the issue.

Prior Board Action

February 2023, approved the revised policy statement "Confidentiality of Patient Information;" revised and approved January 2017 with current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994.

June 2022, approved the revised policy statement "Patient Medical Records in the Emergency Department" revised and approved January 2016, April 2009, and February 2002 with the current title; originally approved January 1997 titled "Patient Records in the Emergency Department."

Resolution 36(21) Mitigating the Unintended Consequences of the CURES Act adopted.

April 2021, approved the revised policy statement, "Health Information Technology for Emergency Care;" replacing rescinded policies "Emergency Care Electronic Data Collection and Exchange," "Health Information Technology Standards," and "Patient Information Systems;" revised June 2015, August 2008 with current title replacing "Internet Access;" rescinded August 2008, February 2003; originally approved October 1998 titled "Internet Access."

Amended Resolution 21(15) Healthcare Information Exchanges adopted.

October 2014, reviewed the information paper, Health Information Exchange in Emergency Medicine.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

Amended Resolution 29(13) Support of Health Information Exchanges adopted.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 36(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Texas College of Emergency Physicians
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: EMTALA Reform to Improve Patient Access to Necessary Care

PURPOSE: Develop a legislative proposal to reform EMTALA to eliminate the ability to deny patients requiring transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

FISCAL IMPACT: Budgeted committee and staff resources. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed.

WHEREAS, The Consolidated Omnibus Resolution Act (COBRA), now known as EMTALA, was passed in 1986 primarily in response to the refusal of large comprehensive medical centers to accept transfer patients from small, primarily rural hospitals who did not have the capability to care for those patients; and

WHEREAS, A secondary concern of Congress was to prevent people without insurance being refused emergency evaluation and stabilizing treatment; and

WHEREAS, Achieving this secondary concern of initial evaluation and stabilization within the capability of the facility the patient presenting to has been successful from a policy standpoint; and

WHEREAS, In 1986 medical center “capacity” was defined simply “as the number of physically unoccupied beds and OR tables”; and

WHEREAS, “Capacity” has subsequently been redefined as the number of “staffed beds” which is determined by non-evidence based, sometimes state mandated, nursing ratios; and

WHEREAS, Every day in the United States transfers of patients who exceed the capabilities of smaller facilities are refused by capable medical centers under the justification that they cannot be accepted because they exceed their capacity based on nursing ratios rather than physical bed space; and

WHEREAS, Even in the worst circumstances hospitals by and large have refused to declare or place contingency or emergency standards of care in effect to override nursing ratios in order to facilitate accepting additional transfers into unoccupied beds from facilities that cannot provide capable care; and

WHEREAS, This results in dangerous delays in care, death, hours of frustration for transferring personnel, and often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients; and

WHEREAS, These unfortunate and unintended consequences of EMTALA demonstrate that EMTALA is no longer assuring the primary intent of the Congress in 1986 to protect patients who needed a higher level of care; therefore be it

RESOLVED, That ACEP develop a legislative proposal to reform EMTALA in such a way that eliminates the ability to deny patients who require transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

Background

The resolution calls for ACEP to develop a legislative proposal to reform Emergency Medical Treatment and Active Labor Act (EMTALA) to eliminate the ability to deny patients requiring transfer access to capable hospitals while preserving patient access to initial evaluation, stabilization, and treatment within the capability of the facility they present to regardless of ability to pay.

As the overall shape of the U.S. health care system has evolved over the decades since the enactment of EMTALA, some suggest that the law has not similarly evolved and does not reflect the current reality of care delivery in emergency departments and hospitals throughout the country. In particular, some suggest these conditions have led to perverse incentives that discourage hospitals and facilities from accepting transfers of patients from transferring facilities in direct conflict with the intended purpose of EMTALA's fundamental patient protections. ACEP's policy statement "Appropriate Interfacility Patient Transfer" outlines principles regarding patient transfer for those patients who require transfer from the ED to another facility. Among these principles is that "[a]greement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer."

Adding to the complexity of this problem is that despite being only four pages when signed into law and focused on protecting patient access to emergency medical care, EMTALA now functions in a more expansive manner as a result of several subsequent amendments, regulatory interpretation and enforcement, and legal determinations that have shaped the law since its enactment. EMTALA is the federal law requiring Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed, or color. EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. The law was enacted in 1986 in response to reports about "patient dumping," a practice where hospitals and emergency rooms would refuse to treat poor or uninsured patients or transfer or discharge emergency patients based upon the anticipation of high costs of diagnosis and treatment. EMTALA requires Medicare-participating hospitals, as a condition of participation (COP) under Medicare, to provide services to any individual presenting at an emergency department, regardless of insurance status or ability to pay, or face potential enforcement actions and penalties for violations.

Hospitals have three main obligations under EMTALA:

1. The law requires hospitals to provide a ***medical screening examination*** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive ***stabilizing treatment*** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, ***they may only be transferred*** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

EMTALA violations may result in the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issuing civil monetary penalties on a hospital ($129,233 for hospitals with more than 100 beds, $64,618 for hospitals with fewer than 100 beds/per violation) or physician ($129,233 per violation) pursuant to 42 CFR §1003.500 for refusing to provide either unnecessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. The HHS OIG also has the authority to exclude physicians from participation in Medicare and State health care programs, and the Centers for Medicare & Medicaid Services (CMS) may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping and equitable relief as appropriate.

Under current federal regulations (42 CFR §489.24) the term "capacity" under EMTALA is defined as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits." The resolution notes that in 1986, medical center "capacity" was defined as "the number of physically unoccupied beds and OR tables," and that since then, "capacity" has subsequently been redefined as the number of "staffed beds" which is determined by arbitrary "nursing ratios." The resolution goes on to explain that this interpretation has resulted in perverse incentives or consequences, where transfers of patients to higher care facilities are refused because of this interpretation of "capacity," and that hospitals refuse to declare or place contingency or emergency standards of care in effect to override nursing ratio requirements in order to facilitate accepting additional transfers into unoccupied beds from facilities that cannot provide care, leading to dangerous delays in care, even death, hours of frustration for transferring personnel, and often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients.

The issue of patient transfers given the constraints of the federal EMTALA mandate remains an area of concern and persistent challenge for overwhelmed EDs. In some cases, an ED or hospital with insufficient resources or ability to care for a patient with complex needs is unable to transfer that patient to a receiving hospital because that facility is also overwhelmed with boarding patients, full units, or insufficient staff. This has resulted in patients succumbing to traumatic wounds or serious illnesses and conditions due to the inability to transfer those patients in a timely fashion. As the resolution also notes, this has been exacerbated as hospitals and facilities have not implemented emergency or crisis standards of care protocols to override nursing ratios or other resource scarcity issues.

A June 2024 article published in *ACEPNow* by James Augustine, MD, FACEP, sheds additional light on this issue. Dr. Augustine notes:

> "The additional lengthy ED stays for transfer patients are equally resource-intense for emergency physicians and especially emergency nurses. Some hospital systems have developed transfer centers or flow centers, which attempt to coordinate patient movement to the best site of care within the system. But for independent, and particularly smaller and rural hospitals, the process of finding an accepting hospital for patients needing transfer is a huge burden that involves placing one phone call or digital request at a time. Once a patient is accepted somewhere, the facility must then begin the process of finding a transport resource, coordinating the right time of transfer with the receiving facility, and completing the required documentation.
>
> This points to a need for centers that may specialize in regional patient movement, to include all hospitals and systems. In regions like San Antonio, Texas, this innovation has taken place already and serves needs across a large geographic region and many patient types (https://www.strac.org/). The state of Georgia has developed and funded a coordinating center for patient movement and EMS communications on hospital capabilities (https://georgiarcc.org/). These coordinating centers have been advantageous when patient surges occurred, such as those experienced during the most stressful days of the COVID-19 pandemic."

There are ongoing efforts outside of amending EMTALA requirements aimed at reducing barriers to patient transfers. Some stakeholders like Apprise Health Insights and others have implemented automated, real-time statewide and

regional bed tracking and capacity management systems to facilitate quicker transfer of patients to appropriate facilities that have the ability and capacity to provide care. ACEP is also in the process of working with legislators to draft federal legislation to help expand the proliferation of these systems throughout the country. Additionally, ACEP has partnered with the American College of Surgeons (ACS) and the ACS Committee on Trauma (COT) to help develop a National Trauma Emergency Preparedness System (NTEPS) blueprint, which envisions a system that provides awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. This coordinated effort should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also
maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

RMOCCs are envisioned as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real-time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Some of these concepts are included in the Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems issued by the Administration for Strategic Preparedness and Response (ASPR), but ACEP and our partners in this effort continue to encourage ASPR to make RMOCCs the centerpiece of the regionalized approach. ACEP also continues to advocate to Congress to implement this approach as part of our nation's larger emergency preparedness infrastructure.

ACEP Strategic Plan Reference

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

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

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

Fiscal Impact

Budgeted committee and staff resources. Alternatively, utilizing a consulting firm with specific legislative drafting

expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed.

Prior Council Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Requests ACEP to: 1) work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; 2) advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and 4) support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 23(11) EMTALA adopted. Directed ACEP to submit recommendations to CMS regarding uniform interpretation and fair application of EMTALA; work with CMS to institute confidential, peer-reviewed process for complaints; work with CMS and others to require that complaints be investigated consistently according to ACEP-developed standards and investigators required to adhere to principles of due process and fairness during investigations; and provide a report to the 2012 Council on this issue.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate and submit recommendations for the CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among all the CMS regional offices, protection of peer review confidentiality, and utilizing consultative peer review for issues involving medical decision making.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA and for the Board to provide a report to members in 2001.

Prior Board Action

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs assigned to the ACEP Federal Government Affairs Committee and State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

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

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

Amended Resolution 23(11) EMTALA adopted.

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

Amended Substitute Resolution 15(00) EMTALA adopted.

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

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 37(24)

SUBMITTED BY: Emily Ager, MD; Michael Bresler, MD, FACEP; Joshua da Silva, DO, FACEP; Kelly Quinley, MD; Monica Rakesh Saxena, MD, JD; Rachel Solnick, MD; Sophia Spadafore, MD; Katherine Wegman, MD; AAWEP Section; California Chapter

SUBJECT: Reinforcing EMTALA in Pregnancy Related Emergency Medical Care

PURPOSE: Develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

WHEREAS, Physician advocacy groups including the American College of Emergency Physicians (ACEP), the American College of Obstetricians and Gynecologists and the American Medical Association have affirmed that emergency physicians must be able to practice high quality, objective, evidence-based medicine without legislative, regulatory or judicial interference in the physician-patient relationship; and

WHEREAS, The Emergency Medicine Treatment and Labor Act (EMTALA) mandates that any patient who presents to an emergency department with an emergency medical condition receive stabilizing and life-saving care, and where such emergency medical conditions are defined as a conditions where the absence of immediate medical treatment could reasonably be expected to result in placing the individual's health in serious jeopardy or jeopardize bodily organs or functions; and

WHEREAS, EMTALA was established to ensure all patients, and specifically pregnant persons, have access to care and, moreover, protect the ability of physicians and clinicians to provide evidence-based care for patients and use their clinical judgment and expertise to determine how and when to stabilize and treat patients with life-threatening emergencies; and

WHEREAS, More than 2.77 million pregnant persons visit U.S. emergency departments annually; and

WHEREAS, Certain pregnancy-related emergencies and complications require termination of pregnancy to prevent death or the endangerment of the health of the pregnant and lifelong impairment including loss of fertility and kidney failure; and

WHEREAS, Abortion bans have created maternity care deserts where pregnant patients have limited access to prenatal care, resulting in greater numbers of patients likely to present to emergency departments with undiagnosed life-threatening pregnancy complications; and

WHEREAS, Abortion bans in some states have also created ambiguity and/or legal threats to emergency clinicians and other physicians for providing pregnancy-terminating care that is medically required, therefore be it

RESOLVED, ACEP develop a policy statement that delineates:

- EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient.
- ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the patient-physician relationship.
- ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by medical best practices and that no procedure or treatment be removed from those treatment options in the care of emergency patients served under federal EMTALA protections.

Background

The resolution directs the College to develop a policy statement that delineates that the Emergency Medical Treatment and Labor Act (EMTALA) applies to all emergency medical conditions and evidence-based treatments used to stabilize a patient, without any exceptions; that ACEP supports the autonomy of the patient-physician relationship without inhibition or obstruction by laws and regulations; and that ACEP reinforces the need for emergency physicians to have all procedures and treatment options available to them to provide care at the standard required by medical best practices in the care of emergency patients served under federal EMTALA protections.

The June 24, 2022, decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization* held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Because emergency departments commonly see patients presenting with obstetrical emergencies, this decision immediately triggered significant uncertainty on whether, in light of the existing federal EMTALA law, restrictions or prohibitions could now be imposed on their treatment in states with abortion and related reproductive health restrictions.

EMTALA has been in place since 1987 and includes three main obligations:

1. The law requires hospitals to provide a ***medical screening examination*** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive ***stabilizing treatment*** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, ***they may only be transferred*** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A little less than a year before *Dobbs,* in September 2021 HHS released guidance reaffirming physicians' legal obligations under EMTALA, specifically when treating patients who are pregnant or are experiencing pregnancy loss. In this guidance, CMS:

- Stated that "an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures." Patients must continue to be monitored until a physician or qualified health professional determines if the individual has an emergency medical condition, and if they do, until they are stabilized or appropriately transferred.
- Included a non-comprehensive list of EMCs involving pregnant people: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. CMS states that the "course of treatment necessary to resolve such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive

therapy, etc.)." In other words, none of these procedures that a physician or other qualified medical professional directly involved in the care of the patient deems necessary to treat and stabilize a patient under the EMTALA mandate can be restricted by state laws.

- Declared that hospitals can only transfer women in labor "if the benefits of the transfer to the woman and/or the unborn child outweigh its risks. For example, if the hospital does not have staff or resources to provide obstetrical services, the benefits of a transfer may outweigh the risks." Hospitals cannot cite state laws or practices as the basis for transfer. In other words, regardless of where the hospital is located and what state laws are in effect, patients with emergency medical conditions must be treated and cannot be transferred—unless the limited transfer allowances under EMTALA apply.

ACEP issued a statement the day of the *Dobbs* ruling in response expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, and reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

Just weeks later, in July 2022 CMS issued additional EMTALA guidance. In this updated guidance, CMS:

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

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

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

Therefore, ACEP joined amicus briefs addressing these issues. ACEP and the Idaho Chapter submitted a brief in the U.S. District Court for the District of Idaho on August 15, 2022, in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. Because the Idaho law only allows for abortion if the life of the mother is in danger, the brief argued that if applied to emergency medical care, Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the EMTALA. The State of Texas had filed suit (*State of Texas v. Becerra*) arguing the federal government did not have the authority to provide medical guidance. The amicus brief emphasized the proper interpretation of EMTALA and the possibility that what under Texas law would constitute pregnancy termination may be appropriate in the emergency department when deemed necessary to provide stabilizing treatment of the patient. The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

Since that time, there has been significant activity at the state level, in the courts, and at the federal level.

State level activities have been too numerous to summarize fully in this resolution background, but of note several states have undertaken their own EMTALA-like policy-setting:

- The Massachusetts governor, in June, released an executive order reaffirming that Massachusetts law provides a right to prompt treatment in an emergency – including emergency abortion care – without discrimination on account of economic status or source of payment.
- New York saw a bill introduced (A.5297A) under which a healthcare practitioner must not be prohibited from providing healthcare services related to complications with pregnancy in cases in which a failure to act would violate the accepted standard of care. The bill also prohibits a healthcare entity from taking adverse action against a practitioner for providing services consistent with this bill.
- In Washington, the Governor issued a directive calling on the Department of Health to issue a policy statement reaffirming and clarifying the requirements under state law for hospitals to provide emergency abortion services. Issued on June 17, the policy statement says, "If a pregnant person presents to a hospital's emergency department with an emergency medical condition for which termination of the pregnancy is the standard of care, the hospital is required to provide that abortion care in accordance with and as promptly as dictated by the standard of care or, if authorized under RCW 70.170.060(2), WAC 246-320-281(1), and other applicable state and federal law, transfer the patient to another hospital capable of providing the care."

In the courts:

- A preliminary injunction was issued by the U.S. District Court of Idaho (Southern Division) on August 24, 2022 that found that the exception for the life of the mother under Idaho's abortion ban was narrower than federal law which "protects patients not only from imminent death but also from emergencies that seriously threaten their health," and blocked the state law. The injunction provided a degree of legal certainty for EMTALA-certified hospitals, medical providers, and pregnant patients that care for obstetrical emergencies was still permissible under EMTALA.
    - The state legislature then filed an appeal before the 9th Circuit. After continued legal wrangling in the Circuit Court, the US Supreme Court intervened in January of 2024, allowing Idaho's criminal abortion ban to take effect and agreeing to hear the case in April.
    - ACEP joined together with ACOG and the AMA as lead amici on an amicus brief joined by 23 other medical societies to educate the Supreme Court on the importance of protecting the physician-patient relationship and ensuring that all patients receive health care that is medically and scientifically sound and in compliance with EMTALA. ACEP also joined these groups in a statement calling for the Court not to weaken EMTALA, noting:

        > "…In many of these emergency situations, the only way to treat or stabilize a patient is to end the pregnancy that is complicating or threatening their health…As organizations representing health care professionals, we understand that not every patient who presents to the emergency room while pregnant will need abortion care. But EMTALA should guarantee that patients experiencing pregnancy complications in the emergency setting are able to get evidence-based care, which includes being counseled fairly and honestly and receiving an abortion if that is the intervention that they need for their health emergency. Without comprehensive EMTALA protections, the lives of pregnant patients will most certainly be at risk. EMTALA must continue to protect pregnant people just as it protects those who aren't pregnant."

    - The Supreme Court ultimately ruled on June 27, 2024, dismissing the case as improvidently granted, and restored the 2022 lower court order to, for now, allow emergency abortions to proceed in Idaho under EMTALA. This decision does not provide any clarity or determination on whether EMTALA supersedes state laws such as Idaho's, and it is expected the case will return back to the Supreme Court in the coming year.
- In Texas, a federal district judge in August 2022 agreed with the state in *State of Texas v. Becerra*, saying the guidance amounted to a new interpretation of EMTALA and granted a temporary injunction upholding the implementation of the state's law.
    - The case eventually made its way to the 5th Circuit which affirmed the lower court's decision. Judge Leslie Southwick at the hearing described HHS's guidance as an effort to expand abortion access beyond life-saving care to "broader categories of things, mental health or whatever HHS would say an abortion is required for." HHS has since asked the Supreme Court to take up the case. In the meantime, the Biden administration's

guidance that EMTALA preempts state abortion bans is suspended in Texas only. It is possible that this case and the Idaho case could be consolidated and considered by the Supreme Court as one.

Federally:

- In May of 2024, CMS launched a new portal for both patients and providers to submit anonymous complaints of potential EMTALA violations in hospital EDs for investigation. ACEP has added a link to the complaint portal on its own resource page on reproductive health care. It should be noted the portal specifically exempts providers in the state of TX due to the injunction resulting from the Texas 5th Circuit decision.
- Following the Supreme Court decision in Idaho, HHS sent another letter to hospital and provider associations across the country reminding them that it is a hospital's legal duty to offer necessary stabilizing medical treatment (or transfer, if appropriate) to all patients in Medicare-participating hospitals who are found to have an emergency medical condition. CMS also announced that the investigation of EMTALA complaints would proceed in Idaho while litigation continues in the lower courts.

ACEP's policy statement "Interference in the Physician-Patient Relationship" states: "The American College of Emergency Physicians (ACEP) believes that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship."

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee, Board, and staff resources.

Prior Council Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine. Directed that ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Prior Board Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

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

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

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

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 38(24)

SUBMITTED BY: Michael Bresler, MD, FACEP
Monica Saxena, MD, JD
Kelly Quinley, MD
Sarah Hoper, MD, FACEP
AAWEP Section
California Chapter
Ohio Chapter

SUBJECT: Termination of Pregnancy

PURPOSE: Ensure that termination of pregnancy is legally permissible in instances of a non-living fetus, a pregnancy with a fetus with no hope of survival, or when needed to protect the health or life of a pregnant woman.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, It is not uncommon for women to present to emergency departments carrying a non-living fetus or one with no hope of survival; and

WHEREAS, It is not uncommon for pregnant women to present to emergency departments with potentially life-threatening obstetrical or other emergency medical conditions; and

WHEREAS, Denial of appropriate medical care, including termination of pregnancy, may constitute a major threat to women's health or their lives, if they present to an emergency department with a non-living fetus or one with no hope of survival, or if they are experiencing other potentially life-threatening obstetrical or emergency medical conditions; and

WHEREAS, Many states are enacting restrictions or prohibitions pertaining to pregnancy termination that do not differentiate between a normal fetus, a non-living fetus, a fetus with no hope of survival, or other obstetrical or medical conditions which may threaten the health or the life of pregnant women; and

WHEREAS, Emergency physicians are ethically bound to provide appropriate medical care or referral for women carrying a non-living fetus or one with no hope of survival, or who are experiencing other potentially life-threatening obstetrical or medical emergencies; and

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) requires emergency physicians to stabilize patients with emergency medical conditions if possible, or to transfer such patients if necessary for stabilization; and

WHEREAS, Pregnant women carrying a non-living fetus or a fetus with no hope of survival, or who are experiencing other obstetrical or medical emergencies, may be at risk for serious medical complications, including death, and are thus not medically stable; and

WHEREAS, In order to protect the health or the life of a pregnant woman, therapeutic abortion or induction of labor may be medically indicated for a number of maternal or obstetrical complications, including but not limited to fetal demise, ectopic pregnancy, intrauterine infection, intrauterine hemorrhage, sepsis, pre-eclampsia, eclampsia, and other emergent conditions; and

WHEREAS, There have already been reports of life-threatening complications resulting from denial of pregnancy termination to women presenting to emergency departments with non-living or non-viable fetuses and other obstetrical or medical emergencies; therefore be it

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that termination of pregnancy of a non-living fetus be legally permissible; and be it further

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that termination of pregnancy of a fetus with no hope of survival be legally permissible; and be it further

RESOLVED, That ACEP work with the appropriate governmental entities at the federal level and assist chapters in working with state governmental entities, as well as work with other relevant stakeholders, to ensure that, when medically indicated to protect the health or life of a pregnant woman, termination of pregnancy or induction of labor be legally permissible.

Background

The resolution calls on ACEP to collaborate with federal and state governmental entities and other stakeholders to ensure that the termination of pregnancy is legally permissible in the cases of 1) a non-living fetus; 2) a pregnancy of a fetus with no hope of survival; and 3) when medically necessary to protect the health or life of a pregnant woman.

An estimated quarter of all women will experience the early loss of a pregnancy in their lifetime (Ghosh 2021) and 20% of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Up to 20% of pregnancies end in early pregnancy loss and early pregnancy loss or bleeding in early pregnancy accounts for a combined 2.7% of all emergency department (ED) visits among reproductive-aged women, or approximately 900,000 ED visits annually. Although some patients go to their primary obstetric providers for evaluation of early pregnancy loss, many seek care in the emergency department. Additionally, patients who come to the ED with early pregnancy loss are younger and more likely to be Black or Hispanic compared with other patients in the ED. Studies have also shown that the patients were also less likely to be the primary insurance policy holder or to have established prenatal care as compared to patients presenting to the outpatient setting; these characteristics were also all associated with decreased odds of active early pregnancy loss management.

