American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 23, 2017

Subj: Action on 2015 Resolutions

The attached report summarizes the actions taken by the Board of Directors on the 37 resolutions (34 non-Bylaws, 2 Bylaws, and one Council Standing Rules) adopted by the 2015 Council. Six resolutions were referred to the Board of Directors.

The actions on resolutions are also included on the ACEP Website.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Action on 2015 Council Resolutions

Resolution 1 Commendation for Marsha D. Ford, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Marsha D. Ford, MD, FACEP, for her service as an emergency physician, scholar, and patient advocate and for her lifelong dedication to the advancement of the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. Ford.

Resolution 2 Commendation for Kevin M. Klauer, DO, EJD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Kevin M. Klauer, DO, EJD, FACEP, for his service as Council Speaker and Council Vice Speaker and for his commitment and dedication to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Klauer.

Resolution 3 Commendation for Alexander M. Rosenau, DO, CPE, FACEP

RESOLVED, That the American College of Emergency Physicians commends Alexander M. Rosenau, DO, CPE, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

Action: A framed resolution was presented to Dr. Rosenau.

Resolution 4 In Memory of Stanley M. Zydlo, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Stanley M. Zydlo, Jr., MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of EMS; and be it further

RESOLVED, That national ACEP and the Illinois College of Emergency Physicians extends to his wife, Joyce Reid, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialties of Emergency Medicine and Emergency Medical Services.

Action: A framed resolution was prepared and sent to the family of Dr. Zydlo.

Resolution 5 EMRA Councillor Allocation – Bylaws Amendment

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

EMRA shall be entitled to ~~four~~ **eight** councillors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA

Action: The Bylaws were updated.

Resolution 6 Fellowship Criteria – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility, be amended by deletion of criterion number four:

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;

B. Satisfaction of at least three of the following individual criteria during their professional career:
   1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
   2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
   3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
   4. active involvement in emergency medicine administration or departmental affairs;
   5. active involvement in an emergency medical services system;
   6. research in emergency medicine;
   7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
   8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
   9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
   10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

~~4. Provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.~~

Action: The Bylaws were updated.

Resolution 11 Ethical Violations by Non-ACEP Members (as amended)

RESOLVED, That ACEP shall extend the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to include non-ACEP members whose actions involve ACEP members; and be it further

RESOLVED, That ACEP's current "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" shall be modified to reflect that any disciplinary actions taken by ACEP and involving non-ACEP members will be reported to the expert's own professional society and may be reported to the expert's state licensing board for further action; and be it further

RESOLVED, That ACEP shall create a summary to be distributed to expert witnesses in cases involving ACEP members putting those experts on notice that:

The expert's testimony is subject to review by ACEP and ACEP's Ethics Committee.

1. Regardless of the expert's specialty or professional society membership, if the expert's testimony is found to be unethical, the expert will subject to:
   a. Admonishment by ACEP.
   b. Public reporting of such admonishment in an appropriate ACEP publication.
   c. Reporting of such admonishment to any professional society or medical organization to which the expert belongs.
   d. Reporting of such admonishment to the expert's state medical licensing board.

Action: Assigned to the Ethics Committee (lead committee) and the Medical-Legal Committee. Note: this resolution cannot be implemented until the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" are amended, which will require a College Manual resolution.

The Ethics Committee and the Medical-Legal Committee had differing viewpoints about the resolution and presented their recommendations to the Board in June 2016. The Board assigned a workgroup of Board members and members of both committees to develop recommendations for implementation of the resolution. A conference call was held and preliminary work completed. The task force will continue in 2017-18.

Resolution 12 Searchable Council Resolution Database (as amended)

RESOLVED, That ACEP improve the existing database of all prior Council resolutions submitted for discussion, designed for use by the ACEP membership, to include the relevant background material, adopted amendments, final disposition of each resolution, and any references to subsequent ACEP action such as a result of the resolution, to improve search functionality, and to publicize this tool to future councillors.

Action: Assigned to Technology Services staff to explore options and provide a recommendation for implementation.