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

In Idaho, the state legislature enacted several laws aimed at restricting abortion access following the *Dobbs* ruling. Among them, the state legislature added Idaho Code § 18-622, which generally makes performance of an abortion—at any pregnancy stage—a felony punishable by two to five years in prison. The initially enacted Section 622 generally defined abortion as the use of any means to intentionally terminate a "clinically diagnosable pregnancy." Section 622 did not (at the time) exclude from the definition actions to address certain pregnancy complications that may necessitate emergency treatment, such as ectopic pregnancies. As initially enacted, Section 622 also did not provide any exceptions to the abortion ban. The provision, instead, provided two affirmative defenses that physicians could invoke upon prosecution. First, an accused physician could avoid conviction by proving, by a preponderance of evidence, that the abortion, in the physician's good faith medical judgment (1) "was necessary to prevent the death of the pregnant woman" and (2) was performed in a manner that "provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." Second, an accused physician could assert an affirmative defense based on a reported case of rape or incest.

On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. It noted,

> "In emergency medicine, what Idaho now defines as criminal abortion has long been understood as a necessary, standard, and evidence-based medical treatment. As medically defined, abortion is a medical intervention provided to individuals who need to end the medical condition of pregnancy. Abortion includes the administration of medication to women already experiencing a miscarriage to complete expulsion of pregnancy tissue, including an embryo or fetus. Abortion includes the removal of an embryo, fetus, and potentially a uterus as the result of infection arising from the preterm premature rupture of membranes. An abortion is the critical treatment option for an ectopic pregnancy, which always involves a nonviable pregnancy. And an abortion is the necessary treatment in the event of uncontrolled bleeding from, for example, placental abruption or an ongoing miscarriage, even when fetal cardiac activity may still be detectable. In these and many similar circumstances, what Idaho Law defines as the criminal felony of abortion is—and has long been understood as—a standard, essential component of emergency medical care."

The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

When the Idaho case eventually came to the United States Supreme Court in April 2024 as *Moyle vs. United States*, ACEP joined together with ACOG and the AMA as lead amici on a new amicus brief, joined by 23 other medical societies to educate the Supreme Court on the importance of protecting the physician-patient relationship and ensuring that all patients receive health care that is medically and scientifically sound and in compliance with EMTALA. ACEP also joined these groups in a statement, noting:

> "…In many of these emergency situations, the only way to treat or stabilize a patient is to end the pregnancy that is complicating or threatening their health…As organizations representing health care professionals, we understand that not every patient who presents to the emergency room while pregnant will need abortion care. But EMTALA should guarantee that patients experiencing pregnancy complications in the emergency setting are able to get evidence-based care, which includes being counseled fairly and honestly and receiving an abortion if that is the intervention that they need for their health emergency. Without comprehensive EMTALA protections, the lives of pregnant patients will most certainly be at risk. EMTALA must continue to protect pregnant people just as it protects those who aren't pregnant."

ACEP has supported chapters in their own advocacy on these issues to state governmental entities. Some recent examples include:

- Supported the Maine ACEP chapter regarding changes to Maine CDC reports requiring physicians to include miscarriage information (pregnancies that end <20 weeks).
- Supported the Idaho ACEP chapter with emergency abortion care after the state banned all forms of abortion in 2023 (in addition to ACEP's participation in the related amicus briefs).
- Supported California legislation that defends Arizona physicians and patients seeking abortion-related care in California.
- Supported North Carolina legislation to decriminalize reproductive health issues.
- Supported Connecticut legislation prohibiting adverse action against health care providers for providing abortion related services and care after an abortion.

ACEP's Policy Statement, Access to Reproductive Health Care in the Emergency Department, includes the following provisions relevant to this resolution:

- ACEP supports the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision-making between patients and their physician regarding 1) discussion of reproductive health care, 2) performance of indicated clinical assessments, 3) evaluation of the viability of pregnancy and safety of the pregnant person, 4) availability of appropriate resources to perform indicated procedure(s), and 5) is to be made only by healthcare professionals with their patients.
- ACEP specifically opposes the penalization of and or retaliation against patients, patient advocates, physicians, healthcare workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services and medications for contraception, abortion, and pregnancy complications, and will further advocate for legal protection of said individuals.
- ACEP opposes the statutory provision of criminal penalties for any medically appropriate care provided in the emergency department. ACEP also opposes mandatory reporting with the intent (explicit or implicit) to prosecute patients or their healthcare providers, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss.
- ACEP supports clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between state and federal laws which include EMTALA and HIPAA.

Elements of this new policy statement were used in ACEP's response to the U.S. Department of Health & Human Services' proposed "HIPAA Privacy Rule to Support Reproductive Health Privacy".

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and

possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Prior Board Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

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

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

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Advocacy and Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Urgent Care Transparency on Available Resources and Credentials

PURPOSE: 1) Advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing resources that are or are not available; 2) advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

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

WHEREAS, Urgent care centers provide an important resource to patients that do not require the higher level of resources of emergency departments, thereby providing relief to already overcrowded emergency departments; and

WHEREAS, Urgent care centers vary in terms of resources available and resources such as x-rays and lab testing are not necessarily constant during hours of operation; and

WHEREAS, Urgent care centers vary widely in the level of educational and/or clinical experience of those providing care to patients; and

WHEREAS, Patients often present to urgent care centers with complaints/medical needs that cannot be provided for in the urgent care setting; therefore be it

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time; and be it further

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

Background

This resolution directs ACEP to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time and to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

The number of urgent care centers has continued to grow in the United States. Urgent care centers offer patients flexible hours and walk-in availability and their medical focus has grown. Many urgent care centers offer broader services and now offer in-house x-rays, lab testing, and specialized services such as pediatric care.

ACEP's "Urgent Care Centers" policy statement defines an urgent care center as a "walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department." The policy also states:

> "Any facility that does not meet the definition of an ED or freestanding ED as defined by ACEP and that advertises itself as providing unscheduled care should:

- Not use the word "emergency" or "ER" in its name in any way.
- Not use the word "emergency" or "ER" in any advertisements, claims of service, or to describe the type or level of care provided or as an alternative to an ED. Doing so may be considered a deceptive trade practice, as defined by federal or applicable state law.
- Be required to comply with appropriate state or federal licensing requirements that specify staffing and equipment criteria to provide clear information to patients accessing medical care."

ACEP has addressed the issue of credentials of care providers on site by supporting the "Health Care Professional Transparency Act," which requires all health care professionals are required to wear a name tag during all patient encounters clearly identifying the type of license they hold. Health care professionals will also have to display their education, training, and licensure in their office.

The AMA conducted a survey that shows there is significant public confusion about the qualifications of different health care professionals. Advertisements and websites for urgent care clinics are not always free of deceptive or misleading information and do not always identify the professional license. The "Truth in Advertising" campaign and model legislation seeks to ensure that any advertisements or professional websites facilities have do not promote services beyond what they are legally permitted to provide. ACEP has supported the passage of this legislation in 20 states as of July 2024.

Throughout the spring of 2023, ABEM piloted a campaign promoting the value of board certification in three markets (urban, suburban, and rural) that included billboards and other environmental ads, a digital campaign, and pre- and post-campaign surveys. Enduring materials for the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP.

ACEP President Aisha Terry, MD, FACEP, recently appointed an Urgent Care Task Force with the following objectives:

1. Determine the current landscape of urgent care centers in terms of quantity, locations, volumes, and capabilities, as well as associated physician and non-physician provision of care.
2. Make the distinction between urgent care centers, retail clinics, minute clinics, and otherwise, particularly relative to collaborative potential in the emergency care space.
3. Assess the prevalence of clinical partnerships between emergency departments and urgent care centers across the country.
4. Explore credentialing opportunities for physicians practicing in urgent care centers, to include possible ABEM sub-specialization as well as by other means of credentialing.
5. Understand business and financial models of urgent care practice and reimbursement, to include the typical billing and charging process when a patient is transferred between an emergency department and an urgent care center.
6. Apart from traditional emergency medicine residency training skills that are taught, determine what additional skills might equip and prepare emergency physicians for practicing urgent care medicine.
7. Identify key supports and resources that emergency physicians who primarily work in urgent care centers need.
8. Make recommendations for how to enhance the body of scholarly work related to urgent care practice, and how ACEP might be instrumental in such efforts.
9. Survey the ACEP membership regarding their participation in urgent care delivery – currently and potential for future, level of involvement (clinical care, management of site, management of system), interest in ABEM focus practice designation/board certification.
10. Make recommendations to ACEP on filling current gaps and our future role in this space.
11. Monitor ABEM's interest in urgent care as an area of focus practice designation.

The task force will hold its first meeting during ACEP24 in Las Vegas.

ACEP Strategic Plan Reference

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

levels, including federal, state, and professional.

- Expand and strengthen the role, approach, and impact of state-level advocacy.

Fiscal Impact

Budgeted staff resources for federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 39(22) Signage at Emergency Departments with Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or eligible emergency physician where care is delivered.

January 2022, approved the revised policy statement "Urgent Care Centers;" originally approved October 2016.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers. Directed ACEP to create a policy statement defining an urgent care center in order to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and value to make informed decisions when seeking care; and ACEP work with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

Prior Board Action

Amended Resolution 39(22) Signage at Emergency Departments with Onsite Emergency Physicians adopted.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted.

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative and Reimbursement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(24)

SUBMITTED BY: New York Chapter

SUBJECT: Telehealth Emergency Physician Standards

PURPOSE: Affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP affirms that the best emergency medical care is provided and led by board certified emergency physicians; and

WHEREAS, Patients expect emergency care to be given or directly supervised by an emergency physician; and

WHEREAS, Emergency medical care may include all levels and locations of emergency departments including but not limited to rural and virtual settings; and

WHEREAS, Recognizing variations in resources and access, patients should be able to expect the same quality of emergency physician led care regardless of the location or setting of the emergency department to which they present; therefore be it

RESOLVED, ACEP affirms that physicians providing telehealth emergency medicine or telehealth urgent care services be board certified or board eligible in emergency medicine.

Background

The resolution calls for the College to affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

ACEP policy statements promote the gold standard for emergency department care as that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.

ACEP's policy statement "Emergency Medicine Telehealth" states:

> "…With the aim of ensuring that all patients seeking telehealth services receive high quality care, the American College of Emergency Physicians (ACEP) endorses the utilization of PAs and/or NPs who are supervised by an American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine (ABEM/AOBEM) board-certified or board-eligible emergency physician according to ACEP guidelines."

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" was most recently updated in June 2023 and states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

The College has considered this broader issue of the gold standard of emergency care being led by board certified or board eligible emergency physicians on several occasions, including previous Council resolutions regarding onsite staffing in both urban and rural emergency departments, and particularly in terms of promoting the gold standard of onsite emergency physician presence to supervise nurse practitioners and physicians. ACEP has promoted and continues to promote the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians. ACEP has also advocated for this standard to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the U.S. Congress. For example, in ACEP's response to the Medicare and Medicaid Programs; Conditions of Participation (CoPs for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates proposed rule and in ACEP's comments on the calendar year (CY) 2022 Hospital Outpatient Prospective Payment (OPPS) proposed rule, stated that all services delivered in REHs to be supervised by emergency physicians either in-person or virtually via telehealth

ACEP's "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth" states:

> "Emergency physicians are uniquely qualified to leverage acute care medical decision making via telehealth, unscheduled or scheduled, to provide medical care across the spectrum of conditions and severity."
>
> and
>
> "Any PA or NP providing emergency telehealth care should be supervised by an emergency physician as determined appropriate by the EP responsible for and providing the supervision and/or collaboration."

A Telehealth Task Force was appointed in 2021 to define a vision for the impact of telehealth on emergency medicine and identify ACEP resources necessary to position emergency physicians to be the leaders in acute unscheduled

telehealth. Substitute Resolution 36(20) Telehealth Free Choice, which was referred to the Board, called on ACEP to address a wide variety of issues in Emergency Telehealth including who should provide emergency care. The resolution was assigned to the Telehealth Task Force to review and provide recommendations. The task force was not instructed to focus solely on the referred resolveds and developed numerous objectives divided into five key subject areas:

- Care Models
- Quality
- Legislative, Regulatory, Policies
- Reimbursement
- Education

The recommendations include that ACEP take the position that emergency medicine and board-certified emergency physicians are appropriate and well suited to practice acute unscheduled telehealth, while recognizing that other specialties practice within certain care models (Direct-to-Consumer, remote home monitoring, etc.); and that ACEP advocate that the practice of emergency telehealth is an extension (via an additional modality) of emergency medicine and clinical practice within the scope of a Board-Certified Emergency Physician.

ACEP President Aisha Terry, MD, FACEP, recently appointed an Urgent Care Task Force with the following objectives:

1. Determine the current landscape of urgent care centers in terms of quantity, locations, volumes, and capabilities, as well as associated physician and non-physician provision of care.
2. Make the distinction between urgent care centers, retail clinics, minute clinics, and otherwise, particularly relative to collaborative potential in the emergency care space.
3. Assess the prevalence of clinical partnerships between emergency departments and urgent care centers across the country.
4. Explore credentialing opportunities for physicians practicing in urgent care centers, to include possible ABEM sub-specialization as well as by other means of credentialing.
5. Understand business and financial models of urgent care practice and reimbursement, to include the typical billing and charging process when a patient is transferred between an emergency department and an urgent care center.
6. Apart from traditional emergency medicine residency training skills that are taught, determine what additional skills might equip and prepare emergency physicians for practicing urgent care medicine.
7. Identify key supports and resources that emergency physicians who primarily work in urgent care centers need.
8. Make recommendations for how to enhance the body of scholarly work related to urgent care practice, and how ACEP might be instrumental in such efforts.
9. Survey the ACEP membership regarding their participation in urgent care delivery – currently and potential for future, level of involvement (clinical care, management of site, management of system), interest in ABEM focus practice designation/board certification.
10. Make recommendations to ACEP on filling current gaps and our future role in this space.
11. Monitor ABEM's interest in urgent care as an area of focus practice designation.

The task force will hold its first meeting during ACEP24 in Las Vegas.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the

independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

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

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

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

September 2022, approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth." June 2022, reviewed the reimbursement recommendations from the Telehealth Task Force report, and approved the recommendations except for number 4, number 8, and number 12.

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

January 2022, reviewed the recommendations from the Telehealth Task Force Report and referred the reimbursement recommendation to the Coding & Nomenclature Advisory Committee and the Reimbursement Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement.

October 2021, filed the Telehealth Task Force Report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board.

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

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

January 2021, approved the policy statement "Telehealth Inclusion."

October 2020, approved the "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. NCCPA advised they would contact the workgroup representatives regarding next steps, however, there was no further contact from NCCPA about the program.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.
June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

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

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

Jonathan Fisher, MD, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 41(24)

SUBMITTED BY: Wellness Section
Arizona College of Emergency Physicians
Colorado Chapter
District of Columbia Chapter
South Carolina Chapter

SUBJECT: Workplace Violence Data Collection

PURPOSE: Advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives. Costs for local reporting would be absorbed by the institution. Creation of a national centralized reporting portal would be very costly, likely in excess of $100,000, and require considerable staff resources to create, analyze, and maintain.

WHEREAS, Episodes of workplace violence are known to be significant contributors to a decline in overall healthcare worker wellbeing; and

WHEREAS, ACEP previously adopted Resolution 55(17) Workplace Violence:

RESOLVED, That ACEP move past policy creation and simple awareness campaigns with state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling provided), to ensure safety in the Emergency Department for patients and staff; and be it further

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters and hospitals addressing workplace violence.; and

WHEREAS, ACEP previously adopted Amended Resolution 35(22) Workplace Violence Towards Health Care Workers:

RESOLVED, That ACEP advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.; and

WHEREAS, The landscape of emergency medical care has significantly changed in the post COVID era with an exodus of experienced healthcare professionals offering emergency medical care in the context of declining hospital bed availability and impaired outpatient care platforms; and

WHEREAS, Challenges with rising prevalence of substance abuse and disparities of health care equity result in greater risks of episodic violence within the workplace; and

WHEREAS, Health care facility leadership encounters barriers to individually institute commonly accepted violence prevention strategies, such as entry screening, metal detectors, armed guards, and/or warning signage in an increasingly competitive healthcare landscape driven by financial incentives to enhance patient recruitment; and

WHEREAS, Health care worker victims of workplace violence are encountering barriers to reporting incidents of violence resulting in uncertainty in the true scope of the problem of workplace violence without a unified means of data collection; and

WHEREAS, Resource allocation to address the issues of workplace violence to care for the caregiver and create effective abatement strategies is contingent upon understanding the scope of the problem; therefore be it

RESOLVED, That ACEP both advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations; and be it further

RESOLVED, That ACEP create a mechanism for tracking workplace violence reports such that the scope of the problem can be identified.

Background

This resolution calls for the College advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening. In a follow-up ACEP survey in 2022, 85% of emergency physicians indicated that they believe the rate of violence experienced in emergency departments has increased over the past five years., ACEP conducted a poll of members in January 2024 and found that 91% of emergency physicians reported that they or a colleague were victims of violence in the past year. As part of that effort, ACEP gathered more than 800 troubling stories directly from emergency physicians. These findings highlight the prevalence regarding workplace violence in emergency settings.

ACEP has advocated for local reporting of violence in the ED. While a national database of violent acts would provide important information on the incidence and prevalence of ED based or hospital violence, creation of such a portal would be costly and time consuming. It would require a data analyst to clean the data and compile the reports. It would also require input of data from a sufficient number of hospitals to be meaningful, which would require a standardized reporting structure as well as universal terminology. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has featured as one of the key advocacy priorities during the recent ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC. ACEP helped inform and supports the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2663/S.1176), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This bill compels on the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent

Incident Log.

- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

Moreover, ACEP has been working with OSHA for several years as they have attempted to develop and issue these standards, which have been in development since 2015. The agency plans to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024. The proposed rule will most likely apply to work performed in hospitals, medical centers, residential treatment centers, nursing homes, mental health centers, and private homes where home health aides or social workers visit clients. The agency is expected to publish a final rule in 2025.

ACEP also helped inform and supports the bipartisan "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768), bipartisan, bicameral legislation introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here, and Christopher Kang, MD, FACEP, who was ACEP president at that time, was quoted in the press release when the legislation was introduced.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence on March 22, 2024. And on July 31, 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED

environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to deal with workplace violence issues and has developed both a white paper and toolkit for chapters and individual groups and hospitals. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

ACEP Strategic Plan Reference

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

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

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives. Costs for local reporting would be absorbed by the institution. Creation of a national centralized reporting portal would be very costly, likely in excess of $100,000, and require considerable staff resources to create, analyze, and maintain.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

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

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

Approved as legislative and regulatory priorities in March 2024, February 2023, January 2022, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(24)

SUBMITTED BY: New York Chapter

SUBJECT: Workplace Violence

PURPOSE: Advocate for all EDs to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes; officially work with OSHA, the Department of Justice, and other relevant stakeholders to push for national legislation standardizing prevention and response measures for violence against health care workers in EDs.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

WHEREAS, Emergency Departments (EDs) are high-risk settings for workplace violence (WPV) often creating occupational hazard conditions for ED physicians; and

WHEREAS, Despite the incidence of WPV episodes there is often under reporting of such incidents[1]; and

WHEREAS, Violence towards ED physicians carry unintended consequences including mental health issues, job dissatisfaction, and decreased quality of patient care; and

WHEREAS, Despite multiple proposed anti-WPV strategies in the literature, there are few empirical metrics of effectiveness associated with these ideas[2]; and

WHEREAS, Physicians and other ED health care workers often choose to not report WPV incidents due to fear of the consequences and lack of management support[3]; therefore be it

RESOLVED, That ACEP advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes; and be it further

RESOLVED, That ACEP officially work with the Occupational Safety and Health Administration, the Department of Justice, and other relevant stakeholders to advocate for national legislation that standardizes the prevention and the response to harmful acts of violence on health care workers in emergency departments.

References
1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357631/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8783572/
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8783572/

Background

This resolution calls for the College to advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion for employment purposes. Additionally, it requests collaborate with the Occupational Safety and Health Administration (OSHA), the Department of Justice, and other relevant stakeholders to push for national legislation standardizing prevention and response measures for violence against health care workers in emergency departments.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at

work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening. In a follow-up ACEP survey in 2022, 85% of emergency physicians indicated that they believe the rate of violence experienced in emergency departments has increased over the past five years. ACEP conducted a poll of members in January 2024 and found that 91% of emergency physicians reported that they or a colleague were victims of violence in the past year. As part of that effort, ACEP gathered more than 800 troubling stories directly from emergency physicians. These findings highlight the prevalence regarding workplace violence in emergency settings.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has featured as one of the key advocacy priorities during the recent ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC. ACEP helped inform and supports the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2663/S.1176), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This bill compels on the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.

- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.

- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

Moreover, ACEP has been working with OSHA for several years as they have attempted to develop and issue these standards, which have been in development since 2015. The agency plans to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024. The proposed rule will most likely apply to work performed in hospitals, medical centers, residential treatment centers, nursing homes, mental health centers, and private homes where home health aides or social workers visit clients. The agency is expected to publish a final rule in 2025.

ACEP also helped inform and supports the bipartisan "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768), bipartisan, bicameral legislation introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here, and ACEP President Christopher Kang, MD, FACEP, was quoted in the press release when the legislation was introduced.

ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence on March 22, 2024. And on July 31, 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced new requirements for accredited hospitals to ensure safer work environments. The

new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

ACEP began a partnership with ENA in 2019 to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers." ACEP and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to deal with workplace violence issues and has developed both a white paper and toolkit for chapters and individual groups and hospitals. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

ACEP Strategic Plan Reference

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

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

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a

healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

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

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

March 2024, February 2023, January 2022, and January 2022, continuing to advocate for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2024 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 43-62

Kurtis Mayz, JD, MD, MBA, FACEP – Chair
Sara Ann Brown, MD, FACEP – (IN)
Angela P. Cornelius, MD, FACEP (TX)
Dan Freess, MD, FACEP (CT)
Michael C. Smith, MD, MBA, FACEP (LA)
Carol Wright Becker, MD, FACEP (WV)

Travis Schulz, MLS, AHIP
George Solomon, MHS, FP-C, CCP-C, TP-C

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 43(24)

SUBMITTED BY: Young Physicians Section
California Chapter
Careers in Emergency Medicine Section

SUBJECT: Addressing Challenges Related to the New ABEM Oral Board Exam Format

PURPOSE: Continue engagement with ABEM to delay implementation of the new oral board format; relocate the primary testing site to a more central US location; implement an income-based fee structure; oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026; provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination; and to establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The American Board of Emergency Medicine (ABEM) announced a new oral board examination format to begin in 2026[1]; and

WHEREAS, The new oral board examination format requires candidates to travel to a single testing site in Raleigh, NC posing significant logistical and financial challenges for candidates, particularly those from the West Coast, Alaska, and Hawaii[2]; and

WHEREAS, Requiring candidates to travel to a single testing site in Raleigh, NC may pose significant health risks for pregnant candidates, particularly those experiencing complications that make travel inadvisable or dangerous; and

WHEREAS, North Carolina's 12-week abortion ban may make it extremely challenging for pregnant candidates experiencing complications to receive necessary medical care while traveling to Raleigh for the oral board examination, potentially putting their health and well-being at risk[3]; and

WHEREAS, Emergency medicine residency programs and graduating residents may not feel adequately prepared for the new oral board examination format by the proposed implementation date; and

WHEREAS, Some emergency medicine physician groups may not offer full salaried physician compensation to doctors until they have achieved board certification[4], placing a significant financial burden on candidates who must delay taking the oral board examination; and

WHEREAS, The cost of the new oral board examination may pose a financial burden for candidates, particularly those with lower incomes or those who are required to make multiple attempts; and

WHEREAS, The American Medical Association has resolved to encourage national specialty boards holding in-person centralized mandatory exams for board certification to provide alternate options when exams are conducted in states with laws that ban or restrict abortion, gender-affirming care, or reproductive health care services, as such laws may limit access to necessary medical care or pose threats of civil or criminal penalties to examinees and examiners[5]; therefore be it

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to:

1. Explore delaying implementation of the new oral board examination format to allow for adequate preparation by emergency medicine residency programs and graduating residents;
2. Relocate the primary testing site to a more central U.S. location or add an additional testing site in the western half of the U.S. to reduce travel costs and minimize time zone impacts for candidates;
3. Implement an income-based fee structure for the new oral board examination to improve affordability and accessibility for all candidates, including differentiating between early career attendings and fellows;
4. Ensure oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026;
5. Provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass;
6. Develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination format to ensure that it equitably assesses communication, procedural skills, patient management, high-stakes communication, difficult conversations, patient communications beyond diagnosis, procedural skills, clinical decision making/shared decision making, team management, leadership, troubleshooting, task switching, prioritization, and continues to bring value to the public and diplomates;
7. Establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

References

1. ABEM. *Certifying Exam.* https://www.abem.org/public/become-certified/certifying-exam. Accessed June 1, 2024.
2. ABEM. *Why Raleigh.* https://www.abem.org/public/docs/default-source/default-document-library/for-website_why-rale igh.pdf?sfvrsn=c4b1d3f4_1. Published January 11, 2024. Accessed June 1, 2024.
3. New York Times. *North Carolina Legislature Passes 12-Week Abortion Ban.* https://www.nytimes.com/2023/05/04/us/abortion-ban-north-carolina.html. Published May 4, 2023. Accessed June 1, 2024.
4. ACEP Policy Statement: "Emergency Physician Compensation Transparency" Approved October 2020
5. AMA Resolution – approved at AMA Annual Meeting House of Delegates, June 2024
   https://www.ama-assn.org/system/files/a24-refcomm-c-annotated.pdf
   a. *"RESOLVED that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners."*

Background

This resolution calls for ACEP to continue engagement with the American Board of Emergency Medicine (ABEM) to revise and delay the implementation of the new oral board format set to begin in 2026. Specific asks to be addressed are: 1) delay implementation of the new oral board format to allow more time for programs to prepare residents; 2) relocate the primary testing site to a more central U.S. location or add additional sites; 3) implement an income-based fee structure; 4) ensure oral board candidates will not bear undue financial burdens; 5) provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; 6) develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination; and 7) establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

Prior to COVID-19, all emergency medicine residency graduates were required to take a qualifying written exam at a local testing center and then travel to Chicago for the oral certification exam. The oral board exams were moved to a virtual format during COVID. According to ABEM, the oral examination measures elements and competencies that are not measured on a written examination as evidence by a study showing that only moderate correlation between the two exams indicating that the exams are related but different. ABEM launched a Becoming Certified Taskforce in 2021 that was informed by a stakeholder advisory group. Multiple stakeholders from a broad range including emergency physicians from both academic and community practices, residents, residency program directors, department chairs, hospital leaders, patients and public, were invited to a summit in March of 2022. Key findings of the Becoming Certified initiative included:

- Assess additional skills and competencies important to the specialty.
- Create an assessment that is more relevant to practice and with the flexibility to adapt to changes in practice.
- Provide a format that can assess the aspects of emergency medicine practice that are not easily replaced by artificial intelligence.
- Provide candidates with a meaningful assessment experience. The current format of the virtual Oral Certification Exam (OCE) cannot adequately grow in size or structure to meet these needs; however, the specialty believes that an exam beyond medical knowledge is still needed.

The new format of the OCE will include clinical care cases and objective structured clinical examination (OSCE) cases. The clinical cases will be similar to the current OCE and will assess procedural skills, complex communication, professionalism, and other technical skills. Scenarios could involve standardized patient actors or procedural equipment.

Conducting the OCE, including the OSCEs, requires a specialized testing center. ABEM explored numerous options and sites that could meet the requirements. The AIME Center in Raleigh, NC was chosen because it is a state-of-the-art facility with flexible space that can accommodate clinical cases, procedural cases, and simulation. Using a single center will help ensure standardized testing for all candidates regardless of administration. The AIME Center has the infrastructure to support both simulation and a group of actors who work as Standardized Patients (SPs).

EMRA released a statement in January 2024 about the new ABEM certifying exam. EMRA's statement expressed several concerns: undue financial and logistical burden for newly-graduated emergency physicians, unclear patient outcome-based evidence showing a clear and proven benefit to in-person oral exams, and lack of stakeholder input since the Becoming Certified Task Force (BCTF) did not include resident or early-career physician representation.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 44(24)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations

PURPOSE: Advocate for CAH funding for EM resident rotations at rural CAHs; collaborate with CORD to enable CAHs and residency programs to use CMS funding for training residents to promote rural experience; task the Rural Emergency Medicine Section to maintain a rural rotation list as a resource for CORD; and request the ACGME to require emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

FISCAL IMPACT: Budgeted committee, section, and staff resources for continuing current initiatives.

WHEREAS, Rural patients have worse health outcomes than their urban peers and face significant barriers to care including long distances to specialty care, primary care deserts, and hospital closures; and

WHEREAS, Rural emergency departments face significant future emergency physician staffing shortages; and

WHEREAS, The vast majority of US residencies (92%) are in urban areas and with no Accreditation Council for Graduate Medical Education (ACGME) requirement for rural emergency medicine education; and

WHEREAS, Only 52% of emergency medicine residency programs offer a rural clinical rotation (ACEP 2020 Rural Task Force Report); and

WHEREAS, ACEP has previously issued the "Rural Emergency Medical Care" policy statement suggesting rural electives as one possible avenue for improving rural access to board certified/board eligible emergency care; and

WHEREAS, Centers for Medicare & Medicaid Services (CMS) can potentially reimburse critical access hospitals (CAHs) 101% of the cost of resident salaries but full reimbursement only applies to the percentage of patients that are covered by Medicare, leaving any other care provided by residents to be funded by the hospital (https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf); and

WHEREAS, CMS does not provide any additional funding for resident housing or travel to rural regions. This is inadequate financial support for any critical access hospital or emergency medicine resident seeking to support rural training; therefore be it

RESOLVED, That ACEP continue to advocate for additional critical access hospital funding to cover the full salary, housing, and travel costs of emergency medicine resident rotations at rural Critical Access Hospitals; and be it further

RESOLVED, That ACEP collaborate with the Council of Residency Directors in Emergency Medicine to create clear pathways that enable rural Critical Access Hospitals and residency programs to use the existing partial Centers for Medicare & Medicaid Services funding for training residents to promote rural clinical experiences including using critical access hospitals as non-provider sites, building rural residency tracks, and expanding rural elective opportunities; and be it further

RESOLVED, That ACEP support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the ACEP Rural Emergency Medicine Section and shared with the Council of Residency Directors in Emergency Medicine; and be it further

RESOLVED, That ACEP request that the Accreditation Council for Graduate Medical Education require all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

Background

This resolution calls for ACEP to advocate for CAH funding for emergency medicine resident rotations at rural critical access hospitals (CAHs); collaborate with CORD to enable CAHs and residency programs to use CMS funding for training residents to promote rural experience; task the Rural Emergency Medicine Section to maintain a Rural Rotation list as a resource for CORD; and request the ACGME to require all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

According to the AHA nearly 35% of hospitals in the US are considered rural. The "National Study of the Emergency Physician Workforce, 2020," reported that the nation's rural emergency physician shortage is expected to worsen in the coming years, the authors note. Of the 48,835 clinically active emergency physicians in the United States, 92 percent (44,908) practice in urban areas with just 8 percent (3,927) practicing in rural communities, down from 10 percent in 2008.

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

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas.

There are several barriers to rural experiences for emergency medicine residents. The complexities of the Medicare Graduate Medical Education funding is tied to resident rotating at the home institution, so when a resident rotates at rural site, it may result in the loss of the funding for the duration of the rotation. Additionally, the ACGME requirements may create challenges around supervision for rural rotations. Additionally, the ACGME requirements may create challenges for faculty and supervision of residents during rural rotations. According to section II.B.2.g) of the ACGME Program Requirements in Emergency Medicine:

> *Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine.*

The 2022 Council and the Board of Directors adopted Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings and assigned the resolution to the Academic Affairs Committee. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine. The committee is in the process of developing an information paper and resources to help promote rural experiences for emergency medicine residents.

ACEP has had three separate task forces in the past ten years to address the issue of attracting emergency physicians to practice in rural areas. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates showed that few, if any, of those who answered the survey took jobs in the rural area, even though those jobs paid an average of $100,000 more in compensation and included loan forgiveness programs. Though they were not asked directly why they did not take rural positions, they were asked the major factors for their decision. The most common responses

were spouse, job needs, and to be near family. Despite an increased supply of emergency physicians and higher salaries in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

ACEP Strategic Plan Reference

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

Fiscal Impact

Budgeted committee, section, and staff resources for continuing current initiatives.

Prior Council Action

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted. Called for ACEP to advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

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

Resolution 49(22) Enhancing Rural Emergency Medicine Patient Care not adopted. The resolution called for ACEP to support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

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

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

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the college including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; seek rural

physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

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

Prior Board Action

March 2024, February 2023, January 2022, and January 2021 approved legislative and regulatory priorities that included several initiatives related to rural emergency care.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted.

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

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

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

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

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

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved June 2000.

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

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 45(24)

SUBMITTED BY: Tabitha Baca, MD
Marc Futernick, MD, FACEP
Gayle Galletta, MD, FACEP
Rita Manfredi-Shutler, MD, FACEP
Dana Mathew, DO, FACEP
Scott Mueller, DO, FACEP
Kristen Nordenholz, MD, FACEP
Matthew Siket, MD, FACEP
David Terca, MD, FACEP
Kreager Taber, MS4
Alexandra Thran, MD, FACEP
California Chapter
Vermont Chapter

SUBJECT: Climate Change Research and Education in Emergency Medicine

PURPOSE: 1) Encourage and support research efforts on the health effects of climate change; 2) Promote initiatives collecting data on climate-related health emergencies; and 3) Support medical school and residency program curricula addressing climate change.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Climate change is recognized as a global health emergency, with adverse effects on public health, including increased risks of heat-related illnesses, vector-borne diseases, and extreme weather events[1,2,3,4]; and

WHEREAS, Emergency medicine plays a vital role in responding to and mitigating the health consequences of climate change, as emergency departments often serve as the first point of contact for individuals affected by climate-related health emergencies[5]; and

WHEREAS, Evidence-based interventions are crucial for effective response and preparedness in the face of climate change-induced health challenges[6]; and

WHEREAS, Research on the health effects of climate change and the role of emergency medicine in addressing these effects is essential for developing efficient strategies for emergency preparedness, response, and mitigation[7,8]; and

WHEREAS, The American Association of Medical Schools (AAMS) has endorsed producing climate-aware physicians[9]; therefore be it

RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; and be it further

RESOLVED, That ACEP call for and promote initiatives to facilitate data collection on climate-related health emergencies, such as heat-related illnesses, vector-borne diseases, and extreme weather events, to inform evidence-based interventions, strengthen disaster preparedness, and enhance the capacity to respond effectively to climate change-induced health challenges; and be it further

RESOLVED, That ACEP support the introduction of curricula that address climate change in medical schools and residency programs.

References

1. Watts N, Adger WN, Agnolucci P, et al. Health and climate change: policy responses to protect public health. Lancet. 2015;386(10006):1861-1914. doi:10.1016/S0140-6736(15)60854-6

2. Haines A, Kovats RS, Campbell-Lendrum D, Corvalán C. Climate change and human health: impacts, vulnerability, and mitigation. Lancet. 2006;367(9528):2101-2109. doi:10.1016/S0140-6736(06)68933-2
3. Patz JA, Frumkin H, Holloway T, Vimont DJ, Haines A. Climate change: challenges and opportunities for global health. JAMA. 2014;312(15):1565-1580. doi:10.1001/jama.2014.13186
4. Abbasi, K., Ali, P., Barbour, V. *et al.* Time to treat the climate and nature crisis as one indivisible global health emergency. *BMC Global Public Health* **1**, 29 (2023). https://doi.org/10.1186/s44263-023-00030-5
5. Ablah E, Konda K, Nabors NA, Ablah N. The role of emergency departments in the context of early warnings and disaster and climate change. Disaster Med Public Health Prep. 2016;10(6):803-807. doi:10.1017/dmp.2016.8
6. Knowlton K, Rotkin-Ellman M, King G, et al. The 2006 California heat wave: impacts on hospitalizations and emergency department visits. Environ Health Perspect. 2009;117(1):61-67. doi:10.1289/ehp.11594
7. Gaffin SR, Rosenzweig C, Xing X, et al. Variations in New York City's urban heat island strength over time and space. Theor Appl Climatol. 2008;94(1-2):1-11. doi:10.1007/s00704-007-0368-3
8. Center for Disease Control and Prevention (CDC). Climate Effects on Health. https://www.cdc.gov/climateandhealth/effects/default.htm
9. Howard, B., By, Howard, B., & 10, Oct. (2019a, October 10). *Climate change in the Curriculum*. AAMC. https://www.aamc.org/news/climate-change-curriculum

Background

This resolution calls for the college to encourage and support research efforts on the health effects of climate change; promote initiatives collecting data on climate-related health emergencies; and support medical school and residency program curricula addressing climate change.

In 2019, multiple public health, environmental health, patient advocacy, healthcare, nursing and medical organizations declared climate change a health emergency and call for immediate action to protect the public's health from the current and future impacts of climate change, and with climate change negatively impacting the health in the U.S. and around the globe, the American Medical Association (AMA) adopted policy in 2022 declaring climate change a public health crisis that threatens the health and well-being of all people. Additionally, the World Health Organization has called climate change the single greatest threat facing humanity.

The health impacts of climate change manifest both directly and indirectly. It alters the patterns of infectious disease transmission, leading to more frequent and severe outbreaks and pandemics; increases the incidence of heat-related illnesses; exacerbates chronic diseases; deteriorates mental health; and affects maternal and neonatal health. These effects often result in heightened demand for emergency medical services, which can lead to prolonged patient wait times, staffing shortages, worker fatigue, and compromised patient outcomes, depending on system-wide capacity and preparedness. To effectively address the current and future health challenges posed by climate change, it is imperative for the healthcare sector to be thoroughly prepared, with robust local leadership and adaptability. Emergency medicine is particularly well-positioned to assume a leading role in this regard, given its function as an acute care provider, a critical support for vulnerable populations, and a leader in disaster medicine. Its involvement is essential for addressing the needs of patients who are most adversely affected by these changing conditions.

A survey of 2,817 medical schools in 112 countries by the International Federation of Medical Students Association found that only 15% of medical schools taught climate change, and a second pilot study of US EM program directors showed that while most program directors believe that climate change and sustainability are important to EM, agreement with the importance of the inclusion of climate change in EM curricula was lower. In 2019, the AMA issued a policy on Climate Change Education Across the Medical Education Continuum, which states that the AMA *supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change*.

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022. The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.

ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine"

states:

> "ACEP supports collaborating with public health agencies and other stakeholders to:
> - Raise awareness of the short- and long-term implications of climate change in population health and its effect in the practice of emergency medicine.
> - Engage in research examining the effects of climate change on human health, health care systems, and public health infrastructure.
> - Advocate for policies and practices to mitigate and address the effects of climate change on human health, health care systems, and public health infrastructure.
> - Expand and improve upon regional surveillance systems of emerging diseases related to extreme weather events linked to climate change.
> - Advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling.
> - Educate patients on appropriate precautions in extreme weather, avoidance of exacerbation triggers, early identification of exacerbations, and temporizing measures when needed."

The Public Health Committee, in partnership with the Ethics Committee, is currently reviewing and revising this policy statement and will be developing a Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to 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.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 46(24)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole Exeni McAmis, MD
California Chapter
Colorado Chapter
Georgia College of Emergency Physicians
Massachusetts College of Emergency Physicians
West Virginia College of Emergency Physicians

SUBJECT: Human Trafficking Training for All Emergency Medicine Residents

PURPOSE: Work with ABEM to incorporate education on human trafficking for EM residents; develop a standardized training presentation for all institutions to use; and incorporate education on human trafficking in *Scientific Assembly* offerings.

FISCAL IMPACT: Unbudgeted and unknown costs to develop a standardized training program by ACEP and ongoing review of the curriculum once developed. It would require diverting current budgeted staff resources from other initiatives to support this effort.

WHEREAS, Emergency physicians are one of the few groups of professionals likely to interact with victims of human trafficking; and

WHEREAS, Up to 88% of victims of human trafficking come into contact with the healthcare system while being trafficked[1,2,3,4]; and

WHEREAS, Approximately 64% of victims of human trafficking present to an emergency department[3]; and

WHEREAS, 57.8% of health care providers across the U.S. have not been trained in identifying human trafficking, while 93.4% felt they would benefit from training[5]; and

WHEREAS, Emergency medicine providers are becoming increasingly aware of human trafficking victims in health care settings due to modifications in practice to help facilitate disclosure; therefore be it

RESOLVED, That ACEP work with the American Board of Emergency Medicine to incorporate education on human trafficking into *The Model of the Clinical Practice for Emergency Medicine* to ensure inclusion in all emergency medicine residency training; and be it further

RESOLVED, That ACEP develop a standardized training presentation for human trafficking that can be used at all institutions; and be it further

RESOLVED, That ACEP include education on human trafficking as part of the annual ACEP Scientific Assembly.

References

[1]Family Violence Prevention Fund, World Childhood Foundation. Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies. Available at: www.endabuse.org. Accessed on February 2024.
[2]Baldwin, S.B., Eisenman, D.P., Sayles, J.N., Ryan, G., Chuang, K.S. (2011). Identification of human trafficking victims in health care settings. *Health Hum Rights*, 13(1):36-49.

[3]Lederer, LJ, Wetzel, CA. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann Health Law. 2014;23:61-91.
[4]Chisolm-Straker, M, Baldwin, S, Gaigbe-Togbe, B, Ndukwe, N, Johnson, PN, Richardson, LD. Healthcare and human trafficking: we are seeing the unseen. J Health Care Poor Underserved. 2016;27:1220-1233.
[5]McAmis NE, Mirabella AC, McCarthy EM, Cama CA, Fogarasi MC, et al. (2022) Assessing healthcare provider knowledge of human trafficking. PLOS ONE 17(3): e0264338. https://doi.org/10.1371/journal.pone.0264338

Background

This resolution calls for ACEP to work with the American Board of Emergency Medicine (ABEM) to incorporate education on human trafficking for emergency medicine residents, develop standardized training presentations for institutions to use, and incorporate education on human trafficking in *Scientific Assembly* offerings.

The "2022 Model of the Clinical Practice of Emergency Medicine" does include Human Trafficking in Table 4, Section 14.6.5. This element was added in 2016 and should already be included in emergency medicine residency curricula.

At ACEP24 there are two lectures that address human trafficking and there have been two lectures per year at *Scientific Assembly* in the last 3 years:

> ACEP24: 2 lectures: Hidden Horrors: Unveiling Human Trafficking and Intimate Partner Violence in EM; Pediatric Sexual Assault: What Do You Need to Know?
>
> ACEP23: 2 lectures: Human Trafficking: It is Happening in Your ED; Abuse or Not Abuse: Interactive Visual Clues in Child Abuse
>
> ACEP22: 2 lectures: Sexual Assault, IPV & Human Trafficking: At Risk Patients in Your ED; Subtle Signs of Abuse: It's Not All About Bruises
>
> ACEP21: 2 lectures: Subtle Signs of Abuse: It's Not All About Bruises; Sexual Assault, IPV & Human Trafficking: At Risk Patients in Your ED

The "Human Trafficking" policy statement is quite comprehensive and recommends that physicians be familiar with potential signs, symptoms and indicators of human trafficking. It is recommended that hospitals and emergency departments (EDs) have protocols in place to manage this population. ACEP further recommends that "Emergency medical services (EMS), medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment, documentation, and interventions for patients surviving human trafficking."

Amended Resolution 25(14) Human Trafficking directed ACEP and its chapters to work together to coordinate with other agencies and participate with existing initiatives (e.g., National Human Trafficking Initiative, State Attorney General' s coalition, law enforcement, etc.) and to coordinate with EMS agencies, hospitals, and other members of the emergency medicine team to provide education on awareness and resources available to help reduce and eliminate human trafficking; and that "ACEP and its chapters work together to ensure indemnification for providers reporting suspected cases of human trafficking to the appropriate authorities." The Public Health & Injury Prevention Committee (PHIPC) developed an information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician" that was reviewed by the Board in October 2015 in response to the resolution. The information paper was published in *Annals of Emergency Medicine* in October 2016 and it is available on the ACEP website. The PHIPC was also assigned an objective to explore development of a policy statement on human trafficking. The policy statement "Human Trafficking" was approved by the Board in April 2016.

Congress passed The Trafficking Victims Protection Act of 2000, which was designed to bring the full power and attention of the federal government to the fight against human trafficking. There have been at least nine federal acts addressing human trafficking since 2000.

The National Human Trafficking Hotline has a resource library with training materials and technical assistance

resources. The Joint Commission has resources on identifying potential victims of Human Trafficking. The American Hospital Association has many resources including webinars and suggested staff training.

Creation of a standardized training program by ACEP would require considerable unbudgeted staff time from Clinical Affairs, Legal, and Education Departments in addition to technical support for videos and other resources. It would also require the creation of a member-based workgroup to compile the materials with review of the materials on an ongoing basis after completion. Once compiled, residency programs would be able to utilize this resource as they are able to utilize existing resources on human trafficking. Residency programs have the freedom to determine what resources and training they provide.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Unbudgeted and unknown costs to develop a standardized training program by ACEP and ongoing review of the curriculum once developed. It would require diverting current budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 25(14) Human Trafficking adopted. Called for the College to support state and federal initiatives to reduce and eliminate human trafficking, coordinate efforts to educate pre -hospital and hospital emergency care providers about this issue and available resources.

Prior Board Action

July 2022, approved the revised policy statement, "2022 Model of the Clinical Practice of Emergency Medicine." Joint policy with American Academy of Emergency Medicine (AAEM), American Board of Emergency Medicine (ABEM), Council of Emergency Medicine Residency Directors (CORD), Emergency Medicine Residents' Association (EMRA), Residency Review Committee for Emergency Medicine (RRC-EM), and Society for Academic Emergency Medicine (SAEM)

February 2020, approved the revised policy statement "Human Trafficking;" originally approved April 2016.

October 2015, reviewed the information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician."