Development was completed and staff are staff are uploading all resolutions since 1972. It is expected to be available to members and staff by spring 2018.

Resolution 13 ACEP and the Pharmaceutical Industry (as amended)

RESOLVED, That ACEP evaluate the expanding role and cost for pharmaceuticals affecting the practice of emergency medicine and identify and collaborate, where appropriate, with interested parties/stakeholders, including pharmaceutical manufacturers and others to best assure an appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and report back to the ACEP Council in 2016.

Action: Assigned to Public Affairs staff and to utilize consultants as needed.

ACEP helped secure in the last reauthorization of the Prescription Drug User Fee Act (PDUFA) in 2012, the "Food and Drug Administration Safety and Innovation Act" (FDASIA), that substantially amended the Food, Drug & Cosmetic Act's (FDCA) drug shortage provisions. FDASIA eliminated the requirement that a company be the sole manufacturer of a drug to be subject to the drug shortage requirements. Additionally, FDASIA explicitly made drugs used in emergency medical care or during surgery subject to the drug shortage notice requirements. FDASIA established an annual report to Congress by the FDA on drug shortage statistics, communication within FDA on addressing shortages and actions taken by FDA to prevent or mitigate shortages. Additionally, this legislation called for regular Government Accountability Office (GAO) reports to Congress on the cause of drug shortages and on recommendations on how to prevent or alleviate shortages. The most recent report was published in July 2016. PDUFA was reauthorized in August 2017, though few substantial changes were made to specifically address drug shortages. ACEP's Public Affairs staff and the Federal Government Affairs Committee will continue to review potential policy recommendations.

ACEP is also a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC also has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is developing bi-partisan, market-based solutions to lower drug prices in the United States.

In late August 2016, several ACEP members briefed House Judiciary Committee staff on the price history and availability of naloxone and buprenorphine and how these changes have subsequently affected availability of these drugs for emergency patients. This discussion led directly to the invitation by the committee for an ACEP witness to testify at an upcoming hearing conducted by the House Judiciary Regulatory Reform Subcommittee on September 22, 2016, to discuss rising drug prices.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the Board of Trustees appointed a 13-member Task Force on Pharmaceutical Costs consisting of representatives of AMA councils, state medical associations, and national medical specialty societies, to provide guidance on AMA advocacy and grassroots efforts aimed at addressing pharmaceutical costs. Between January and May 2016, the task force held four meetings/conference calls and reached agreement that the first phase of the AMA grassroots campaign should focus on increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. Board of Trustees Report 10-I-16 summarizes the work of the Task Force and describes the first phase of the grassroots campaign. An online petition calling on Congress to demand that pharmaceutical companies, pharmacy benefit managers, and health plans introduce greater transparency in the processes for determining prescription drug prices was promoted in late summer 2016 on the AMA's Patients' Acton Network (PAN) and other cause-oriented websites (e.g., standunited.org and care2.org). More than 62,000 individuals have signed the petition. On November 1, 2016, consistent with the recommendations of the task force, the AMA launched TruthInRx.org, which seeks to highlight the lack of transparency and inherent unfairness involved in prescription drug pricing. The interactive microsite allows supporters to take action, from sending a message to Congress to sharing content with their own social networks. Notably:

- The overall design of the microsite uses pharmaceutical, scientific and technical industries as inspiration for creative design, and vibrant, energetic colors help emphasize important points throughout the site, such as facts, figures and callouts
- The homepage immediately takes the user through an interactive experience after he/she lands on the site, scrolling through the labels of a drug box to learn about the lack of transparency in drug pricing.
- The interior pages include a campaign page that opens with a striking visual related to understanding the issue; a "your stories" page that engages the audience to share content with their social networks, including a meme generator, prepopulated tweets/Facebook posts and a traditional submit your own story option for users; a "get involved" page that houses the traditional take action features, allowing users the ability to contact Congress via email, phone and social media; and a "get informed" page that houses a variety of resources for the user to explore to gain more knowledge on the issue.