Amended Resolution 25(14) Human Trafficking adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 47(24)

SUBMITTED BY:

Michael Bresler, MD, FACEP	Massachusetts College of Emergency Physicians
Gus Garmel, MD, FACEP	New York Chapter
Nicole Exeni McAmis, MD	Oregon Chapter
California Chapter	West Virgina College of Emergency Physicians
Colorado Chapter	Wisconsin Chapter

SUBJECT: Human Trafficking is a Public Health Crisis

PURPOSE: ACEP declare human trafficking as a public health crisis in the United States.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to human trafficking and communications to members and the public. Budgeted committee and staff resources to updated ACEP's "Human Trafficking" policy statement. Potential unknown and unbudgeted costs depending on the scope of a communications campaign and whether staff and financial resources are diverted from other projects.

WHEREAS, Emergency physicians have the privilege of working on the front lines of health care; and

WHEREAS, Emergency physicians have the responsibility to care for victims of human trafficking in our communities; and

WHEREAS, Human trafficking is defined as "Recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of involuntary servitude, debt bondage, or commercial sex acts;" and

WHEREAS, Human trafficking affects over 1 million people within the United States with 70% being women and girls and one in four victims being children under the age of 18[1,2,3]; and

WHEREAS, Up to 88% of victims have come into contact with the healthcare system while being trafficked with up to 64% being in the Emergency Department[4,5,6,7]; and

WHEREAS, Emergency department providers are often the only professionals that interact with trafficking victims who are still in captivity; therefore be it

RESOLVED, That ACEP declare human trafficking is a public health crisis in the United States.

References

[1]UN Office on Drugs and Crime (UNODC), *Global Report on Trafficking in Persons*, 2021. Available at: https://www.unodc.org/documents/data-and-analysis/tip/2021/GLOTiP_2020_15jan_web.pdf. Accessed October 2021.

[2]International Labour Organization (ILO), *Global Estimates of Modern Slavery, Geneva, 2017*. Available at: https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/publication/wcms_575479.pdf. Accessed October 2021.

[3]Banks, D., Kyckelhahn, T. Characteristics of suspected human trafficking incidents, 2008-2010. Special report, US Department of Justice. Available at: http://www .bjs.gov/content/pub/pdf/cshti0810.pdf. Accessed April 2020.

[4]Family Violence Prevention Fund, World Childhood Foundation. Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies. Available at: www.endabuse.org. Accessed on February 2024.

[5]Baldwin, S.B., Eisenman, D.P., Sayles, J.N., Ryan, G., Chuang, K.S. (2011). Identification of human trafficking victims in health care settings. *Health Hum Rights*, 13(1):36-49.

[6]Lederer, LJ, Wetzel, CA. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann Health Law. 2014;23:61-91.

[7]Chisolm-Straker, M, Baldwin, S, Gaigbe-Togbe, B, Ndukwe, N, Johnson, PN, Richardson, LD. Healthcare and human trafficking: we are seeing the unseen. J Health Care Poor Underserved. 2016;27:1220-1233.

Background

This resolution calls for ACEP to declare human trafficking a public health crisis in the United States.

ACEP has included support for legislation to prevent human trafficking and helping victims as part of its legislative priorities every year since 2019.

Human trafficking is a human rights violation affecting individuals of all ages and has significant implications for the physical, sexual, and psychological health of those affected. Trafficking victims are treated for acute injuries and illnesses in emergency departments more often than in any other health care facility and thus emergency physicians are in the best position to assess, intervene, and refer for assistance. It is estimated that approximately 24.9 million people worldwide are victims of human trafficking at any given moment, with more than 1 million affected in the United States alone. Among these victims, approximately 70% are women and girls, and one in four is a child under 18. Research suggests that over 60% of trafficking victims seek care at an emergency department at some point during their captivity. A study found that 68.3% of 173 trafficking victims surveyed had visited a health care provider, typically an emergency or urgent care facility, while being trafficked. Additionally, in 2023, according to the Nasdaq 2024 Global Financial Crime Report, $346.7 billion in illicit funds were linked to human trafficking.

ACEP's policy statement on "Human Trafficking" could be updated to declare human trafficking a public health crisis. A similar approach was taken to declare firearm violence a public health crisis by amending ACEP's "Firearm Safety and Injury Prevention" policy statement in response to Resolution 35(23) Declaring Firearm Violence a Public Health Crisis that was adopted by the 2023 Council and the Board of Directors. Additionally, ACEP could seek to work with the U.S. Surgeon General's office to declare human trafficking a public health crisis. The U.S. Surgeon General issued an advisory on June 25, 2024, declaring firearms violence a public health crisis. ACEP provided a brief quote from ACEP's President Aisha Terry, MD, FACEP, to be included in the press release on this issue: "By raising awareness of this public health crisis, the Surgeon General's Advisory on Firearm Violence Prevention speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives related to human trafficking and communications to members and the public. Budgeted committee and staff resources to updated ACEP's "Human Trafficking" policy statement. Potential unknown and unbudgeted costs depending on the scope of a communications campaign and whether staff and financial resources are diverted from other projects.

Prior Council Action

Amended Resolution 25(14) Human Trafficking adopted. Directed ACEP to: 1) work with chapters to coordinate with other agencies and participate with existing initiatives (e.g., National Human Trafficking Initiative, State Attorney General's coalition, law enforcement, etc.) and coordinate with EMS agencies, hospitals, and other members of the emergency medicine team to provide education on awareness and resources available to help reduce and eliminate human trafficking; and 2) work with chapters to ensure indemnification for providers reporting suspected cases of human trafficking to the appropriate authorities.

Prior Board Action

March 2024, February 2023, January 2022, January 2021, February 2020, and January 2019 approved a legislative priority to support legislation to prevent human trafficking and help victims.

February 2020, approved the revised policy statement "Human Trafficking;" originally approved April 2016.

June 2017, approved a grant to the Trauma & Injury Prevention Section for their project "ACEP Human Trafficking Curriculum: Defining Core Competencies and Developing Educational Online Resources for Emergency Medicine."

October 2015, reviewed the information paper, "Human Trafficking – A Guide to Identification and Approach for the Emergency Physician."

January 2015, approved a grant to the Minnesota Chapter for their project "Human Trafficking & Exploitation – Front Line Intervention."

Amended Resolution 25(14) Human Trafficking adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 48(24)

SUBMITTED BY: Laurel Barr, MD, FACEP
Elyse Lavine, MD, FACEP
Samuel Sondheim, MD
AAWEP Section
Quality Improvement & Patient Safety Section
Young Physicians Section

SUBJECT: Alarm Fatigue

PURPOSE: Support research for evidence-based solutions to alarm fatigue in the ED and identify a multidisciplinary workgroup to develop evidence-based best practices to minimize clinically inactionable or false alarms.

FISCAL IMPACT: Unbudgeted and unknown costs to support research on alarm fatigue. Costs will vary depending on how the resolution is implemented, such as ACEP pursuing grant funding for external research.

WHEREAS, Management of the cardiac or undifferentiated patient in the ED often includes cardiac monitoring; and

WHEREAS, 72-99% of clinical alarms are false[1] and one study demonstrated including up to 34% of alarms for accelerated ventricular rhythm of which 95% were false or inactionable[1]; and

WHEREAS, High rates of clinically inactionable alarms result in desensitization to alarms, alarm fatigue, and missed alarms[3] and The Joint Commission reported 80 deaths between 2009-2013 attributed to alarm fatigue[4]; and

WHEREAS, Despite alarm fatigue being the focus of a 2014 Joint Commission National Patient Safety Goal[1], few strategies for reduction in the number of clinically significant alarms have been rigorously studied in the ED; and

WHEREAS, Methods for reducing alarms often differ between the ED and inpatient setting and best practices on which alarms can be silenced, and which can be silenced after the initial alert is addressed (latching), would be helpful to reduce clinically inactionable alarms; and

WHEREAS, With lack of evidence-based approaches to reduce monitoring, developing a system to limit false alarms while preserving actionable alarms would require access to data from alarm vendors, and it is often difficult to obtain data from vendors on numbers of clinically significant alarms; and

WHEREAS, The effective development and implementation of artificial intelligence could represent a unique opportunity to help reduce the number of audible alarms to caregivers to combat alarm fatigue, therefore be it

RESOLVED, That ACEP support further research into evidence-based solutions to alarm fatigue in the emergency department setting, with topics including indications for cardiac monitor use in the emergency department for both cardiac and undifferentiated ED patients, appropriate silencing of clinical alarms including when latching (silencing the alarm after the initial alert) is appropriate, indications to discontinue cardiac monitoring; and be it further

RESOLVED, That ACEP identify a workgroup to facilitate collaboration between clinicians, computer scientists, industry vendors, and regulatory agencies to develop evidence-based best-practices to reduce clinically inactionable alarms and alarm fatigue that can result in patient harm and avoidable deaths to build a culture of safety around the use of cardiac monitors.

Resolution References
[1]Sendelbach S, Funk M. Alarm fatigue: a patient safety concern. AACN Adv Crit Care. 2013 Oct-Dec;24(4):378-86; quiz 387-8. doi: 10.1097/NCI.0b013e3182a903f9. PMID: 24153215.
[2]Drew BJ, Harris P, Zègre-Hemsey JK, et al. Insights into the problem of alarm fatigue with physiologic monitor devices: a comprehensive observational study of consecutive intensive care unit patients. PLoS One. 2014;9(10):e110274. doi: 10.1371/journal.pone.0110274.
[3]Hravnak M, Pellathy T, Chen L, Dubrawski A, Wertz A, Clermont G, Pinsky MR. A call to alarms: Current state and future directions in the battle against alarm fatigue. J Electrocardiol. 2018 Nov-Dec;51(6S):S44-S48. doi: 10.1016/j.jelectrocard.2018.07.024. Epub 2018 Jul 29. PMID: 30077422; PMCID: PMC6263784.
[4]Joint Commission. Medical device alarm safety in hospitals. Sentinel Event Alert. 2013 Apr 8;(50):1-3. PMID: 23767076.

Background

This resolution calls for ACEP to support research for evidence-based solutions to alarm fatigue in the ED and identify a multidisciplinary workgroup to develop evidence-based best practices to minimize clinically inactionable or false alarms.

Clinical alarm systems can alert caregivers to any problem ranging from a patient exiting their bed without assistance to dangerous arrhythmias. A valid clinical alarm correctly alerts the clinical staff to a change in the patient's physiology. Actionable alarms are those that do require intervention or attention. Invalid alarms are alarms that are neither actionable nor valid and have recently been measured to account for 85% to 99.4% of all alarms.[1] The frequency of false alarms leads to alarm fatigue. Alarm fatigue leads to increased response time, contributes to burnout, and contributes to missed actionable alarms. Beginning in 2013 and continuing through 2024, the Joint Commission's National Patient Safety Goals highlight the problems surrounding alarm fatigue by including "Reduce patient harm associated with clinical alarm systems" in their annual goals.[2] According to the Joint Commission, hospitals should be prioritizing alarm system safety and implementing changes in alarm parameters, staff training, and individualized monitor parameters.[2]

Alarm fatigue has been studied extensively, particularly from the nursing and intensive care perspective.[1] The American Association of Critical Care Nurses (AACN), for example, has researched and promoted the use of a CEASE bundle (Communication, Electrodes, Appropriateness, Setup, Education) to improve alarm management,[3] however, there is limited published research regarding implementation or long-term efficacy of this bundle. A systematic review of intelligent management interventions to reduce false alarms confirms that various strategies can improve nurse response time, but also calls for additional research to identify ways artificial intelligence can be used to improve clinical alarm systems.[4] The Association for the Advancement of Medical Instrumentation (AAMI) has also worked extensively with hospital executives, researchers, and The Joint Commission to develop strategies to improve alarm systems and reduce alarm fatigue.[5]

Despite the focus and research done by critical care and nursing organizations, there are no studies assessing the impact of these initiatives in the emergency department. There is little literature regarding false alarms, alarm fatigue, or patient outcomes in the emergency department when changes are made to alarm systems. Interventions studied have included reduction in telemetry/cardiac monitoring[6,7] and customizing alarm parameters for each patient.[8] Studies monitoring the impact of alarms and alarm fatigue in emergency medicine are also limited.[9,10]

ACEP does not have policy statements regarding alarm fatigue or reducing invalid alarms in cardiac monitoring, however, ACEP's policy statement "Protection of Physicians and other Health care Professionals from Criminal Liability for Medical Care Provided" includes the following information:

- Institution based physicians and other health care professionals should be able to rely on the integrity of institutional endorsed patient safeguards, automation, and alarm or warning systems.
- This system utilizing patient care technology should acknowledge the well validated adverse impact of "alarm fatigue" occurring in acute care settings, and develop a vendor partnered system to deliver only valid and appropriate warning alerts.

Background References
[1]Albanowski K, Burdick KJ, Bonafide CP, Kleinpell R, Schlesinger JJ. Ten Years Later, Alarm Fatigue Is Still a Safety Concern. *AACN Adv Crit Care*. 2023;34(3):189-197. doi:10.4037/aacnacc2023662
[2]Joint Commission. National Patient Safety Goals Effective January 2024 for the Hospital Program. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2024/npsg_chapter_hap_jan2024.pdf on August 6, 2024.
[3]Bosma S, Christopher R. Implementing a Unit-Based Alarm Management Bundle for Critical Care Nurses. *Crit Care Nurse*. 2023;43(2):36-45. doi:10.4037/ccn2023418
[4]Li B, Yue L, Nie H, et al. The effect of intelligent management interventions in intensive care units to reduce false alarms: An integrative review. *Int J Nurs Sci*. 2023;11(1):133-142. Published 2023 Dec 14. doi:10.1016/j.ijnss.2023.12.008
[5]Association for the Advancement of Medical Instrumentation (AAMI). Alarm Anthology. Retrieved from https://www.aami.org/anthology-alarm-management-solutions/alarm-anthology-a-robust-collection-of-knowledge on August 6, 2024.
[6]Krouss M, Israilov S, Alaiev D, et al. Tell-a provider about tele: Reducing overuse of telemetry across 10 hospitals in a safety net system. *J Hosp Med*. 2023;18(2):147-153. doi:10.1002/jhm.13030
[7]Horwood CR, Moffatt-Bruce SD, Rayo MF. Continuous Cardiac Monitoring Policy Implementation: Three-year Sustained Decrease of Hospital Resource Utilization. *Adv Health Care Manag*. 2019;18:10.1108/S1474-823120190000018007. doi:10.1108/S1474-823120190000018007
[8]Fujita LY, Choi SY. Customizing Physiologic Alarms in the Emergency Department: A Regression Discontinuity, Quality Improvement Study. *J Emerg Nurs*. 2020;46(2):188-198.e2. doi:10.1016/j.jen.2019.10.017
[9]Jämsä JO, Uutela KH, Tapper AM, Lehtonen L. Clinical alarms and alarm fatigue in a University Hospital Emergency Department-A retrospective data analysis. *Acta Anaesthesiol Scand*. 2021;65(7):979-985. doi:10.1111/aas.13824
[10]Fleischman W, Ciliberto B, Rozanski N, Parwani V, Bernstein SL. Emergency department monitor alarms rarely change clinical management: An observational study. *Am J Emerg Med*. 2020;38(6):1072-1076. doi:10.1016/j.ajem.2019.158370

ACEP Strategic Plan Reference

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

- Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Unbudgeted and unknown costs to support research on alarm fatigue. Costs will vary depending on how the resolution is implemented, such as ACEP pursuing grant funding for external research.

Prior Council Action

None

Prior Board Action

June 2022, approved the policy statement "Protection of Physicians and other Health care Professionals from Criminal Liability for Medical Care Provided."

Background Information Prepared by: Kaeli Vandertulip, MBA, MS, AHIP
Clinical Practice Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 49(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Texas College of Emergency Physicians
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Centralized Repository of Credentialing Data

PURPOSE: 1) Create a policy statement advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and 2) Work with the AMA, AOA, FSMB, TJC, AHA, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement. Working with the AMA and other organizations to create a centralized repository is not a current initiative of the College and is unbudgeted. It would require diverting staff time and resources from other initiatives to support this effort.

WHERAS, Emergency physicians are the safety net for society and our communities; and

WHERAS, Emergency physicians have always had a tradition of working at multiple facilities, often in different states or regions within states; and

WHERAS, Movement of emergency physicians between states and practice locations has been shown to increase willingness to provide additional hospital coverage and prolong the careers of emergency physicians; and

WHEREAS, The current process for granting hospital privileges to provide this coverage requires a credentialing process; and

WHEREAS, Credentialing processes are focused on providing identical “primary source verification” of relevant documents to verify the physicians identity and qualifications; and

WHEREAS, In past years doing this at each individual hospital was necessary based on 20th century concerns to prevent individuals from falsifying their credentials; and

WHEREAS, The advent of instant digital communications and electronic verifications have essentially made the established means of individual hospital verification antiquated; and

WHEREAS, Performing the exact same process repeatedly at each hospital is redundant, time consuming, and expensive; and

WHERAS, Based on 21st century protections, state licensure compacts have been established to decrease this type of burden on applicants; therefore be it

RESOLVED, That ACEP create a policy advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and be it further

RESOLVED, That ACEP work with the American Medical Association, the American Osteopathic Association, the Federation of State Medical Boards, The Joint Commission, American Hospital Association, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

Background

This resolution calls for ACEP to create a policy statement advocating for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials and work with the AMA, AOA, FSMB, TJC, AHA, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

ACEP's policy statement, "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" and the corresponding Policy Resource and Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine" contain "guidelines to assist individuals and institutions in creating application procedures for hospital medical staff appointments in the department of emergency medicine (credentialing), plus delineation of clinical privileges in emergency medicine (privileging). The policy, and the PREP, includes a list of considerations for emergency medicine credentialing as well as a sample request for emergency medicine privileges. While physician credentialing is a medical staff and hospital process, these documents emphasize the role of the ED medical director and ED in the process of determining emergency physician credentialing and delineation of clinical privileges.

The Federation of State Medical Boards has established the Federation Credentials Verification Service (FCVS) as a way for physicians to store core credentials. FCVS has created a centralized, uniform process for obtaining primary source verified, medical education information, post graduate training, and examinations to create a permanent credentials profile that can be used throughout the medical professional's career. Core credentials verified by FCVS can be used for state licensure, hospital privileges, employment and professional memberships. FCVS is accredited by the National Committee for Quality Assurance (NCQA) and meets the requirements of The Joint Commission's ten principles for a primary source verification. Currently, FCVS focuses on educational information, but does not include work history, case logs, certificates of insurance, and other materials.

The National Association of Medical Staff Services (NAMSS) has a standardized form, the "Verification of Graduate Medical Education Training Form" (VGMET). NAMSS partnered with the American Hospital Association (AHA), the Accreditation Council for Graduate Medical Education (ACGME), and the Organization of Program Director Associations (OPDA) to develop the VGMET Form to streamline the process physicians and hospitals use to verify graduate medical education training and alleviate duplications associated with this credentialing step. The VGMET Form captures all primary-sourced components of a physician's medical-education history so hospitals can confirm this information from program directors and GME programs. The concept is that a GME program would create a completed and signed form for each graduate that is then included in the trainee's file that can be used to facilitate verification when requested in the future.

Several years ago ACEP offered a service where members could upload their personal information and documents into a cloud based system. However, ACEP was not able to do direct reporting because we could not verify the materials that were uploaded. There were other competing commercial products that were able to act as repositories and ACEP's service was discontinued.

ACEP Strategic Plan Reference

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

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

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement. Working with the AMA and other organizations to create a centralized repository is not a current initiative of the College and is unbudgeted. It would require diverting staff time and resources from other initiatives to support this effort.

Prior Council Action

Resolution 20(18) Verification of Training adopted. Directed ACEP to work with various stakeholders to support the development of standardized forms and applications to create a streamlined process for hospital credentialing.

Amended Resolution 15(03) Granting Clinical Privileges adopted. The resolution directed ACEP to revise the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" to reflect that the emergency physician medical director or chief of emergency medicine, acting in a manner consistent with the hospital credentialing process, should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of the ED's physicians with respect to the clinical privileges granted to that physician.

Resolution 53(95) Managed Care – Application and Certification adopted. This resolution states ACEP believes there should be a standardized application to be used by all managed care companies, with a single completed application centrally stored and distributed to managed care companies as required, with annual updated only if pertinent changes occur and that ACEP should work with other physician organizations to promulgate this policy.

Prior Board Action

January 2024, reaffirmed the policy statement "Emergency Medicine Training, Competency and Professional Practice Principles;" reaffirmed June 2018 and April 2012; revised and approved January 2006; originally approved November 2001.

Resolution 20(18) Verification of Training adopted.

August 2017, reviewed the revised PREP "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally published June 2006.

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

Amended Resolution 15(03) Granting Clinical Privileges adopted.

Resolution 53(95) Managed Care – Application and Certification adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 50(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Communication to Established Patients Being Referred to the Emergency Department

PURPOSE: 1) Gather information to quantify the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression; 2) develop feedback and a behavioral modification campaign to physicians through both general and specialty societies; and 3) action to advocate for appropriate payor incentives and disincentives to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting staff resources from other initiatives to support this effort.

WHEREAS, The Code of Ethics of the American Medical Association, the American Osteopathic Association, and the American College of Emergency Physicians implicitly require that physicians fully communicate diagnostic, treatment and prognostic information to their patients for the conditions that they are treating them for; and

WHEREAS, It is increasingly common for patients with complex medical conditions, such as end stage cancer, to be sent to the Emergency Department (ED) with expected complications and disease progression for which their doctors have not educated, discussed, or prepared them for, placing this burden on the emergency physician; and

WHEREAS, Patients with chronic or terminal diseases should be educated on their prognosis and disease progression by their specialist in the appropriate outpatient setting; and

WHEREAS, Education by an emergency physician on prognosis and disease progression is inappropriate and consumes large amounts of time and resources in the emergency department that could be devoted to other patients; therefore be it

RESOLVED, That ACEP gather information to quantify the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so; and be it further

RESOLVED, That information quantifying the extent of the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression be used to develop feedback and a behavioral modification campaign to physicians through both general and specialty societies; and be it further

RESOLVED, That ACEP take action to advocate that appropriate payer incentives and disincentives be developed to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

Background

This resolution calls on ACEP to address the problem of patients who have terminal or end stage disease being referred to the ED by primary care physicians and specialists to be informed of the diagnosis, prognosis, and planning by studying the extent of the problem, work with other medical societies to develop a campaign to change the behavior of these referring physicians, and work with payers to develop incentives and disincentives to require physicians caring for patients with end stage or terminal diseases to educate them on prognosis and to make timely decisions about advance directives, hospice, and other palliative care.

The prevalence of chronic and behavioral health conditions is rising as the U.S. population ages and people often have multiple, complex underlying conditions. Half of adult Americans have at least one chronic condition and more than two-thirds of Medicare patients have two or more. People with complex, chronic, and behavioral health conditions contribute to higher health care costs and account for more than 90%t of the nation's $3.3 trillion in health care spending.

Hospitals, health systems and other health care workers are increasingly facing financial pressures, including decreased fee-for-service reimbursements and increased operating costs at a time when payers are driving them to take on more risk. Costs associated with chronic conditions are of particular concern for health care professionals participating in two-sided risk payment arrangements with commercial and public payers. High value networks, such as accountable care organizations (ACOs), and clinically integrated networks (CINs), for instance, must be able to provide high-quality care while efficiently managing the health care expenditures of these populations.