An AMA press statement announcing TruthInRx.org was also released. ACEP promoted the link to the microsite via the PAN and the Physicians' Grassroots Network, and used other online and social media promotion to aid in the launch. The microsite was also featured at the AMA grassroots booth at the AMA Interim Meeting in November 2016 and related materials were distributed to the AMA House of Delegates.

Resolution 17 Electronic Nicotine Delivery Systems

RESOLVED, That ACEP support legislative and regulatory efforts to control the use of electronic nicotine delivery systems and regulate the toxicity of vapor(s) produced for primary and second hand exposures; and be it further

RESOLVED, That ACEP develop recommendations for tobacco and nicotine cessation that avoid the use of unregulated electronic nicotine delivery systems; and be it further

RESOLVED, That ACEP promote awareness of the risk of primary inhalation injury and direct toxicity from electronic nicotine delivery systems to ACEP members and the physician community as a whole.

Action: Assigned first resolved to Chapter & State Relations staff and Public Affairs staff to include in state and federal advocacy initiatives. Assigned second and third resolveds to the Public Health & Injury Prevention Committee.

This issue was included in the state advocacy reports provided to the chapters.

The Public Health & Injury Prevention Committee developed the revised policy statement "Tobacco and Nicotine Products – Public Policy Measures" and recommended : 1) incorporating updates on the rapidly growing body of research on tobacco cessation and electronic nicotine delivery systems into the curriculum at ACEP *Scientific Assembly* and similar academic and professional forums; and 2) partnering with other medical professional organizations committed to tobacco control, such as the American College of Preventive Medicine, focused on primary prevention to increase reach, improve messaging coherence, and provide a template for future collaboration on prevention-based issues. The Board approved the policy statement and the committee's recommendations in October 2016.

Resolution 19 Graduate Medical Education Funding (as amended)

RESOLVED, That ACEP work with the agencies that provide graduate medical education funding to create measures to ensure that all institutions that receive graduate medical education funding be required to maintain publicly available records of the distribution and utilization of these funds.

Action: Assigned to the Academic Affairs Committee and to consult with Public Affairs staff as needed regarding legislative and regulatory issues related to GME funding.

The Academic Affairs Committee worked in collaboration with the ACEP-SAEM GME Work Group to address this resolution.

The 2014 Institute of Medicine (IOM) report called for additional transparency and accountability in GME payments. The committee reviewed and discussed these issues at length, consulted with ACEP's Federal Government Affairs Committee and State Legislative/Regulatory Committee, institutional finance officials, graduate medical education officials, as well as other stakeholders to address this matter and to explore rules governing funding utilization and reporting by institutions receiving funding from the CMS. Additionally, the committee consulted with the ACEP-SAEM GME Work Group that has been working on this important issue for some time. The Academic Affairs Committee agrees with the ACEP-SAEM GME Work Group's opinion that until more information and data become available, the resolution to create measures to ensure maintenance of publicly available records of GME funding is premature. While all agree the resolution has merit and greater transparency on how the funds are used is needed, it may have the unintended consequence of reducing funding, particularly indirect medical expenses (IME), at this time. Per a request for proposal (RFP), the ACEP-SAEM GME Work Group will be collecting additional research to further define the potential benefits AND risks of transparency. There is at least one state (Michigan) whose Medicaid department is attempting to institute a "boilerplate" set of expectations for institutional reporting of GME funding use, including IME. According to specialists in GME financing and institutional finance managers, this is nearly impossible to do. Whether other states will follow this lead is unclear. Health Policy Alternatives, Inc., ACEP's health policy consultant, provided opinions on Michigan's Boilerplate document for the ACEP-SAEM Work Group when or if a response is called for and appears to agree that additional information is required. At present, CMS has no reporting requirements on spending and does not appear to have any available annual reports on GME expenses, utilization, etc. The agency's focus is to ensure no duplicative or excessive payments are made to the institutions. The Inspector General has made GME and IME a priority this year, and will be specifically investigating the Intern/Resident Information System (IRIS) reporting processes, hospital IME, whether IME payments are calculated correctly, and whether they are in accordance with federal regulations. It is unclear what CMS's response would be to the suggestion by an organization such as ACEP to require hospital reporting measures to ensure transparency. It is

our recommendation that ACEP not engage CMS at this time until the issue of transparency and accountability is further defined and researched, and potential consequences are studied.