Patients with serious illness often have a lack of understanding of their disease process and prognosis. Patients are even sent to the ED after a life-altering critical test result without being informed of the diagnosis. Emergency physicians are often put in the situation of "breaking" the bad news to a patient they have just met. One study found that while 87% of patients with terminal cancer have documentation of a discussion with clinicians about their goals by the end of their lives, these discussions begin, on average, one month before death, and the majority take place in acute care settings with clinicians who are not the treating oncologist.[1] Literature suggests that having clear goals of care will improve quality of life, reduce hospital length of stay, ED visits, improve patient and family satisfaction, result in less utilization of intensive care, and provide significant cost savings.[2,3,4,5,6] Patients with chronic or terminal diseases should be educated on their prognosis and disease progression by their primary care physician or specialist in the appropriate outpatient setting. Education by an emergency physician on prognosis and disease progression consumes large amounts of time and resources in the emergency department that could be devoted to other patients. Conversations held by a patient's primary care team would allow better linkages to resources and ongoing care.

Per the AMA Code of Ethics, a patient has a right:

- *To courtesy, respect, dignity, and timely, responsive attention to his or her needs.*
- *To receive information from their physicians and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.*
- *To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.*

Additionally, the AMA Code of Ethics states: *The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.*

ACEP has multiple policy statements regarding the role of emergency medicine physicians such as the "Definition of Emergency Medicine" and "Emergency Physician Rights and Responsibilities." Emergency physicians are firmly committed to providing care for everyone who needs it and in emergency medicine anyone who has an emergency must be treated or stabilized, regardless of their insurance status or ability to pay. While emergency physicians are certainly capable and qualified to have these goals of care discussions when necessary; the question what roles the

emergency department should play in these conversations. The Geriatric ED Accreditation program (GEDA) guidelines state that "the provision of appropriate end-of-life care in the geriatric population is essential to a successful Geriatric ED program, and that the ED will provide access to palliative care and end-of-life care for medically complex patients in the Geriatric ED."

Background References

1. Paladino J, Bernacki R, Neville BA, et al. Evaluating an Intervention to Improve Communication Between Oncology Clinicians and Patients With Life-Limiting Cancer: A Cluster Randomized Clinical Trial of the Serious Illness Care Program. *JAMA Oncol.* 2019;5(6):801–809. doi:10.1001/jamaoncol.2019.0292
2. Beemath A, Zalenski R. Palliative emergency medicine: resuscitating comfort care? Ann Emerg Med. 2009;54: 103-105. 161. Ciemins EL, Blum L, Nunley M, et al. The economic and clinical impact of an inpatient palliative care consultation service: a multifaceted approach. J Palliat Med. 2007;10: 1347-1355.
3. Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? CMAJ. 2010;182: 563-568.
4. Grudzen CR, Richardson LD, Hopper SS, et al. Does palliative care have a future in the emergency department? Discussions with attending emergency physicians. J Pain Symptom Manage. 2012;43: 1-9.
5. Penrod J, Deb P, Luhrs C, et al. Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. J Palliat Med. 2006;9: 855-860.
6. Penrod J, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. J Palliat Med. 2010;13: 973-979.

ACEP Strategic Plan Reference

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

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting staff resources from other initiatives to support this effort

Prior Council Action

Amended Resolution 31(11) End of Life Care adopted. Directed ACEP to study how emergency medicine can positively affect end of life care, specifically addressing the provision of compassionate and dignified end of life care, and the necessary stewardship of resources; work with other appropriate entities to address patient focused, compassionate end of life care; and update the membership regarding actions being taken by ACEP on the important topic of end of life care.

Prior Board Action

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; 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."

March 2023, approved the revised policy "Guidelines for Emergency Physicians on the Interpretation of Portable Medical Orders"; originally approved April 2017 titled, "Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy (POLST)."

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

January 2021, approved the revised policy statement "Definition of Emergency Medicine;" revised and approved June 2015, April 2008, and April 2001; reaffirmed October 1998; revised April 1994 with the current title replacing "Definition of Emergency Medicine and the Emergency Physician."

April 2020, approved the revised policy statement "Ethical Issues at the End of Life;" reaffirmed April 2014; revised and approved June 2008 with the current title; originally approved September 2005 titled "Ethical Issues in Emergency Department Care at the End of Life."

Background Information Prepared by: Sam Shahid,
Director, Emergency Medicine Clinical Practice and Innovation

Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 51(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Consultant Communication and Feedback to Referring Emergency Physicians

PURPOSE: 1) Gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning ED patients and its impact on our mutual patients; and 2) Work with stakeholders and specialty societies to develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning ED patients.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting budgeted staff resources from other initiatives to support this effort.

WHEREAS, The Code of Ethics of the American Medical Association, the American Osteopathic Association, and the American College of Emergency Physicians implicitly require that physicians treat each other with courtesy and communicate information between each other for the benefit of the patient; and

WHEREAS, It seems increasingly common for specialists to not communicate their findings, decisions, recommendations, and plans to the emergency physician; and

WHEREAS, Poor communication of recommendations or plans to the emergency physician can cause dangerous delays in care that can be detrimental to both the involved patient and to the care of other patients in the emergency department; therefore be it

RESOLVED, That ACEP gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning emergency department patients and its impact on our mutual patients; and be it further

RESOLVED, That ACEP, in coordination with other stakeholders and specialty societies, develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning emergency department patients.

Background

This resolution calls for ACEP to gather information to quantify the extent of poor communication and/or untimely feedback from consultants and/or hospitalists concerning emergency department (ED) patients and its impact on our mutual patients and to work with stakeholders and specialty societies to develop a campaign to improve communication and feedback to emergency physicians from consultants and/or hospitalists concerning ED patients.

The Joint Commission identified miscommunication as a leading cause of the adverse events reported by over 22 000 health care organizations between 2010 and 2022.[1] Several frameworks exist for best practices for communicating consults.[2,3] There is also a body of literature on communication regarding results of imaging procedures.

In response to Amended Resolution 32(15) Critical Communications for ED Radiology Findings, the Emergency Medicine Practice Committee developed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings." ACEP leaders met with leaders of the American College of Radiology (ACR) in June 2016 and ACR expressed interest in a joint writing task force to address communication between radiology and emergency physicians. The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to incorporate the "Guiding Principles" into existing policy. ACR communicated its support to work with ACEP to revise the policy statement, "Interpretation of Imaging Diagnostic Studies." A draft revision was completed and reviewed by ACR. A significant concern raised by ACR was the inclusion of language addressing reimbursement for emergency physicians. ACR recommended that the language addressing reimbursement be eliminated from the policy. The Emergency Medicine Practice Committee believed the language concerning reimbursement should be retained in the policy, although it was softened to indicate any clinician providing contemporaneous interpretations is entitled to reimbursement. The ACEP Board of Directors reviewed the revised policy statement "Interpretation of Diagnostic Imaging Tests" in June 2018.

The American College of Radiology (ACR) has a practice parameter for Communication of Diagnostic Imaging Findings. The parameter states "Effective communication is a critical component of diagnostic imaging. Quality patient care can only be achieved when study results are conveyed in a timely fashion to those responsible for treatment decisions." The ACR also has a practice parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments. This parameter states "The timely interpretation of ED imaging examinations by qualified radiologists facilitates decisions regarding patient diagnosis, treatment, and the potential need for hospital admission. Radiologists should be available, either onsite or remotely via teleradiology, to provide timely interpretation of imaging examinations performed on ED patients. These interpretations are then promptly made available to the ED health care providers so they may be integrated into patient care decisions. Communication of the interpretation should be in accordance with the ACR Practice Parameter for Communication of Diagnostic Imaging Findings." ACEP does not have an analogous guidance for general consultation in the emergency department although there are several models available from other sources.

The College has not addressed feedback from consultations done in the ED beyond radiology. Feedback regarding the immediate care and recommended disposition of the patient is generally good, however, feedback on the ultimate outcome of the case is usually lacking. The one exception is when there is an adverse outcome. This lack of feedback is not true in other consultations between specialties and/or primary care. This lack of feedback, especially in admitted and transferred cases, provides an obstruction to learning and emphasizes the feedback of negative results.

ACEP has a grant with the Council of Medical Specialty Societies (S Schneider PI) to examine the feasibility of creating a feedback loop for emergency physicians. The Technical Expert Panel for this grant is beginning to grapple with basic questions such as which cases warrant feedback, the form and structure of that feedback, and whether the feedback is provided on an individual basis or group performance. The remainder of the grant is to examine the feasibility of creating a functional, efficient feedback process using our Emergency Medicine Data Institute as a prototype data repository.

ACEP's policy statement "Code of Ethics for Emergency Physicians" states:

> II.C.1. Relationships with other physicians
>
> "Emergency physicians must interact with other physicians to achieve their primary goal of benefitting patients. Channels of communication among physicians must remain open to optimize patient outcomes. Communication may, however, be delayed when a sick patient requires immediate and definitive intervention before discussion with other physicians can take place. When practical, emergency physicians should cooperate with the patient's primary care physician to provide continuity of care that satisfies the needs of the patient and minimizes burdens to other health care professionals. Emergency physicians should support the development and implementation of systems that facilitate communication with primary care physicians, consultants, caregivers, and others involved in patient care."

> "On-call physicians, like emergency physicians, are morally obligated to provide timely and appropriate emergency medical care. Emergency physicians should strive to treat consultants fairly and to make care as efficient as possible. In choosing consultants, emergency physicians may be guided by primary care physicians, patients and institutional protocols. If multiple physicians work in the ED, each patient should have clearly identified physician who is responsible for his or her care. Transfer of this responsibility should be communicated clearly to the patient, family, caregivers, and staff and should be clearly documented in the patient's medical record. When a patient is discharged from the ED, there must be a clearly communicated transfer of responsibility to the admitting inpatient physician or follow-up outpatient physician."

Background References

1. The Joint Commission on the Accreditation of Healthcare Organizations. Sentinel event data summary. n.d. Available: https://www.jointcommission.org/resources/sentinel-event/sentinel-event-data-summary/
2. Cohn SL. Communication With Consultants. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2016.
3. Kessler CS, Kalapurayil PS, Yudkowsky R, Schwartz A. Validity evidence for a new checklist evaluating consultations, the 5Cs model. Acad Med. 2012 Oct;87(10):1408-12. doi: 10.1097/ACM.0b013e3182677944. PMID: 22914527.

ACEP Strategic Plan Reference

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

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Estimated costs of $250,000 for a consultant to conduct a study and an additional $50,000 to develop an educational and behavioral modification campaign and disseminate it to other medical societies depending on the social media requirements. This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

Amended Resolution 32(15) Critical Communications for ED Radiology Findings adopted. Directed ACEP to work with the American College of Radiology to develop a joint best practice guideline regarding imaging findings that should be communicated in real-time and in a closed-loop manner by the radiologist to the emergency provider, weighing the benefit of immediate communication of critical information against the risk of excessive interruptions in provider workflow.

Prior Board Action

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; 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."

June 2018, approved the revised policy statement "Interpretation of Diagnostic Imaging Tests" revised and approved February 2013, and June 2006 with current title; reaffirmed October 2000; originally approved March 1990 titled "Interpretation of Diagnostic Studies."

April 2016, reviewed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings."

Resolution 32(15) Critical Communications for ED Radiology Findings adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 52(24)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Delegation of Critical Care to Non-Physician Practitioners

PURPOSE: Revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to include that: emergency physicians should retain primary responsibility for performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; the scope of practice for nurse practitioners and physician assistants in EDs should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians are trained extensively in the management of critical care situations, possessing specialized knowledge and skills crucial for delivering high-quality care in emergency settings; and

WHEREAS, Critical care requires a deep understanding of complex medical conditions, rapid decision-making, and the ability to manage life- threatening situations promptly and effectively; and

WHEREAS, Emergency medicine residency programs need the following minimum procedures: Adult medical and nontraumatic surgical resuscitation – 45; Adult trauma resuscitation – 35; Cardioversion/ Defibrillation/ Pacing – 6; Central venous access – 20; Chest tube insertion – 10; Procedural sedation – 15; Cricothyrotomy – 3; Dislocation reduction – 10; Endotracheal Intubation – 35; Lumbar puncture – 10; Pediatric medical and nontraumatic surgical resuscitation – 15; Pediatric trauma resuscitation – 10; Pericardiocentesis – 3; Vaginal delivery – 10; emergency department bedside ultrasound – 150[1]; and

WHEREAS, Standardized care protocols and guidelines established for critical care are essential for ensuring consistent and reliable treatment outcomes, which may not be uniformly applied or understood across different healthcare disciplines; and

WHEREAS, Nurse practitioners (NPs) and physician assistants (PAs) have had an increasing role in emergency departments; and

WHEREAS, The training pathways and scope of practice for NPs and PAs differ significantly from those of emergency medicine physicians, with potentially variable levels of experience and exposure to critical care scenarios. In addition, there is no accepted national standard for non-physician provider emergency department training[2]; and

WHEREAS, Hospital medical staff committees recommend hospital privileges for physicians and non-physician providers; and

WHEREAS, Medical staff committees require patient procedure logs, letters of recommendation, evidence of training, and so on, during the intense credentialing and privileging process for physicians, however, medical staff committees may require different training for non-physician providers who work in the emergency department and grant privileges to non-physician practitioners who are not competent or trained to perform emergency department duties; and

WHEREAS, This negligent credentialing where practitioners are granted privileges beyond their training or competence levels poses significant risks to patient safety and quality of care in critical care settings and has legal implications in almost 30 states[3,4] and, furthermore, emergency physicians and other physicians train and allow non-physician practitioners to perform critical care management and procedures[5]; therefore be it

RESOLVED, That ACEP revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department"[6] policy statement to include that:

1. Emergency physicians should retain primary responsibility for performing critical care activities within emergency departments to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; and
2. Credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; and
3. The scope of practice for nurse practitioners and physician assistants in emergency departments should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

Resolution References

1. ACGME International. Case Log Information for Emergency Medicine Programs. 2018
2. Roberta Proffitt Lavin, Tener Goodwin Veenema, Lesley Sasnett, Sarah Schneider-Firestone, Clifton P. Thornton, Denise Saenz, Sandy Cobb, Muhammad Shahid, Michelle Peacock, Mary Pat Couig. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation. Volume 12, Issue 4, 2022. Pages 50-62
3. *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007)
4. https://medicalmalpracticelawyers.com/6-1m-oklahoma-medical-malpractice-verdict-for-death- of-19-year-old-in-er/
5. Colin Campo. "Family waits for closure, wants answers about death after hospital restraint, intubation." The Courier April 4, 2023
6. ACEP. "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." Revised 2023.

Background

This resolution asks for ACEP to revise the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to address the supervision of PAs and NPs performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care patients safely and effectively.

Emergency departments (EDs), which serve patients 24 hours a day, 7 days a week, play a vital role in the U.S. health care system. With over 130 million visits each year – 14% of which result in hospitalization – millions of Americans receive care in EDs.[1] In fact, EDs contribute nearly one-half of all hospital-associated medical care in the country; more than 4 in 10 hospitalized patients enter through the ED. Often the first stop for urgent or lifesaving care, EDs have also become the "safety net of the safety net," given the role they play in providing care to the uninsured and underinsured.[2]

The ED environment is distinguished by its imperative to swiftly and efficiently manage a wide array of medical conditions, frequently under significant time constraints and with limited initial information. This setting demands a high level of adaptability and expertise from healthcare professionals, who must deploy advanced diagnostic and therapeutic skills to navigate the considerable variability in patient presentations. The complexity of cases often necessitates rapid decision-making and the ability to integrate diverse clinical knowledge to provide effective, timely care. This dynamic and high-pressure environment underscores the critical need for healthcare professionals to exhibit exceptional clinical acumen and flexibility in their approach to patient management.

While NPs, PAs, and physicians (MDs and DOs) all work in EDs, each possess distinct academic degrees and licenses, complete a different number of clinical hours of training, and have different requirements for entry into practice. Physicians complete between 10,000 – 16,000 hours of clinical education and training, four years in medical school, and another three to seven years of residency training. By comparison, NPs complete between 500–720 hours

of clinical training during two or three years of graduate-level education.

ACEP has continued to highlight the significance of physician-led health care teams in the emergency care setting. ACEP advocates for a model in which emergency physicians lead and coordinate multidisciplinary teams to ensure comprehensive and high-quality patient care. By underscoring the central role of emergency physicians in directing clinical decisions, managing complex cases, and overseeing patient care, ACEP highlights the essential nature of their leadership in optimizing outcomes. This approach not only enhances the efficiency and effectiveness of emergency care but also ensures that patients receive timely and coordinated treatment across various aspects of their care. ACEP's efforts in promoting physician-led teams reflect a commitment to advancing standards in emergency medicine and improving overall patient safety and care quality.

A recent study showed that unsupervised NPs led to unnecessary tests and procedures, and hospital admissions. Overall, the study shows that NPs increase the cost of care in the emergency department by 7%, about $66 per patient, increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%. While many other studies attempt to draw comparisons based on NPs or other nonphysicians who are actually practicing in collaborative arrangements with physicians, this study leverages data from a time—2017 to 2020, right before the pandemic—in which NPs within the Veterans Health Administration were truly practicing without physician supervision.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the medical director of the ED and the director of emergency nursing should assess staffing needs on a regular basis." It further states: "staffing patterns should accommodate the potential for unexpected arrival of additional critically ill or injured patients. A plan should exist for the provision of additional nursing, physician assistant, advanced practice registered nurse, and physician support in times of disaster, natural or man-made." The policy also states that each nurse working in the ED should "provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark."

ACEP launched a new national scope of practice campaign in correlation with National Doctors Day on March 30, 2022, Who Takes Care of You in an Emergency?, to educate people about emergency physicians' role and the vast difference in experience, education, and training compared to other members of the care team. In addition to the results of a national opinion poll on scope of practice issues, ACEP released a Chapter/Spokesperson toolkit with talking points, media materials (including a template op-ed), sample social media, and infographics. A series of videos were also created to better explain the vital role of emergency physicians.

Background References

1. Cairns, Christopher and Kang, Kai (2022). National Hospital Ambulatory Medical Care Survey: 2020 Emergency Department Summary Tables.
2. Institute of Medicine (US). Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary. Washington (DC): National Academies Press (US); 2008. PMID: 21391346
3. Chan, D. and Chen, Y. (2022) The Productivity of Professions: Evidence from the Emergency Department. National Bureau of Economic Research, Working Paper 3060

ACEP Strategic Plan Reference

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

- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work

with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and continue to promote the gold standard for physicians working in an ED is a board-certified/board-eligible emergency physician certified by the ABEM, AOBEM, or certified by the ABP in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

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

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

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

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2012, reviewed the information paper, "Physician Assistants and Nurse Practitioners in Emergency Medicine." The information paper was posted on the ACEP website.

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. NCCPA advised they would contact the workgroup representatives regarding next steps, however, there was no further contact from NCCPA about the program.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

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

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 53(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Nursing and Emergency Department Accreditation

PURPOSE: Collaborate with relevant organizations to modify the requirements for emergency nursing in the ED accreditation criteria.

FISCAL IMPACT: Budgeted staff resources for administration of the ED Accreditation Program and staffing support to the ED Accreditation Program Board of Governors. Delay in implementation of the ED accreditation program would result in lost revenue.

WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and Resource Guidelines" states that "Appropriately educated and qualified emergency physicians, NPs, PAs, registered nurses and ancillary staff should staff the ED during all hours of operation"[1]; and

WHEREAS, The April 2021 ACEP-approved policy statement "Emergency Department Planning and Resource Guidelines" states that "Each nurse working in the ED should: Provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark. Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice"[1]; and

WHEREAS, The April 2022 ACEP-approved policy statement "Emergency Department Nurse Staffing" states that "The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of emergency nursing"[2]; and

WHEREAS, The January 2024 ACEP-approved policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine" states that "The American College of Emergency Physicians supports the efforts of the Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN) regarding defining standards of emergency nursing care and the provision of resources, support, and incentives for emergency nurses to be able to readily attain Certified Emergency Nurses (CEN) certification"[3]; and

WHEREAS, In April 2024, ACEP released its Emergency Department Accreditation Criteria, modeled after the successes of ACEP's Geriatric ED Accreditation (GEDA) Program, which argued that a "...tiered system aims to allow any ED to obtain at least a level 3 accreditation easily, while Level 1 and 2 sites involve more significant investments and demonstrate a true commitment to excellent geriatric care. Thus, access to accreditation is appealing to a range of sites, from small, rural hospitals to tertiary care academic centers. Accreditation can add value to all of them.[4]"; and

WHEREAS, The ACEP Emergency Department Accreditation Criteria notes that this accreditation process "will allow the public to find and utilize those facilities with the best staffing to handle any emergency" and also "ensures that staff work in an environment that best supports their practice[4]"; and

WHEREAS, Despite the above support for emergency nursing, there are no requirements related to emergency nursing in the ACEP ED accreditation pathway; therefore, be it

RESOLVED, That ACEP collaborate with relevant organizations to amend and include requirements for emergency nursing within the tiered levels of the ACEP ED accreditation pathway.

Resolution References

1. https://www.acep.org/siteassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-department-nurse-staffing/
3. https://www.acep.org/siteassets/new-pdfs/policy-statements/advocating-for-certified-emergency-nurses-cens-in-departments-of-emergency-medicine.pdf
4. https://www.acep.org/siteassets/sites/edap/media/documents/ed-accreditation-criteria.pdf

Background

The resolution asks for the College to collaborate with relevant organizations to modify the requirements for emergency nursing in the ED accreditation criteria.

ACEP's ED Accreditation Program will help improve patient care and promote fair, productive, and safe working environments for emergency physicians and other members of the emergency care team through the implementation of evidence-based policies and practices across all practice settings and all staffing models. The overall goal of ED accreditation is to elevate the practice of emergency medicine and the role of emergency physicians in leading the ED health care team. The accreditation criteria was developed based on ACEP's policies and the current accreditation criteria have been in development for several years. The criteria have been proposed by emergency physicians, written, and re-written by emergency physicians, and represent the values and desires of emergency physicians for their workplace. Most importantly, this program highlights staffing with board-certified emergency physicians and the importance of physician-led teams and recognizes the critical role of other clinicians and the need for resources to ensure that every patient receives the best possible care.

There were discussions with the Emergency Nurses Association (ENA) early in the development of the ED accreditation program about participating in the process. ENA declined to participate after exchanges about ACEP's goals for the program and the commitment to physician-led teams.

The initial ED accreditation criteria and levels were approved by the ACEP Board of Directors in March 2024 and a pilot application process was initiated. The ED Accreditation Board of Governors oversees the standards for each tier of ED Accreditation. The program has begun accepting pilot applications, with early pilot sites able to provide feedback of suggested improvements for future consideration.

ENA sent a letter to its members and issued a statement shortly after the public release of the criteria urging ACEP to delay the roll out of the program. ACEP was not contacted by ENA about their concerns prior to these actions. According to Becker's Healthcare, "the Emergency Nurses Association said the accreditation program does not recognize the vital role emergency nurses, nurse practitioners and advanced practice nurses play in successfully operating an ED." An additional concern raised by the ENA is that "the program does not allow nurse practitioners to work to their full scope of practice."