In June 2016, the Board approved delaying engaging in discussions with CMS regarding GME funding transparency and accountability until reporting requirements are further defined and researched and potential consequences are studied. The GME Work Group is drafting an RFP to address the value of emergency medicine residency programs to institutions and hospitals. The ACEP-SAEM Working Group continues to collect data to address this issue.

Resolution 20 Group Purchasing Effects on Patient Care (as amended)

RESOLVED, That ACEP study the effects on patient care from the lack of availability of appropriate medications and medical equipment due to group purchasing practices, medication shortages, and orphan product restrictions; and be it further

RESOLVED, That ACEP work with stakeholders such as the American Medical Association to develop model legislation that protects physicians from liability as a result of the inability to provide optimal care due to lack of appropriate medical devices or pharmaceuticals to diagnose and treat emergency patients.

Action: Assigned first resolved to the Emergency Medicine Practice Committee and second resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee developed survey questions on the lack of availability of appropriate medication and medical equipment due to medication shortages that were included in an Emergency Medicine Practice Research Network (EMPRN) survey distributed in early July. Results from the survey were compiled, reviewed by the Board in October 2016, and communicated to ACEP members. Information on group purchasing and the potential effects on medication shortages will be posted on the ACEP website.

The AMA Section Council on Emergency Medicine conferred with AMA staff who indicated they were unaware of any action that would likely impact a physician for failure to administer a medication or use a device if it was not available to the physician. Further, they believed joint and severable liability reforms that exist in several states would sufficiently protect physicians should any such action like this surface. ACEP and the AMA already support joint and severable liability reform. ACEP's Medical–Legal Committee concurred with the AMA's position and responded affirmatively that no separate action was warranted.

See additional information about medication shortages and the AMA's actions in the report for Resolution 13.

Resolution 21 Healthcare Information Exchanges (as amended)

RESOLVED, That ACEP identify a recommended standard for ED information summary contained in Healthcare Information Exchanges; and be it further

RESOLVED, That ACEP work with relevant stakeholders to identify and promote the standard that allows for notification (in the ED electronic health record) of the existence of applicable Healthcare Information Exchange data; and be it further

RESOLVED, That ACEP promote the standardized requirements to the Healthcare Information Exchanges currently in the process of development.

Action: Assigned to the task force appointed to address Amended Resolution 20(14). The 2014 resolution 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. Their work is ongoing.

Collective Medical Technologies (CMT) entered into a corporate sponsor agreement and exclusive partnership with ACEP in April 2016 to aid in the promotion and support of the CMT's Emergency Department Information Exchange (EDIE) program. EDIE, also called PreManage ED, collects data from all EDs visited by a patient, packages that data into actionable insights, and then delivers the information to emergency physicians via real-time notifications during the patient visit. EDIE is currently available in 13 states and CMT continues to pursue participation in other states.

Resolution 22 Increasing Use of Advance Directives by Designation on Drivers Licenses (as amended)

RESOLVED, That ACEP support efforts to encourage adults of all ages and states of health to talk with family, friends, spiritual advisors, health professionals, and physicians about advance directives and to record and keep these wishes updated.

Action: Assigned to the Public Relations Committee to develop public media campaign materials for distribution.

The committee developed and distributed a press release on advance directives and posted an article on ACEP's public website EmergencyCareforYou.org.

Resolution 23 Integrating Emergency Care Into the Greater Healthcare System

RESOLVED, That ACEP pursue reimbursement strategies to promote care coordination in the Emergency Department; and be it further

RESOLVED, That ACEP promote reimbursement strategies to incentivize ED's to perform intensive case management to optimize ED utilization for high utilizers; and be it further

RESOLVED, That ACEP promote effective ED information sharing systems across health systems to facilitate care coordination and effective resource utilization.

Action: Assigned first two resolveds to the Alternate Payment Models (APM) Task Force. Assigned third resolved to ED Information System Safety Issue Recognition and Management Task Force that was assigned to address Amended Resolution 20(14) and Amended Resolution 21(15). Additionally, ACEP's partnership agreement with CMT (see comments on Resolution 21) addresses the third resolved.

The Board reviewed a status report from the APM Task Force in October 2016. This is a complicated issue and the task force continued its work in 2016-17 and 2017-18. Several payment models have been developed and are now undergoing analysis, which may require use of Medicare and emergency medicine group data. Once the models have been analyzed and are considered potentially viable, the next step is to use the results to address the questions put forth by MACR's Physician Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will provide technical assistance to applicants in bringing their proposals to a level for final review and submission to CMS.

The work of the ED Information System Safety Issue Recognition and Management Task Force was delayed because of various changes in ACEP staffing. Their work is now underway and a meeting will be held at *ACEP17*.

Resolution 27 Reimbursement for Ultrasound Performed by Emergency Physicians (as amended)

RESOLVED, That ACEP develop a statement declaring that insurance companies and other payers reimburse emergency physicians for ultrasound studies and services that they perform and interpret as separate and identifiable procedures while providing patient care services in the Emergency Department; and be it further

RESOLVED, That ACEP support efforts to reduce payment denials for appropriately performed and documented clinical ultrasonography.

Action: Assigned to the Reimbursement Committee in consultation with the Emergency Ultrasound Section.

The Reimbursement Committee developed the policy statement, "Payment for Ultrasound Services in the Emergency Department," that was approved by the Board in June 2016.

Resolution 29 Support for Drug "Take-Back" Programs (as amended)

RESOLVED, That ACEP supports the development of drug "take-back" programs at no cost to patients; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine consider submitting a resolution to the American Medical Association to support drug "take-back" programs.

Action: The first resolved is a policy statement. Assigned to the Public Health & Injury Prevention Committee to review and determine if any additional information is needed to develop a policy statement. Assigned to the AMA Section Council on Emergency Medicine to discuss submitting a resolution to the AMA.

The Public Health & Injury Prevention Committee developed the policy statement, "Drug Take Back Programs," that was approved by the Board in June 2016.

The AMA Section Council on Emergency Medicine determined that the AMA already has policy in support of drug take-back programs:

> "Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
> 1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling."

Resolution 31 American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure (as amended)

RESOLVED, That ACEP communicate its appreciation to ABEM for its efforts to be sensitive to the practicing emergency physician in interpreting the American Board of Medical Specialties (ABMS) mandates; and be

it further

RESOLVED, That ACEP develop policy supporting the American Board of Medical Specialties Maintenance of Certification as appropriate support for state medical license Maintenance of Licensure, but actively oppose mandates that require or link Maintenance of Certification as the only pathway for ongoing Maintenance of Licensure; and be it further

RESOLVED, That ACEP develop policy that specifically opposes efforts of specialty boards to become the independent sole source and for profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy for emergency physicians.

Action: Assigned to the Academic Affairs Committee.

In October 2016, the Board approved the committee's recommendations to 1) communicates appreciation to ABEM for its efforts in the realm of ABMS mandates; 2) take no further action *at this time* regarding development of a policy opposing mandates linking maintenance of certification as the only path to maintenance of licensure; and 3) take no further action *at this time* regarding development of a policy opposing specialty boards as the sole source mandating continuing education credit. ACEP continues to work with ABEM on maintenance of certification/ maintenance of licensure (MOC/MOL) issues as well as Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification that was referred to the Board by the 2016 Council. During this time, ACEP has relayed the growing discontent among some ACEP members with the MOC process and particularly the high-stakes ConCert exam. ABEM has been active in exploring alternative approaches to physician assessment. This exploration includes detailed analyses of every pilot project in which other specialty boards are involved. ABEM informs ACEP that it is participating in direct discussions and research consortia with other ABMS specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited. ABEM has assembled panels of senior ABEM leaders to explore modification and options to the ConCert examination. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination. ABEM will hold a national ConCert Summit October 2-3, 2017, that will include representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is also looking to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates. Additionally, ACEP, along with dozens of other specialty societies and state medical societies will meet with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

A similar resolution on Maintenance of Certification was submitted to the 2017 Council.