ACEP leaders and the ED Accreditation Board of Governors have held several meetings with ENA leadership since the concerns were expressed. ACEP strives to continue the dialogue with ENA about how to incorporate nursing criteria. ENA has stated that part of their public policy agenda is to support efforts to allow Advanced Practice Registered Nurses (APRNS) to practice autonomously and independently prescribe medication. Additionally, ENA will support public policies that remove restrictions on the role and scope of practice of Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs) in appropriate health care settings. ENA will support efforts to allow these professionals to practice to the full extent of their education and training. The current ED accreditation criteria adheres to Council resolutions and ACEP policy statements that have been adopted addressing the need for supervision of nurse practitioners and physician assistants.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted staff resources for administration of the ED Accreditation Program and staffing support to the ED Accreditation Program Board of Governors. Delay in implementation of the ED accreditation program would result in lost revenue.

Prior Council Action

Amended Resolution 42(23) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and continue to promote that the gold standard for those physicians working in an ED is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Prior Board Action-

April 2024 approved the revised ED Accreditation Program Criteria, with the "Blue Ribbon Recognition" approved only in "concept."

January 2024 approved the revised ED Accreditation Program Criteria; originally approved October 2023.

Amended Resolution 42(23) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

October 2023 approved the ED Accreditation Program Criteria.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse

Practitioners in the Emergency Department;" revised and approved March 2022 and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing two policy statements. "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

February 2023 approved establishing an ED Accreditation Program based on the business plan. Also approved the preliminary criteria and tiers for the accreditation program.

January 2023, agreed to proceed with adoption and execution of an accreditation program for Emergency Departments (ED's).

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

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

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

Background Information Prepared by: Nicole Tidwell
Senior Accreditation Program Manager

Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 54(24)

SUBMITTED BY: New York Chapter

SUBJECT: Mandated Public Health Screening

PURPOSE: Work with relevant stakeholders to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department and develop a policy statement noting that mandating the ED to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the ED may have unintended consequences on workflow and care of ED patients.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, HIV, tobacco, and hepatitis screening and testing is being required in some states emergency departments (ED) for all patients; and

WHEREAS, EDs are already overcrowded and serving as a safety net for the health care system; and

WHEREAS, These mandates do not come with additional funding or resources for already struggling EDs; therefore be it

RESOLVED, That ACEP work with relevant stakeholders, including departments of health, to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department; and be it further

RESOLVED, That ACEP develop a policy statement noting that mandating the emergency department to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department may have unintended consequences on workflow and care of emergency department patients.

Background

This resolution requests the College to work with relevant stakeholders to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department and develop a policy statement noting that mandating the ED to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department may have unintended consequences on workflow and care of ED patients.

With recent policy changes, including the movement toward accountable care organizations as health delivery systems, there has been an increasing priority placed on both screening for social risk factors, (defined as the “adverse social conditions that are associated with poor health”) and assessing social needs, or the patient’s prioritization of social interventions. Although emergency department (ED) patient populations have a high prevalence of social risk, optimal strategies for identifying these factors within the busy and time-limited setting of the ED have yet to be described. The Joint Commission and other regulatory entities require that patients be assessed during an ED visit for a variety of high-risk situations (e.g., suicidal ideation, physical/sexual abuse, intimate partner violence [IPV]). Regulatory entities do not dictate when during the visit these assessments must occur, only that they must occur. To meet these regulatory assessment requirements, the temptation is to add them to the triage process, precisely because every patient is triaged, although these questions may not add to the assignation of an accurate acuity level. Risk assessment for social determinants of health and associated comorbidities such as mental health status, self-harm behaviors, and various types of abuse is often conducted during triage, yet the evidence is absent regarding whether

querying patients during the triage process is the most effective approach to identify at-risk patients. Required screenings and assessments may overburden the triage encounter, lengthening the process and delaying rapid assessment of patients in the triage queue.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians treat more than 25% of all acute care in the U.S. with more than 50% of that for the uninsured. Additionally, EDs are often referred to as society's "safety net," leading some to define the ED as a de facto environment for incorporating social context into patient care. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. Others believe that taking on a SDH perspective could overburden already overwhelmed EDs and that it would interfere with the ED's primary mission of caring for acute medical issues, while others rebuttal that without treating patients adequately (to include SDH) patients will likely continue to return. Additionally, the added costs, lack of available follow-up services, and the potential impact on ED throughput. One study looking at the feasibility of incorporating a SDH screening process within an ED found that while they were able to demonstrate the ability to systematically screen and refer for needs, ensuring buy-in from staff conducting the screening was critical as well as ensuring that there were available resources within the community.

ACEP's policy statement "Screening for Disease and Risk Factors in the Emergency Department" states:

> "…ACEP recommends that EDs strongly consider screening for disease and risk factors based on the following criteria:
> - Screening should only occur if there is sufficient capacity, such that primary ED functions (treating emergency conditions) are not delayed, and key quality metrics are largely unaffected.
> - Screening processes should be developed to work within ED workflow and minimize impact on patients and ED staff.
> - Screening with inadequate or inappropriate follow-up systems available for the targeted disease or risk factor may lead to unintentional harm.
> - Screening should be performed in a manner that is financially sustainable to patients and the health system."

A supporting Policy Resource & Education Paper (PREP) "Principles of Screening for Disease and Health Risk Factors in the Emergency Department," which is an adjunct to the policy statement, was published in *Annals of Emergency Medicine*.

ACEP's policy statement "Social Services and Care Coordination in the Emergency Department" states: "ACEP recognizes the impact of health-related social needs (HRSN).…ACEP further recognizes that comprehensively addressing HRSN within the ED is best accomplished by dedicated staff, such as social workers, case managers, patient navigators, and other individuals with specialized training in social services delivery. Social service professionals are more experienced and better equipped than medical staff to coordinate outpatient follow-up care and social support services."

ACEP's policy statement ""Screening Questions at Triage," which is a joint policy statement with the Emergency Nurses Association, states:

> "Delays can occur when regulatory questions are routinely asked of patients during initial triage. Although screening for active thoughts of harm to self or others, substance use/abuse, and interpersonal violence can provide important information about the care some patients may require, the routine inclusion of general screening questions in the initial triage process creates a preventable delay in caring for patients. Screening information should be obtained after the initial prioritization process is complete and should not interfere with timely access to needed care."
>
> "The American College of Emergency Physicians and the Emergency Nurses Association support initial triage processes that limit the focus and content of questions to information pertinent to the patient's condition to determine the priority in which patients should be seen by an emergency physician, PA, or NP."

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted. Directed ACEP to support evaluation of social determinants of health in the emergency department and advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Amended Resolution 46(14) Triage Screening Questions adopted. Directed ACEP to create a practice resource that identifies best practice triage processes.

Prior Board Action

October 2023, approved the revised policy statement "Social Services and Care Coordination in the Emergency Department;" revised and approved October 2020 titled "Social Work and Case Management in the Emergency Department;" revised and approved April 2019; originally approved October 2007 titled "Patient Support Services."

April 2022, approved the revised policy statement "Screening Questions at Triage;" originally approved October 2016.

April 2021 approved the policy statement "Screening for Disease and Risk Factors in the Emergency Department."

Amended Resolution 46(14) Triage Screening Questions adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 55(24)

SUBMITTED BY: New York Chapter

SUBJECT: Patient Experience Reporting

PURPOSE: Work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and revise ACEP's "Patient Experience of Care" policy statement to advocate for mean score rather than percentile scores.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements and ongoing advocacy initiatives.

WHEREAS, ACEP has recognized that patient experience of care surveys can be reflective of the patient's perception of their health experience; and

WHEREAS, ACEP has noted survey issues include variable inclusion/ exclusion criteria, lack of standardization, small sample sizes, and exclusion of the most acutely ill patients where emergency physicians appropriate devote a disproportionate amount of time; and

WHEREAS, Factors leading to poor scores including wait times are often extrinsic to ED operations and outside the control of ED staff; and

WHEREAS, ACEP has issued a policy statement on appropriate sampling; and

WHEREAS, Small variations in mean score can lead to drastic fluctuations in percentile ranking; and

WHEREAS, Mean scores are typically much higher and a better representation of a department's performance than a more variable percentile ranking; therefore be it

RESOLVED, That ACEP work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score; and be it further

RESOVLED, ACEP revise the "Patient Experience of Care Surveys" policy statement to advocate for mean score to be the reporting metric rather than percentile scores.

Background

This resolution calls for ACEP to work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and to revise the "Patient Experience of Care Surveys" policy to advocate for mean score rather than percentile. The current language of the policy statement includes the following language that aligns with the intent of the resolution to move away from percentiles.

> "Patient experience scores whether attributed to an individual physician, other elements of the department, or the entire ED must be criterion-referenced. The standard to which it is compared must be previously determined and applicable to similar institutions in similar settings. The use of rank ordered percentiles must be abandoned, given irrelevant meaning of such comparative positioning."

The 2023 Council and the Board of Directors adopted Amended Resolution 51(23) Quality Measures and Patient Experience Scores:

> RESOLVED, That ACEP advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; and be it further
>
> RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and be it further
>
> RESOLVED, That ACEP work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

The resolution was assigned to the Emergency Medicine Practice Committee to revise the policy statement "Patient Experience of Care Surveys" to reflect the intent of Amended Resolution 51(23). The committee is still working on the revisions to the policy statement. Additionally, the Advocacy and Practice Affairs staff in Washington, DC, have been addressing the issue at the federal and regulatory levels.

In the past, and with input from ACEP members, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. The program was introduced by CMS in the mid-2000s as part of the overall shift of healthcare from a fee-for-service to a pay-for-performance model. The program was designed to assess the experiences of adult ED patients who were subsequently discharged home. Importantly, acutely ill or injured patients who are admitted to the hospital are typically excluded. ACEP members were appointed to the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. Even in its revised format, it was 24 questions long with an additional 11 demographic questions. CMS decided to not make the ED CAHPS survey mandatory. The current ACEP policy defines standardized inclusion and exclusion criteria for the patient populations and define improved methodologies.

In response to Amended Resolution 55(21) Patient Experience Scores, ACEP included specific recommendations about modifying the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) survey along with the ED CAHPS survey in response to the Calendar Year (CY) 2023 Physician Fee Schedule proposed rule. Specifically, ACEP cautioned CMS that most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution. We further urged CMS that we believe the patient engagement module ACEP offers for all participants of our qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR) is superior to ED CAHPS and advocated that we believe strongly that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

Hospitals and survey vendors may sample or receive responses from a small percentage of the patients seen in the emergency department (ED) potentially leading to results with poor validity. Currently, CMS states the minimum number is 30, and recommend 50, however that standard is not applied uniformly by physician groups and hospitals when they act on these scores. Press Ganey reports a response rate of 16.5%.

It should be noted that the use of patient experience scores during the pandemic had greater detrimental effect. It is widely known that boarding and crowding affect patient experience scores, particularly when they include the question "Did you receive timely care?"[1]

A 2013 JAMA study comparing CAHPS data and mortality, found that higher patient satisfaction was associated with lower emergency department utilization, higher inpatient utilization, greater total health care expenditures, and higher expenditures on prescription drugs. The most satisfied patients also had statistically significantly greater mortality risk compared with the least satisfied patients.[2]

Background References

1. Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. Acad Emerg Med. 2008 Sep;15(9):825-31.

2. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality. Arch Intern Med. 2012;172(5):405–411. doi:10.1001/archinternmed.2011.1662

ACEP Strategic Plan Reference

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

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

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements and ongoing advocacy initiatives.

Prior Council Action

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted. Directed ACEP to advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy; define standardized inclusion and exclusion criteria for patient experience survey populations; define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

March 2024, February 2023, and January 2022, approved legislative and regulatory priorities that include advocating for patient experience validity and working with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted.

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016 with the current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 56(24)

SUBMITTED BY: New York Chapter

SUBJECT: Patient and Visitor Code of Conduct

PURPOSE: Develop and adopt a universal code of conduct for patients and visitors in the emergency department.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The provisions of EMTALA apply to all individuals who attempt to gain access to a hospital for emergency care; and

WHEREAS, All patients deserve to be cared for with dignity in a safe environment; and

WHEREAS, Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing are not welcome in any workplace; and

WHEREAS, Workplace violence is a continued threat in all of our ED's and the top concern of most emergency physicians; and

WHEREAS, The safety and wellbeing of emergency physicians is a priority for ACEP; and

WHEREAS, Some hospitals have already adopted a patient code of conduct; therefore be it

RESOLVED, That ACEP develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Background

This resolution calls for ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Violence in the emergency department is unacceptable. ACEP is working to strengthen protections for physicians, care teams and patients by increasing public awareness, advocating for policy changes, and developing resources to help professionals mitigate and respond to these incidents.

According to a January 2024 poll of ACEP members, 91% of emergency physicians said that they, or a colleague, were a victim of violence in the past year. In a 2022 ACEP survey, 85% of emergency physicians said they believe the rate of violence experienced in emergency departments has increased over the past five years.

The Board of Directors adopted the new policy statement in "Emergency Department Patient Rights and Responsibilities" in January 2024. The policy is a "Bill of Rights" that applies to every ED patient and also includes patient responsibilities:

- act with courtesy and respect to staff, patients, and visitors
- participate in communication and decision making
- comply with reasonable medical care and perform self-care
- respect other patients' privacy and confidentiality

- respect boundaries set for safety by staff
- be respectful and considerate of other patients, staff, and property
- never exhibit threatening, violent, abusive, or discriminatory speech or behavior"

ACEP's "Code of Ethics for Emergency Physicians" states: "Hospitals have a duty to provide adequate numbers of trained security personnel to assure a safe environment. Ensuring safety may mean that patients who present a high risk of violence will lose some autonomy if they need to be restrained physically or chemically."

ACEP's advocacy initiatives continue to support protecting emergency physicians from ED violence. Emergency physicians' support has led to the introduction of the "Workplace Violence Prevention Act for Health Care and Social Service Workers," H.R. 2663/S.1176), a bill introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI) that calls on the Occupational Safety and Health Administration (OSHA) to require health care and social service employers to create and implement workplace violence prevention plans.

ACEP also strongly supports the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) introduced by Reps. Larry Bucshon (R-IN) and Madeleine Dean (D-PA), and Sens. Joe Manchin (D-WV) and Marco Rubio (R-FL). The SAVE Act establishes federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP's letter of support can be found here. ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA) on January 30, 2024. Another congressional briefing was held on March 22, 2024, and co-hosted with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA).

ACEP and the Emergency Nurses Association have partnered since 2018 on the No Silence on ED Violence campaign to raise awareness, advocate for policy changes and strengthen protections for frontline workers. Emergency physicians can advocate within their own workplace using ACEP's sample checklist of safety and violence prevention measures that they can ask their workplace about to understand which are in place.

In early 2022, The Joint Commission established and began enforcing new workplace violence prevention requirements to guide hospitals in developing strong workplace violence prevention programs. ACEP contributed to the development of these new requirements by participating in an expert workgroup and supplying comments.

Many health systems have Patient Rights and Responsibilities. Some examples include:

- Texas Health Resources (TX) "Aggressive behavior will not be tolerated. Examples of aggressive behavior includes physical assault, verbal harassment, abusive language and threats."

- St. Elizabeth Healthcare (KY) "Aggressive language or violent behavior will not be tolerated on hospital grounds." "There is a zero tolerance of all forms of aggression. In accordance with Kentucky law, these types of incidents may result in removal from this facility, potential arrest and prosecution. St. Elizabeth Healthcare fully supports associates reporting to law enforcement aggressive or violent behavior they encounter on hospital premises."

- Inova (VA) "… zero tolerance for inappropriate language or behavior that is aggressive, disruptive or threatening. This allows us to ensure a safe and positive healing environment for everyone at our care sites."

- WellSpan (PA) "As a patient, family member or health care representative, we expect that you: recognize and respect the rights of other patients, families and staff. Any threatening, violent or harassing behavior exhibited toward other patients, visitors and/or care location staff for any reason,…"

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 34(22) Emergency Department Safety adopted. Directed ACEP to work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state, and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. The resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against health care providers, advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

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

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. It directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

March 2024, approved the legislative and regulatory priorities for the 2nd session of the 118th Congress that includes continuing to advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

January 2024, approved the policy "Emergency Department Patient Rights and Responsibilities."

October 2023, approved the revised policy "Code of Ethics for Emergency Physicians"; revised and approved January 2017; revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved June 1997 with the current title; originally approved January 1991 titled "Ethics Manual."

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

Resolution 34(22) Emergency Department Safety adopted.

June 2022, approved revised policy "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved April 2016 and June 2011 with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 57(24)

SUBMITTED BY: Marco Coppola, DO, FACEP
Robert Suter, DO, FACEP
Locums Tenens Emergency Medicine Section
Wellness Section

SUBJECT: Rationalizing Communication of Imaging Hazards to Improve Care

PURPOSE: 1) Create a task force, in conjunction with the American College of Radiology and other stakeholders to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients; and 2) provide information to hospital imaging departments and Chief Medical Officers to update their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

FISCAL IMPACT: Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

WHEREAS, Imaging is necessary for the practice of emergency medicine and the care of emergency patients; and

WHEREAS, There are certain known risks to imaging modalities, including radiation, and contrast reactions; and

WHEREAS, Much has been learned over the decades about the actual risks associated with specific types of imaging and the types of reactions to contrast dye, which has evolved in terms of its safety; and

WHEREAS, The National Institute of Health advises that in pregnant patients there is zero radiation risk to fetuses when the imaging beam is not pointed the uterus; and

WHEREAS, The risk of radiation to patients varies based upon the type of imaging and the age of the patient with CT scans being the highest risk; and

WHEREAS, The concept of "contrast allergy" is based upon reactions to iodinated contrast that is no longer used in the United States; and

WHEREAS, Reactions to other forms of imaging contrast are believed by most experts to be idiosyncratic and unpredictable; and

WHEREAS, Nephrotoxicity from imaging contrast has improved over time with the development of better contrast agents;

WHEREAS, A number of large studies show nephrotoxicity from imaging is now minimal; and

WHEREAS, Emergency physicians must frequently make decisions that balance risks and benefits of imaging with potentially immediately life-threatening diagnoses that are otherwise difficult to diagnose; and

WHEREAS, Radiology policies and procedures in many hospitals are designed for routine outpatients receiving these studies and not specifically focused on the lifesaving benefits of imaging for emergency patients; and

WHEREAS, It is not unusual for radiology personnel following hospital policies and protocols to frighten Emergency Department (ED) patients, especially pregnant ones, by overstating the risks of imaging or contrast as we now understand them to patients and families; and

WHEREAS, This creates distrust and otherwise very difficult situations for emergency physicians, placing a barrier between them and their patients; and

WHEREAS, This is not conducive to good patient care and the identification of life-threatening emergencies to facilitate proper disposition and treatment; therefore be it

RESOLVED, That ACEP create a task force, ideally in conjunction with the American College of Radiology and other stakeholders, to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients; and be it further

RESOLVED, That information be transmitted to hospital imaging departments and Chief Medical Officers for the purpose of updating their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

Background

This resolution seeks for the College to create a task force in conjunction with the American College of Radiology and other stakeholders to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients. Additionally, the resolution requests that information be transmitted to hospital imaging departments and Chief Medical Officers for the purpose of updating their imaging and patient communication and consent policies to be consistent with the findings in a policy statement or other resource information developed by ACEP, the American College of Radiology, and other stakeholders.

Diagnostic imaging has revolutionized the practice of medicine and is essential in emergency medicine, though it carries risks such as radiation exposure and contrast reactions. Patient safety has improved over time as knowledge of the risks has evolved. For example, the National Institutes of Health states that when imaging beams are not directed at the uterus, there is no radiation risk to fetuses. Risks vary by imaging type with CT scans having the highest risk. Reactions to contrast agents are generally unpredictable but have become less severe with improved agents. Despite these advancements, radiology policies often focus on routine outpatient care rather than the urgent needs of emergency patients, which can lead to overstated risk warnings that can create distrust and complicate patient care in the ED.

The refusal of imaging studies in emergency departments (EDs) is a notable issue but can vary widely depending on several factors, including patient demographics, medical conditions, and institutional practices. Precise statistics on the percentage of patients who refuse imaging studies specifically are not universally available, however:

- Refusal rates for imaging in the ED can range from 1% to 10% of patients, depending on the study and context. Factors influencing refusal include the patient's understanding of the need for imaging, perceived severity of their condition, concerns about radiation exposure, and financial constraints.

- Studies have shown that refusal rates can be higher among certain groups, such as those with lower health literacy, non-English speakers, or individuals with a history of distrust in the healthcare system. Additionally, patients who are anxious or have high levels of pain may be more likely to refuse imaging.

- When patients refuse recommended imaging, it can impact diagnostic accuracy and potentially lead to missed diagnoses or delayed treatment. In some cases, refusal may be due to concerns about radiation or the cost of procedures, highlighting the need for effective communication and education by healthcare providers.

- The refusal rate can also vary by institution and is influenced by the ED's protocols, the approach of the medical staff in explaining the need for imaging, and the availability of alternative diagnostic methods.

Overall, while specific statistics can vary, understanding the reasons behind imaging refusal and addressing patient concerns through clear communication and education can help improve compliance and patient outcomes in the ED setting.

ACEP has participated in and supported various efforts regarding imaging practice targeted at both physicians and patients during the past year. ACEP was a supporting organization for the Image Wisely and Image Gently campaigns, attended and participated in multiple American College of Radiology (ACR) Summits, and National Council on Radiation Protection and Measurements workshops. ACEP continues to partner with ACR on the development of their Appropriateness Criteria and has developed multiple policy statements related to the use of imaging, such as:

- "Emergency Ultrasound Imaging Criteria Compendium"
- "Optimizing Advanced Imaging of the Pediatric Patient in the Emergency Department"
- "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine"

A complete list of ACEP's imaging policy statements can be found on the ACEP website.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work

Prior Council Action

Substitute Resolution 27(12) Radiation Exposure in the Emergency Department Patient adopted. Directed ACEP to work with appropriate stakeholders to promulgate techniques to minimize radiation exposure.

Prior Board Action

Substitute Resolution 27(12) Radiation Exposure in the Emergency Department Patient adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 58(24)

SUBMITTED BY: Rita Manfredi-Shutler, MD, FACEP
Kristen Nordenholz, MD, FACEP
Matthew Siket, MD, FACEP
Alexandra Thran, MD, FACEP
Vermont Chapter

SUBJECT: Reducing Waste in Our Emergency Departments

PURPOSE: 1) Encourage and support comprehensive research efforts to facilitate data collection of the measurements of ED waste and energy consumption; 2) Work with stakeholders to decrease energy consumption and decrease the amount of hospital waste; and 3) Support research to decrease waste in the health care sector.

FISCAL IMPACT: Budgeted committee and staff resources to update ACEP's "Impact of Climate Change on Public Health and Implications for Emergency Medicine" policy statement. Unbudgeted staff resources and unbudgeted and unknown costs to work with stakeholders to decrease energy consumption and hospital waste and support research to decrease waste in the health care sector.

WHEREAS, The health care sector especially in developed countries produce significant amounts of multiple types of waste[1]; and

WHEREAS, The total amount of waste generated by health-care activities, about 85% is general, non-hazardous and 15% is considered hazardous material that may be infectious, toxic or radioactive[1];

WHEREAS, Evidence-based interventions are crucial for effective response and preparedness in the face of climate change-induced health challenges [2];and

WHEREAS, CMS has developed the CMS Innovation Center, a voluntary Decarbonization and Resilience Initiative which is designed to address threats posed by climate change to the nation's health and health care system by collecting, monitoring, assessing, and addressing hospital carbon emissions and their effects on health outcomes, costs, and quality[3]; therefore be it

RESOLVED, That ACEP wholeheartedly encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and be it further

RESOLVED, That ACEP work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste; and be it further

RESOLVED, That ACEP work to support research to decrease waste in the health care sector.

References

1. World Health Organization. (n.d.). *Health-Care Waste*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/health-care-waste
2. Knowlton K, Rotkin-Ellman M, King G, et al. The 2006 California heat wave: impacts on hospitalizations and emergency department visits. Environ Health Perspect. doi:10.1016/S0140-6736(06)68933-2
3. Centers for Disease Control and Prevention. (2024a, June 11). *NAMCS/NHAMCS - Ambulatory Health Care Data Homepage*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ahcd/index.htm

Background

This resolutions directs ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; 2) work with stakeholders, such as hospital administrations to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics and non-recycled glass, as well as biohazard/medical waste; and 3) support research to decrease waste in the health care sector.

The health care sector has a large supply chain that generates huge amounts of waste, uses enormous amounts of chemicals and pharmaceuticals, and demands significant food production and disposal, all of which contribute to pollution. According to *The Lancet*, climate change is the biggest public health threat of the 21st century and hospitals in the United States generate a total of 14,000 tons of waste per day, 20% to 25% of which is plastic products or packaging. The health care sector's supply chain is the second largest expense in health care after labor and is a significant contributor to waste and pollution. The health care sector is also the single largest consumer of chemicals in the United States, spending more than twice the amount spent by the next-largest-consuming sector, and is also the largest consumer of pharmaceuticals worldwide.

Emergency departments (EDs) produce various types of waste due to the nature of their operations. The main types of waste generated include:

- Medical Waste: includes items that have been in contact with bodily fluids or are considered hazardous such as sharps, infectious waste, and pathological waste/
- Chemical Waste: includes unused or expired pharmaceuticals, chemicals used in diagnostic tests or treatments, and cleaning agents.
- Hazardous Waste: encompasses any waste that poses a risk to health or the environment, such as some chemical agents or certain types of batteries.
- General Waste: non-hazardous, non-recyclable waste, including packaging materials and food waste.
- Recyclable Waste: items that can be sorted for recycling, such as paper, cardboard, and certain plastics. Efforts to increase recycling in EDs can help reduce overall waste.
- Electronic Waste: discarded or obsolete electronic equipment, including old monitors, computers, and medical devices.

"Climate Smart Healthcare" is a term defined in the 2017 joint report by the World Bank Group and Health Care Without Harm, referring to the combination of low-carbon and resilient health care strategies. Key features of climate-smart health care include waste minimization and sustainable waste management; low-carbon procurement policies for products, supplies, and pharmaceuticals; energy and water efficiency; sustainable transportation policies; and resilience strategies to withstand extreme weather events.

Transitioning to renewable energy, reducing fossil fuel use, and cutting greenhouse gas emissions offer immediate health and environmental benefits. Climate smart healthcare can be both environmentally protective and economically advantageous, potentially saving U.S. hospitals nearly $1 billion over five years through energy efficiency improvements. Additionally, implementing waste reduction and operational efficiency measures could save more than $5.4 billion in five years and $15 billion in ten years for the entire U.S. health care sector. Resilience strategies are crucial for withstanding extreme weather events that can disrupt hospital infrastructure, supply chains, and essential services. Health leaders can ensure operational continuity during crises and preserve financial stability by committing to climate resilience.

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022. The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.

ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" states:

"ACEP supports collaborating with public health agencies and other stakeholders to:

- Raise awareness of the short- and long-term implications of climate change in population health and its effect in the practice of emergency medicine.
- Engage in research examining the effects of climate change on human health, health care systems, and public health infrastructure.
- Advocate for policies and practices to mitigate and address the effects of climate change on human health, health care systems, and public health infrastructure.
- Expand and improve upon regional surveillance systems of emerging diseases related to extreme weather events linked to climate change.
- Advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling.
- Educate patients on appropriate precautions in extreme weather, avoidance of exacerbation triggers, early identification of exacerbations, and temporizing measures when needed."

The Public Health Committee, in partnership with the Ethics Committee, is currently reviewing and revising this policy statement and will be developing a Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee and staff resources to update ACEP's "Impact of Climate Change on Public Health and Implications for Emergency Medicine" policy statement. Unbudgeted staff resources and unbudgeted and unknown costs to work with stakeholders to decrease energy consumption and hospital waste and support research to decrease waste in the health care sector.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to 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.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 59(24)

SUBMITTED BY: Tabitha Baca, MD
Marc Futernick, MD, FACEP
Gayle Galletta, MD, FACEP
Rita Manfredi-Shutler, MD, FACEP
Dana Mathew, DO, FACEP
Scott Mueller, DO, FACEP
Kristen Nordenholz, MD, FACEP
Matthew Siket, MD, FACEP
David Terca, MD, FACEP
Kreager Taber (MS4)
Alexandra Thran, MD, FACEP
California Chapter
Vermont Chapter

SUBJECT: Tap Water is Sufficient Treatment

PURPOSE: 1) Advocate to health care administrators in the U.S. to adopt the use of hospital tap water for wound irrigation; 2) Emphasize the importance of research and education within the emergency medicine community on the safety, efficacy, and potential cost savings of using hospital tap water for wound irrigation; and 3) Urge U.S. policymakers and health care administrators to support initiatives, such as the use of hospital tap water for wound irrigation, that contribute to broader global efforts to enhance environmental sustainability and combat climate change in health care by decreasing the carbon footprint of EDs.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The impacts of climate change on human health necessitate urgent action to mitigate its effects, including reducing the carbon footprint of health care facilities[1]; and

WHEREAS, The significant public health and environmental damage caused by health care pollution in the United States, urging the adoption of sustainable practices[2]; and

WHEREAS, The efficacy of tap water compared to sterile saline in the United States, for wound irrigation, resulting in potential cost savings[3]; and

WHEREAS, 12.2 to 14.1 million people present to the ED for wound management, and assuming each one uses one bottle for irrigation, that would be 12.2 to 14.1 million bottles of plastic annually saved[4,5]; and

WHEREAS, Endorsing the use of tap water, in the U.S., instead of sterile saline solutions, emergency physicians can contribute to significant cost savings, reduce the carbon footprint of emergency departments, and advance efforts to mitigate climate change, all while maintaining high standards of patient care; and

WHEREAS, There are significant financial strains on health care systems and the need for cost-effective solutions; and

WHEREAS, There are significant environmental implications of medical waste and resource consumption[6]; therefore be it

RESOLVED, That ACEP advocate to transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change; and be further

RESOLVED, That ACEP emphasize the importance of research and education within the emergency medicine community, and to raise awareness of the financial and environmental benefits of tap water for wound irrigation in the United States highlighting its safety, efficacy, and potential for cost savings; and it further

RESOLVED, That ACEP urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Resolution References

1. Haines A, Kovats RS, Campbell-Lendrum D, Corvalán C. Climate change and human health: impacts, vulnerability, and mitigation. Lancet. 2006;367(9528):2101-2109. doi:10.1016/S0140-6736(06)68933-2
2. Eckelman, M. J., Huang, K., Lagasse, R., Senay, E., Dubrow, R., & Sherman, J. D. (2020). Health Care Pollution and public health damage in the United States: An update. *Health Affairs*, *39*(12), 2071–2079. https://doi.org/10.1377/hlthaff.2020.01247
3. Moscati, R. M., Mayrose, J., Reardon, R. F., Janicke, D. M., & Jehle, D. V. (2007). A multicenter comparison of tap water versus sterile saline for wound irrigation. *Academic Emergency Medicine*, *14*(5), 404–409. https://doi.org/10.1197/j.aem.2007.01.007
4. Lewis, K. (2023, March 27). *Wound irrigation*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538522/
5. Centers for Disease Control and Prevention. (2024b, June 11). *NAMCS/NHAMCS - Ambulatory Health Care Data Homepage*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ahcd/index.htm

Background

This resolution calls for ACEP to advocate to health care administrators in the U.S. to adopt the use of hospital tap water for wound irrigation; emphasize the importance of research and education within the emergency medicine community on the safety, efficacy, and potential cost savings of using hospital tap water for wound irrigation; and urge U.S. policymakers and health care administrators to support initiatives, such as the use of hospital tap water for wound irrigation, that contribute to broader global efforts to enhance environmental sustainability and combat climate change in health care by decreasing the carbon footprint of emergency departments.

Climate change refers to long-term shifts in the Earth's temperatures and weather patterns. The causes attributed to the shifts can be natural, due to changes in the sun's activity or large volcanic eruptions, or, more controversially, human industrial carbon emissions from the consumption of fossil fuels.[1] It is estimated that activities related to health care contribute to as much as 5% of industrial carbon emissions globally, with the US health care system contributing up to 1.25% of total global carbon emissions.[2]

Medical supply expenses comprise approximately 10.5% of the average hospital's budget.[3] The cost per milliliter of sodium chloride solution for wound irrigation can range from $0.02 to $0.12 U.S. dollars[4,5] with 1 liter containers being most common. While this price is small, there is a supply, stocking, and disposal cost, and an environmental impact of the plastic containers. The price of tap water in the United States varies greatly from city to city, but on average tap water is less than a penny per gallon or about $1.50 for 1,000 gallons.[6,7]

The World Health Organization (WHO) has advocated for and has encouraged member states to develop and implement strategies that promote sustainable health care practices.[2] ACEP and several other prominent medical organizations, including, but not limited to, the American Medical Association (AMA), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), the American Lung Association (ALA), and the American Public Health Association (APHA), and the World Association for Disaster and Emergency Medicine (WADEM) have policy statements regarding the impacts of climate change. ACEP's policy statement "Impact of Climate Change on Public Health Implications for Emergency Medicine" makes collaborating with public health agencies and other stakeholders to address key issues relating to climate change official policy of the College. The policy statement calls for the College to "advocate for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling."

ACEP joined the Medical Society Consortium on Climate and Health, a consortium consisting of 25 state network groups and 56 major medical societies representing over 1 million physicians and health professionals, in 2022.[8] The Medical Society Consortium on Climate and Health tasks itself with educating the public and local, state, and federal policymakers in government and industry about the harmful human health effects of global climate change.[3] During their 2019 annual meeting, the Medical Society Consortium on Climate and Health co-created the "U.S. Call to Action on Climate, Health and Equity: A Policy Action Agenda" with their member organizations. Item number 8 of the policy action agenda calls for hospitals and health care systems to "implement climate-smart health care, build

facility resilience, and leverage their economic power to decarbonize the supply chain and promote equitable local economic development."

Several studies have endeavored to compare the use of tap water versus normal saline for wound cleansing. A 2021 Cochrane Review by Fernandez et al included 13 randomized controlled trials that compared wound cleansing with tap water, distilled water, cooled boiled water, or saline with each other or with no cleansing on wound infection, wound healing, reduction in wound size, rate of wound healing, costs, pain, and patient satisfaction.[9] For all wounds, eight trials found the effect of cleansing with tap water compared with normal saline was uncertain: very low-certainty evidence. Regarding cost, two trials examined in the systematic review reported cost analyses, but the cost-effectiveness of tap water compared with the use of normal saline was uncertain: very low-certainty evidence.

A relevant paper published after the Cochrane Review is a literature review by Monika Holman published in the *Journal of Wound Care.*[10] Of the seven studies included in the literature review, six studies demonstrated that use of tap water had no significant influence on wound infection rates when compared to normal saline; one study demonstrated that tap water did not increase wound contamination; and four studies established that tap water was cost-effective compared to normal saline.

Background References

1. The United Nations. What is Climate Change? Accessed August 6, 2024. https://www.un.org/en/climatechange/what-is-climate-change
2. Masud FN, Sasangohar F, Ratnani I, et al. Past, present, and future of sustainable intensive care: narrative review and a large hospital system experience. Crit Care. 2024;28(1):154. Published 2024 May 9. doi:10.1186/s13054-024-04937-9
3. The American Hospital Association. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities. Published April 2024. Accessed August 19, 2024. https://www.aha.org/costsofcaring#:~:text=Comprising%20approximately%2010.5%%20of%20the%20average%20hospital's,and%20science%20are%20constantly%20evolving%2C%20hospitals%20routinely
4. UpToDate Lexidrug Standard. Sodium Chloride. Accessed August 19, 2024. https://online.lexi.com/
5. McGraw Hill Access Medicine. Sodium Chloride. Accessed August 19, 2024. https://accessmedicine.mhmedical.com/
6. Idaho Falls Public Works. The Price of Water. Access August 19, 2024. https://www.idahofallsidaho.gov/411/The-Price-of-Water#:~:text=The%20average%20price%20of%20water,costs%20less%20than%20one%20penny
7. Statista. Average monthly residential cost of water in the U.S. from 2010 to 2019 (in U.S. dollars). Accessed August 19, 2024. https://www.statista.com/statistics/720418/average-monthly-cost-of-water-in-the-us/
8. The Medical Society Consortium on Climate and Health. Homepage. Accessed August 7, 2024. https://medsocietiesforclimatehealth.org/
9. Fernandez R, Green HL, Griffiths R, Atkinson RA, Ellwood LJ. Water for wound cleansing. *Cochrane Database Syst Rev*. 2022;9(9):CD003861. Published 2022 Sep 14. doi:10.1002/14651858.CD003861.pub4
10. Holman M. Using tap water compared with normal saline for cleansing wounds in adults: a literature review of the evidence. *J Wound Care*. 2023;32(8):507-512. doi:10.12968/jowc.2023.32.8.507

ACEP Strategic Plan Reference

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

- Streamline and innovate our advocacy approach and content to better communicate the relevance, impact and accomplishments of advocacy efforts and empower members to advocate for themselves within their own workplaces, regardless of employment model.

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

- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to 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.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine was referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

June 2018, approved the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine."

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 60(24)

SUBMITTED BY: Ashley Foster, MD, FACEP
Sophia Lin, MD
Theresa Walls, MD, MPH
Pediatric Emergency Medicine Section

SUBJECT: Lethal Means Firearm Safety Counseling

PURPOSE: Develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Unknown costs to develop resources and training and ongoing review of the resources and training once developed This project would require diverting budgeted staff resources from other initiatives to support this effort.

WHEREAS, Lethal means safety counseling is an evidence-based suicide prevention practice directed at limiting the availability of lethal methods of self-harm and suicide, notably firearm-related methods, thereby reducing the risk of death due to suicide; and

WHEREAS, Suicide acts with firearms have the highest case fatality rate of all methods used to attempt suicide with 89.6% of attempts resulting in death; and

WHEREAS, In June 2024, the U.S. Surgeon General issued a public health advisory declaring firearm violence a public health crisis and calling for firearm risk reduction strategies; and

WHEREAS, Suicide among children and young adults 10-24 years of age is a leading cause of death in the United States, with nearly half of suicide deaths in this age group occurring by firearms; and

WHEREAS, Since 2012, the rate of firearm-related suicide has increased by 68% in children 10-14 years of age and by 45% in adolescents and young adults 15-24 years of age; and

WHEREAS, The emergency department serves as a critical contact point for youth at increased risk of suicide and one-third of youth who die by suicide visit the ED in the six months prior to their death; and

WHEREAS, Interventions in the ED can be effective at reducing subsequent suicide attempts and connecting youth to mental health care; and

WHEREAS, Studies have shown that safety planning is effective for youth who are identified in the ED as safe for discharge but have increased risk of suicide; and

WHEREAS, A crucial component of safety planning is screening for and counseling on access to firearms and resources for ED physicians who wish to provide this critical service to at risk youth are lacking; therefore be it

RESOLVED, That ACEP develop resources for ACEP members to provide evidence-based firearm-related lethal means safety counseling to at risk youth; and be it further

RESOLVED, That ACEP work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Lethal Means Safety for Suicide Prevention. September 29, 2023. Accessed June 28, 2024. https://www.samhsa.gov/blog/lethal-means-safety-suicide-prevention
2. Connor A, Azrael D, Miller M. Suicide case-fatality rates in the United States, 2007-2015: a nationwide population-based study. *Ann Int Med*. 2019;171(12):885-895.
3. U.S. Department of Health and Human Services (HHS). Firearm Violence: A Public Health Crisis in America. June 25, 2024. Accessed June 27, 2024. https://www.hhs.gov/sites/default/files/firearm-violence-advisory.pdf
4. American Academic of Pediatrics and American Foundation for Suicide Prevention. Suicide: Blueprint for Youth Suicide Prevention. Accessed February 1, 2024. https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention
5. Centers for Disease Control (CDC). Suicide Prevention. April 25, 2024. Accessed June 28, 2024. https://www.cdc.gov/suicide/facts/index.html
6. Goldman-Mellor S, Olfson M, Lidon-Moyano C, Schoenbaum M. Association of suicide and other mortality with emergency department presentation. *JAMA Netw Open*. 2019;2(12):e1917571.
7. King C, Grupp-Phelan J, Brent D, et al. Predicting 3-month risk for adolescent suicide attempts among pediatric emergency department patients. *J Child Psychol Psychiatry*. 2019;60(10):1055-1064.
8. Fontanella C, Warner L, Steelesmith D, Bridge J, Sweeney H, Campo J. Clinical profiles and health service patterns of Medicaid-enrolled youths who died by suicide. *JAMA Pediatr*. 2020;174(5):470-477.
9. Braciszewski J, Lanier A, Yeh H, et al. Health diagnoses and service utilization in the year before youth and young adult suicide. *Psychiatr Serv*. 2023;74(6):566-573.
10. Naureckas Li C, Sacks, Cummings B, Samuels-Kalow M, Masiakos P, Flaherty M. Improving pediatric residents' screening access to firearms in high-risk patients presenting to the emergency department. *Acad Pediatr*. 2021;21(4):710-715.
11. Betz M, Kautzman M, Segal D, et al. Frequency of lethal means assessment among emergency department patients with a positive suicide risk screen. *Psychiatry Res*. 2018 Feb:260:30-35.

Background

This resolution calls for ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and to work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

Suicide is the second leading cause of death among individuals aged 10–34 in the U.S., with approximately 48,000 suicides in 2018, and suicide is a leading cause of death among children and young adults 10-24 years of age in the United States, with nearly half of suicide deaths in this age group occurring by firearms. Since 2012, the rate of firearm-related suicide has increased by 68% in children 10-14 years of age and by 45% in adolescents and young adults 15-24 years of age, and the increasing suicide rates and associated emotional toll highlight the urgent need for effective public health interventions. Each year, over 500,000 people visit emergency departments (EDs) for self-harm or suicidal thoughts, which are strong predictors of future suicide risk. Studies show that those who visit EDs for self-harm or suicidal ideation have significantly higher suicide mortality rates within the following year. Additionally, more than 12% of suicides involve individuals who had been treated in an ED within three months of their death, emphasizing the critical need for robust prevention strategies in these settings.

Lethal means safety counseling in the emergency department (ED) is a crucial evidence-based suicide prevention intervention aimed at reducing the risk of suicide and self-harm among patients. This recommended practice involves healthcare providers assessing patients' access to means that could be used for self-injury, such as firearms, medications, or other harmful substances, with the goal is to create a supportive environment that helps patients develop coping strategies and access mental health resources, ultimately minimizing the risk of suicide. Effective lethal means safety counseling not only addresses immediate safety concerns but also contributes to long-term mental health support and recovery.

Unfortunately, earlier studies involving emergency physician self-reports found that lethal means assessment was not routine; less than 50% of providers 'almost always' or 'often' ask about suicidal patients' access to firearms, even though more than half thought that this assessment is important. Additionally, it is not uniformly implemented across all facilities, and its frequency can vary based on several factors, including institutional policies, physician training, and the specific protocols of the ED. Training programs and guidelines that emphasize the importance of this counseling can increase its implementation. However, not all EDs may have comprehensive training or resources

available. Overall, while there is growing recognition of the importance of lethal means safety counseling, its frequency of implementation in EDs varies, and efforts are ongoing to standardize and improve its application across different healthcare settings.

ACEP has created a wide variety of resources, in multiple formats targeted at providing care for as well as improving the care of patients presenting with behavioral and mental health emergencies. ACEP is a member of the Coalition on Psychiatric Emergencies and has partnered with multiple organization, such as American Association of Emergency Psychiatry and American Academy of Pediatrics to work towards improving the care of these patients. For example:

- In partnership with the American Foundation of Suicide Prevention, ACEP has developed the ICAR2E point of care tool. This is a bedside/clinical tool to provide guidance to emergency physicians on the risk assessment and reduction, communication, and management of suicidal patients in the ED
- January 2022, the ACEP Board approved the revised joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies." This is a joint policy statement (and supporting technical report) of the American College of Emergency Physicians, American Academy of Pediatrics (AAP), and Emergency Nurses Association (ENA).
- ACEP is also partnering with the AAP on the revision/update of the Clinical Reports on Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems:
  - Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies
  - Evaluation and Management of Children With Acute Mental Health or Behavioral Problems. Part II: Recognition of Clinically Challenging Mental Health Related Conditions Presenting With Medical or Uncertain Symptoms
- June 2024, the ACEP Board approved the revised policy statement "Firearm Safety and Injury Prevention."
- April 2023, the ACEP Board approved the revised policy statement "Adult Psychiatric Emergencies."
- In 2023-24, the ACEP Pediatric Emergency Medicine (PEM) Committee had the following objective: "Develop a point-of-care tool for screening and assessment of children with suicidality", and this is currently in development. Additionally, in 2024, the PEM Committee also published: and information paper in JACEP Open: Management of youth with suicidal ideation: Challenges and best practices for emergency departments
- For 2024-25, the Pediatric Emergency Committee has been assigned an objective to develop an information paper on safety planning and counseling of youth with increased suicide risk and their families in the emergency department.

ACEP also supports a variety of other firearm safety and injury prevention efforts. The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." The policy states that "ACEP supports public health and health care efforts that:

- Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries;
- Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior;

The College also supports federal legislation to establish and support hospital-based violence intervention programs (HVIPs), which are trauma-informed collaborative care initiatives for patients who have suffered a violent injury, including but not limited to non-fatal firearm injuries. HVIPs incorporate efforts to engage patients in care and support networks to reduce recidivism and retaliation for at-risk populations.

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

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

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

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

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP member serves and ACEP staff supports.

- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

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

The U.S. Surgeon General Vivek Murthy, MD, released an advisory on the public health crisis of firearm violence in the U.S. on June 24, 2024. This new advisory is the first publication from the Office of the Surgeon General dedicated to firearm violence and its consequences for the health and well-being of the American public. The advisory details the impact of gun violence beyond death and injury, describing the layers of cascading harm for youth, families, communities, and other populations. The Advisory outlines an evidence-informed public health approach to addressing the crisis of firearm violence. This approach involves critical research funding, implementation of prevention strategies, and increased mental health access and support. In concert with the Surgeon General's Advisory, leaders at nine of the nation's medical organizations and the YWCA issued statements, including ACEP

President Aisha T. Terry, MD, MPH, FACEP, who said, "By raising awareness of this public health crisis, The Surgeon General's Advisory on Firearm Violence speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP Strategic Plan Reference

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

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Unknown costs to develop resources and training and ongoing review of the resources and training once developed This project would require diverting budgeted staff resources from other initiatives to support this effort.

Prior Council Action

The Council has discussed and adopted many resolutions related to firearms, but none that are specific to lethal means safety counseling to at risk youth or developing training for health care providers in firearm-related lethal means safety training.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

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

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

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

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

Prior Board Action

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

April 2023, approved the revised policy statement "Adult Psychiatric Emergencies;" originally approved October 2020.

January 2022, approved the revised joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies."

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

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

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

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

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 61(24)

SUBMITTED BY: Ugo Ezenkwele, MD, FACEP
Andrea Green, MD, FACEP
Michael McGee, MD, MPH, FACEP
Christopher L. Smith, MD, FACEP
Alexndra Nicole Thran, MD, FACEP
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Safe Storage of Firearms

PURPOSE: 1) Create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; 2) collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and 3) encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, U.S. Surgeon General Vivak Murthy, MD, has issued a landmark Surgeon General's Advisory on Firearm Violence, declaring firearm violence in America to be a Public Health Crisis; and

WHEREAS, Since 2020, Firearm-related injuries have been the leading cause of death for American children and teens ages 1-19 years of age, and injures thousands more annually; and

WHEREAS, An estimated 4.6 million children live in homes with loaded, unlocked firearms; and

WHEREAS, More than half of owners acknowledge storing at least one firearm unsafely, without any locks or other safe storage measures, and nearly a quarter of all gun owners report storing all their firearms in an unlocked location in the home; and

WHEREAS, An unlocked firearm is associated with a higher risk of suicide and unintentional firearm injury among children and adolescents; and

WHEREAS, Over 80% of child firearm suicides involved a gun obtained from their own home or that of a friend or relative and suicide rates among children who live in homes with firearms are four times higher than among those in homes without firearms; and

WHEREAS, Most unintentional firearm-related shootings among children occur in or around the home, and most firearms used in school shootings perpetrated by shooters under the age of 18 are acquired from the home or the homes of relatives or friends; and

WHEREAS, Research indicates that strong child access prevention laws decrease unintentional shootings, suicides, and school shootings; and

WHEREAS, States with secure storage or child access prevention laws had the lowest rates of injury or death

from unintentional child shootings, but only 26 states have secure storage laws; and

WHEREAS, Evidence strongly suggests secondary prevention which limits access of firearms to children and teens decreases the risk of injury and death and this same evidence indicated that storage of a firearm locked, unloaded, or separate from ammunition can reduce the risk of suicide in children and teens; therefore be it

RESOLVED, That ACEP create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; and be it further

RESOLVED, That ACEP collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and be it further

RESOLVED, That ACEP encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

Background

This resolution seeks for the College to: 1) create education to raise awareness that secure gun storage, storing guns locked, unloaded and separate from ammunition, can prevent theft and access by children, unauthorized users, and anyone who may pose a danger to themselves or others, and that secure gun storage can save children's lives; 2) collaborate with Doctors for America and take the pledge to become a credible messenger to advocate for and promote gun safety and help reduce firearm related injuries; and 3) encourage emergency physicians to function as messengers to their patients, adopting messages from established, credible organizations such as Gun Violence Prevention Experts, the White House Office of Gun Violence Prevention, the National Organization of Black Law Enforcement Executives (NOBLE), and Everytown for Gun Safety.

Firearms were the leading cause of death in children and youth 0 to 24 years of age in the United States in 2020. Among all causes of death, firearms were responsible for the most deaths in this age group, accounting for 10 197 deaths, compared with 8309 motor vehicle-related deaths. Rates of homicides and suicides from firearms in U.S. youth, especially those 15 to 24 years of age, have increased by 14% and 39%, respectively over the past decade. Among all youth firearm deaths, homicides account for 58%, suicides account for 37%, unintentional shootings account for 2%, and legal intervention accounts for 1%. In 2020, more than 6,000 U.S. youth 15 to 24 years of age died by suicide. Firearms, the most lethal means of suicide, are the cause of death in one-third of suicides among those 10 to 14 years of age and half of all suicides among those 20 to 24 years of age. Although youth firearm suicides decreased from 1994 to 2007, they have increased 53% since then. Several studies have demonstrated an independent relationship between access to firearms and suicide. Approximately 80% of firearm-related suicides take place in the home of the youth or a relative, with the firearm belonging to either the youth or parent or caregiver in 90% of cases. Approximately 40% of U.S. households with children have firearms, of which 15% stored at least one firearm loaded and unlocked, the storage method with the highest risk.

Safely storing firearms can reduce gun injuries and deaths, and is supported by researchers, health care professionals, and gun owners alike. Research has demonstrated a decreased risk for suicide among adolescents when guns are stored safely. Safe and secure storage practices also help prevent guns from being stolen, diverted into illegal markets and used in gun crime. Child-protective firearm safety and safe storage systems encompass a variety of measures – safes or lockboxes for handguns, locked gun safes for rifles and shotguns, trigger locks that prevent the trigger from being pulled, cable locks, and separate lockboxes for ammunition, among others. Supporters of child-protective or safe storage policies note growing evidence-based research that such policies are associated with reductions in suicide, unintentional injuries and death, and homicides, including for young adults. The AAP, for example, "…supports a number of measures to reduce the destructive effects of guns in the lives of children and adolescents, including safe storage and CAP laws."

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements. The 2023 Council and the Board of Directors adopted Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems directing ACEP to support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems. ACEP's policy statement "Firearm Safety and Injury Prevention" was revised in June 2024 in response to Resolution 36(23) Mandatory Waiting Period for Firearm Purchases and Resolution 35(23) Declaring Firearm Violence a Public Health Crisis.

The provisions of the "Firearm Safety and Injury Prevention" policy statement include:

ACEP supports legislative and regulatory efforts that:
- Actively support both private and public funding into firearm safety and injury prevention research;
- Protect the duty of physicians to discuss firearm safety with patients"

ACEP supports public health and health care efforts that:
- Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries;
- Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior"

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

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

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

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

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric

Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP member serves and ACEP staff supports.

- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

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

The U.S. Surgeon General Vivek Murthy, MD, released an advisory on the public health crisis of firearm violence in the U.S. on June 24, 2024. This new advisory is the first publication from the Office of the Surgeon General dedicated to firearm violence and its consequences for the health and well-being of the American public. The advisory details the impact of gun violence beyond death and injury, describing the layers of cascading harm for youth, families, communities, and other populations. The Advisory outlines an evidence-informed public health approach to addressing the crisis of firearm violence. This approach involves critical research funding, implementation of prevention strategies, and increased mental health access and support. In concert with the Surgeon General's Advisory, leaders at nine of the nation's medical organizations and the YWCA issued statements, including ACEP President Aisha T. Terry, MD, MPH, FACEP, who said, "By raising awareness of this public health crisis, The Surgeon General's Advisory on Firearm Violence speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

ACEP's committees continue to address firearms issues during the 2024-25 committee year. The Federal Government Affairs Committee has an objective to continue to serve as subject matter experts to ACEP's efforts to develop and assess potential legislative ideas to address firearm safety and injury prevention. The Public Health Committee has an objective to develop resources for patients on gun safety.

ACEP Strategic Plan Reference

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

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

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted. Directed that ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

Resolution 36(23) Mandatory Waiting Period for Firearm Purchases adopted. Directed ACEP to advocate for a mandatory federal waiting period prior to firearm purchases; assist state chapters in promoting legislation on mandatory waiting periods at the state level; and add language to the "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

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

Prior Board Action

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

March 2024, approved ACEP's legislative and regulatory priorities to continue to work with Members of Congress to promote efforts that may prevent firearm-related injuries/deaths and support continued and increased funding for firearms injury research.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted.

Resolution 36(23) Mandatory Waiting Period for Firearm Purchases adopted.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

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

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

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 62(24)

SUBMITTED BY: Ugo Ezenkwele, MD, FACEP
Andrea Green, MD, FACEP
Michael McGee, MD, MPH, FACEP
Christopher L. Smith, MD, FACEP
Alexandra Nicole Thran, MD, FACEP
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section

SUBJECT: Stop the Bleed Education

PURPOSE: Provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative and promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

FISCAL IMPACT: Budgeted committee and staff resources. Potential unbudgeted and unknown costs depending on the scope of the promotional, marketing, and outreach needs.

WHEREAS, The devastating and far-reaching consequences that traumatic injuries resulting in significant blood loss poses to the health and well-being in many U.S. communities is widely recognized and that some victims could be saved if bystanders given the tools and knowledge to stop life threatening bleeding; and

WHEREAS, The "Stop the Bleed" campaign is a national awareness effort to educate people about the importance of measures to control bleeding; and the goal of this initiative is to build national resilience by empowering the public to be aware of the simple steps that can be taken to stop or slow life threatening bleeding, and to promote the general public's access to Bleeding Control Kits; and

WHEREAS, Per the CDC, more than 275,000,000 people die each year (one person every three minutes) from traumatic injuries sustained because of events including motor vehicle collisions, falls, industrial and farm accidents, natural disasters, tragic mass casualties, mass shootings, and violence; and

WHEREAS, Trauma is the leading cause of death for people ages 1-46 in the U.S.; and

WHEREAS, The most common preventable cause of death in these situations is the loss of too much blood in the minutes before advance responders arrive; and

WHEREAS, U.S. military experience has proven that bleeding control techniques result in reduced rates of death from a hemorrhage; and therefore be it

RESOLVED, That ACEP provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative; and be it further

RESOLVED, That ACEP promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

Background

This resolution requests ACEP to provide education and encourage emergency physicians' awareness of the "Stop the Bleed" initiative and promote activities that foster awareness and empowerment among at-risk youth via collaboration with such entities as Community Violence Intervention Program (CVIP) to take proactive measures in teaching "Stop the Bleed" techniques to youth.

ACEP has been a key stakeholder since the initiation of the "Stop the Bleed" campaign in October 2015, when it was launched by both the White House and the National Security Council. The "Stop the Bleed" campaign had a series of objectives, including public access to bleeding control kits and public training on their utilization. ACEP has engaged and supported these objectives since its inception through various avenues, including promoting the campaign through the EMS Committee, EMS-Prehospital Care Section, other pertinent ACEP sections, and ACEP's National EMS Week Campaign. Concurrently, the American College of Surgeons – Committee on Trauma (ACS-COT) developed a public-focused bleeding control course, with which ACEP was invited and partnered in the promotion of this course.

The recognition of the "Stop the Bleed" course has been enhanced since 2019 with the mentioning of various section content pieces by the Event Medicine Section, Disaster Medicine Section, the Tactical & Law Enforcement Medicine Section, and through various ACEP marketing channels.

ACEP collaborated with the American College of Surgeons Committee on Trauma (ACS-COT) in 2023 on various initiatives to support the "Stop the Bleed" course. The focus of these collaboratives for ACEP was to identify and engage at the various levels of course development, advocacy, and implementation among current initiatives and programs. ACEP received an invitation to join the ACS-COT "Stop the Bleed" Champions group in 2024. Within this group, ACEP will provide representation and support as a member on various initiatives of the "Stop the Bleed" course, including curriculum and course review, implementation, education, community outreach, and other initiatives as determined by the ACS-COT Stop the Bleed Champions Group.

ACEP has brought a greater awareness of the "Stop the Bleed" course within current programs in the College through further collaboration and work with the ACS-COT. May 2024 marked the 50th anniversary of National EMS Week. Each day had a specific theme and the theme for Thursday was "Save a Life Day" where the focus shifted to providing community education and training on various initiatives such as "Stop the Bleed" training and compression-only CPR. ACEP worked closely with the ACS-COT on marketing and content to be utilized as an outreach initiative within National EMS Week. ACS-COT provided an outreach campaign for "Stop the Bleed" that was then shared with 17 national organizations, 6 federal organizations, and 3 media partners who support National EMS Week in their efforts to enhance their reach for EMS Week. The EMS Week 2024 reach through campaign resources and distribution of materials throughout the week was almost 4 million.

ACEP worked with our EMS Week partner, the National Association of Emergency Medical Technicians (NAEMT), as well as DC Fire and EMS, ACS-COT, and GW Hospital Med Star, to hold a large in-person event on the National Mall in Washington, DC, on May 23, 2024, to enhance awareness of various chain-of-survival initiatives such as "Stop the Bleed" and Chest Compression Only CPR. The event included various tables and displays that provided in-person education and training on "Stop the Bleed" and Chest Compression-only programs. These initiatives included various manikins and low-fidelity trainers along with the needed tools and resources to provide on-the-spot training. Additionally, ACS-COT published 500 quick access cards regarding "Stop the Bleed" that included the key steps for applying a tourniquet along with a QR code to access an online free version of the "Stop the Bleed" course. Several speakers presented on National EMS Week and the importance of the community education event, including ACEP's president, the NAEMT president, American College of Surgeons executive director, the DC Fire and EMS medical director, and the National Highway Traffic Safety Administration (NHTSA) Office of EMS.

The EMS Committee continues to bring a heightened awareness, greater visibility, and accessibility to various community education courses and training that can increase the chain of survival in out-of-hospital patient care. The EMS Committee has an objective for the 2024-25 committee year to "collaborate with other organizations to support the accessibility and visibility of community education programs, such as Stop the Bleed, Chest Compression-Only CPR, Narcan, etc., to enhance the chain of survival in patient care."

ACEP staff were tasked in 2018 with developing a new public-focused in-person course that contained bleeding control and lay-person CPR to bring greater awareness to the need for bleeding control in the out-of-hospital setting. Around the same time period, ACEP was approached by staff at the U.S. Department 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. 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. ACEP has now partnered with the American Red Cross to provide Until Help Arrives as a 90-minute online course designed to equip students with the basic knowledge to assist trained responders during a life-threatening emergency. Until Help Arrives is a non-certification course that provides the general public with the basic actions to take during a life-threatening emergency that can help sustain or save a life until EMS arrives.

ACEP Strategic Plan Reference

Member Engagement and Advocacy

Fiscal Impact

Budgeted committee and staff resources. Potential unbudgeted and unknown costs depending on the scope of the promotional, marketing, and outreach needs.

Prior Council Action

Resolution 34(20) Public/School Bleeding Control Kit Access and Training adopted. Directed ACEP to support access and training for bleeding control kits in all schools and public venues.

Prior Board Action

Resolution 34(20) Public/School Bleeding Control Kit Access and Training adopted.

June 2019, approved funding for the Until Help Arrives campaign.

Background Information Prepared by: George Solomon, MHS, FP-C, CCP-C, TP-C
Director, EMS and Disaster Medicine

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 63(24)

SUBMITTED BY: James Augustine, MD, FACEP
Nicholas Genes, MD, PhD, FACEP
Emily Hayden, MD, FACEP

SUBJECT: Commendation for Todd B. Taylor, MD, FACEP

WHEREAS, Todd B. Taylor, MD, FACEP, has served the College and the specialty for more than three decades with skill and dedication as a member of ACEP and leader of the Emergency Medicine Data Institute (EMDI); and

WHEREAS, He has served as the Chief Vision Officer for the EMDI and as the Transition Team Executive for the Clinical Emergency Data Registry; and

WHEREAS, He has volunteered his time for the last four years, providing more than 6,000 volunteer hours equivalent to $1.5 million of in-kind services; and

WHEREAS, His dedication and commitment to ACEP and the EMDI has led to the successful transition and advancement of the Clinical Emergency Data Registry to the new EMDI platform; and

WHEREAS, Dr. Taylor's expertise in informatics and dedication to excellence successfully transitioned more than 30 physician groups to the new EMDI platform; and

WHEREAS, Dr. Taylor selflessly served as a mentor and was instrumental to the establishment and launch of the EMDI Board of Governors; and

WHEREAS, Dr. Taylor's expertise, leadership, and vision has led to the development and launch of new products and services; and

WHEREAS, Dr. Taylor's dedication, hard work, and commitment contributed significantly to ACEP's and the EMDI's success; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Todd B. Taylor, MD, FACEP, to the advancement of emergency medicine; and be it further

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 64(24)

SUBMITTED BY: Richelle Cooper, MD, MSHS, FACEP
Gregory Hendey, MD, FACEP
David Schriger, MD, MPH, FACEP
Kabir Yadav, MDCM, MD, MSHS, FACEP
Donald M. Yealy MD, FACEP

SUBJECT: In Memory of Amy H. Kaji, MD, PhD, MPH

WHEREAS, Emergency medicine lost a compassionate physician, dedicated educator, mentor, investigator, editor, and colleague in Amy H. Kaji, MD, PhD, MPH, who died on August 1, 2024, at the age of 56; and

WHEREAS, Dr. Kaji graduated from Harvard-Radcliffe College (*cum laude*) and then attended Thomas Jefferson Medical College (AOA, *summa cum laude* and Valedictorian Class of 1997), then completed her emergency medicine residency at the Harbor-UCLA Emergency Medicine program and completed a Doctor of Philosophy in Epidemiology at the UCLA School of Public Health; and

WHEREAS, Dr. Kaji served as faculty at Harbor-UCLA Medical Center and the David Geffen School of Medicine at UCLA, served as Vice Chair of Academic Affairs, Interim Chair and Executive Vice Chair at the Harbor-UCLA Department of Emergency Medicine; and

WHEREAS, Dr. Kaji provided service for more than 20 years on numerous American College of Emergency Physicians (ACEP) committees including the Disaster Preparedness & Response Committee, Public Health & Injury Prevention Committee, Clinical Policies Committee (as Methodological Reviewer), and the Research Committee as well as the Research Forum Subcommittee and served as chair for the Research Committee's Scientific Review Subcommittee and Pipeline Subcommittee, and also served on the Emergency Medicine Foundation Board of Trustees; and

WHEREAS, Dr. Kaji served on numerous Society for Academic Emergency Medicine (SAEM) committees including the Research Committee, Consensus Conference Steering Committee, Membership Committee, Nominating Committee, Diversity Equity and Inclusion Committee, Boarding Committee, Work Force Committee, Joint ACEP-SAEM Work Force Committee, and served in several leadership roles on the Board of Directors, including Secretary-Treasurer and President of SAEM; and

WHEREAS, Dr. Kaji improved and elevated published emergency medicine research as a peer-reviewer and editor, including serving on the editorial board of *Annals of Emergency Medicine* for 18 years and for *Academic Emergency Medicine,* and she also fostered knowledge sharing as section editor for *Rosen's Emergency Medicine: Concepts and Clinical Practice*, and co-editor for the Kaji and Pedigo *Emergency Medicine Board Review* book; and

WHEREAS, Dr. Kaji advanced the science of emergency medicine and health care with her research and authorship of more than 234 peer-reviewed publications and 15 book chapters; and

WHEREAS, Dr. Kaji was recognized for her excellence in teaching and service with numerous awards including the UCLA Public Health Student Association Teaching Assistant of the Year, the Harbor-UCLA Medical Center Department of Emergency Medicine Faculty Teaching Award (for multiple years), the American College of Emergency Physicians National Faculty Teaching Award, the UCLA Distinguished Lecturer Award for outstanding contributions to university teaching, the Academy for Women in Academic Emergency Medicine (AWAEM) Early Career Faculty Award, the Harbor-UCLA Medical Center DEM, Academic and Administrative Giant Award; and

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

WHEREAS, Dr. Kaji mentored hundreds of undergraduate (pre-med) students, medical students, resident and fellow trainees, and faculty in emergency medicine with her warm, patient, and caring approach, always making time to help others; and

WHEREAS, Dr. Kaji put caring about people at the forefront of all her interactions, be it with patients, hospital staff and leadership, medical learners, and her colleagues; and

WHEREAS, Dr. Kaji supported, advocated for, and sponsored efforts to enhance diversity, equity, and inclusion; and

WHEREAS, Dr. Kaji touched the lives of countless individuals by setting a quiet, powerful example of how to be a great leader and excellent physician, being a role model for all who knew her; and

WHEREAS, Dr. Kaji shaped the future of emergency medicine in Los Angeles and nationally with her academic service, research, and editorial work, and with her leadership, vision, enthusiasm, and dedication; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Amy H. Kaji MD, PhD, MPH, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Amy H. Kaji, MD, PhD, MPH, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine, and to the patients and physicians of California and the United States.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 65(24)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Joseph Sabato, Jr., MD, FACEP

WHEREAS, Joseph Sabato, Jr., MD, FACEP, who dedicated his life to the field of emergency medicine and the betterment of public health, died on July 9, 2024; and

WHEREAS, Dr. Sabato pursued his undergraduate education at Boston University and went on to earn his medical degree from the University of Massachusetts (UMASS) Chan Medical School demonstrating his commitment to academic excellence and the pursuit of medical knowledge; and

WHEREAS, Dr. Sabato's career, spanning over four decades, included serving as an esteemed emergency physician and assistant professor at Parkland Medical Center in Derry, NH; the University of Florida College of Medicine in Jacksonville, FL; and the UMASS Chan Medical School in Worcester, MA; and

WHEREAS, Dr. Sabato was a dedicated advocate for public health, demonstrating unwavering commitment to injury and illness prevention; and

WHEREAS, In response to the tragic deaths of 11 teenagers in 1996, Dr. Sabato founded the Community Alliance for Teenage Safety in Derry, NH, and championed the cause to raise the mandatory seat belt age in New Hampshire from 12 to 18 years old; and

WHEREAS, Dr. Sabato's passion for preventing cardiac deaths led him to tirelessly promote hands-only community CPR and the use of automated external defibrillators; and

WHEREAS, Dr. Sabato found immense joy in working with and teaching first responders and medical students, thus fostering the next generation of emergency medical professionals; and

WHEREAS, Dr. Sabato was actively involved in the American College of Emergency Physicians, contributing to the Critical Care, Emergency Medical Services, and Disaster Medicine Sections; and

WHEREAS, Dr. Sabato's contributions to emergency medicine and public health have left an indelible mark on the communities he served; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Joseph Sabato, Jr., MD, FACEP, and extends its deepest sympathies to his family, friends, and colleagues and acknowledges that his legacy will continue to inspire and guide the emergency medicine community.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 66(24)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Christopher J. Karns, DO

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Christopher J. Karns, DO, passed away tragically in a tractor accident while working on his property, something he found great joy in doing, on August 7, 2024, at the age of 38; and

WHEREAS, Dr. Karns completed his undergraduate studies at Allegheny College in 2008; and

WHEREAS, He completed his medical school training at the Des Moines University College of Osteopathic Medicine in 2012; and

WHEREAS, He then completed his residency in emergency medicine at Saint Vincent Hospital in Erie, PA; and

WHEREAS, He continued his work in emergency medicine at Saint Vincent Hospital as a faculty member; and

WHEREAS, He later served as an emergency physician and Vice President of the medical staff at Westfield Memorial Hospital; and

WHEREAS, Dr. Karns mostly recently was an emergency physician at Titusville Area Hospital; and

WHEREAS, He and his wife owned and operated Coventina Day and Medical Spa in Waterford where their dedication and innovation brought new services to the area; and

WHEREAS, Dr. Karns was married to his high school sweetheart, Dawn, in 2010 and they attended college, medical school, and residency together and shared a life filled with love and partnership; and

WHEREAS, His greatest joy was his family; and

WHEREAS, He and his wife had three children, loved spending time outdoors with them, created countless cherished memories with them such as building trails, working on their country property, camping, fishing, hunting, enjoying campfires, and spending time at their family's camp; therefore, be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Christopher J. Karns, DO; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Dawn E. Beemer Karns, their three children Nathan Christopher, Carter Alexander, and Alaina Grace, his parents John and Cynthia Karns, and the rest of his family gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.