Resolution 32 Critical Communications for ED Radiology Findings (as amended)

RESOLVED, That ACEP 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.

Action: Assigned to the Emergency Medicine Practice Committee and include representation from the American College of Radiology in development of the policy statement.

The Emergency Medicine Practice Committee developed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings." The principles were reviewed by the Board in April 2016. ACEP leaders met with leaders of the American College of Radiology (ACR) in June 2016. 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, "Intrepretation of Imaging Diagnostic Studies." A draft revision was completed and sent to ACR in September 2017 for review. It will be submitted to the ACEP Board following review by ACR.

Resolution 33 Defining and Transparency in Urgent Care Centers (as amended)

RESOLVED, That ACEP 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 be it further

RESOLVED, That ACEP work with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

Action: Assigned first resolved to the Emergency Medicine Practice in consultation with the Freestanding Emergency Centers Section. Assigned second resolved to the State Legislative/Regulatory Committee for state advocacy initiatives and Public Affairs staff for federal advocacy initiatives.

The Emergency Medicine Practice developed the policy statement "Urgent Care Centers" with input from the Freestanding Emergency Care Section. It was approved by the Board in October 2016.

This issue was included in the weekly legislative tracking reports provided to state chapters. The issue was also addressed with AMA staff and other relevant stakeholders.

Resolution 34 Enabling Access to Epinephrine for Anaphylaxis (as amended)

RESOLVED, That ACEP, in conjunction with other interested organizations, evaluate state efforts to provide timely access to epinephrine for anaphylaxis, including current state legislation that includes liability protection for appropriate use, public education, awareness and timely access, including cost effective mechanisms for availability of devices that may be used for bystander or self-administration, and report back to the Council in 2016.

Action: Assigned to the State Legislative/Regulatory Committee. The committee provided a report to the Board in October 2016. At the federal level, in 2013, President Obama signed into law the School Access to Emergency Epinephrine Act, which encourages schools to stock epinephrine (epi) for severe asthma attacks and allergic reactions. The law also made changes to the Children's Asthma and Treatment Grants Program so that HHS will give preferential funding to a state's asthma treatment grants if: 1) the state maintains an emergency supply of epi; 2) permit trained personnel at the school to administer the epi; and 3) develop a plan for ensuring trained personnel are available to administer epi during all hours of the school day. All states currently have legislation in place addressing epi in schools. However, the legislation varies by state. In most states, except West Virginia and Alabama, students are allowed to carry their own epi device. Most states require the student to have physician authorization, but there is no physician authorization mandate in Idaho, Iowa, and West Virginia. Most states have a student competency requirement, except Arizona, Colorado, Florida, Idaho, Illinois, Iowa, Michigan, New Jersey, Rhode Island, West Virginia, and Wisconsin. In most states, the school nurse and/or a staff administrator can give the epi; however, in Minnesota, only the nurse can give the epi. In Idaho, Maine, and North Dakota neither the nurse nor a staff administrator can give the epi and only the student can self-administer. Approximately 50% of states allow and/or require stockpiling of epi at schools. Most states have a release from liability, except for Delaware, Idaho, Indiana, Maine, Massachusetts, Pennsylvania, and Texas. This information was compiled from The Network for Public Health Law (the Network) and Food, Allergy, Research and Education (FARE). Both are non-profit organizations that maintain current information on state school laws. There is also legislation in many states to allow other places such as restaurants, children's camps, adventure parks, and other "entities" to have access to epi. The Network provides a brief review of all legislation on "entities" as well as the state-by-state legislation. Currently, 27 states have entity stocking epi laws and six states have pending legislation. Seventeen states do not have laws or pending legislation on entities stocking epi. All 27 states that allow entity stocking have training requirements and liability exemptions for the entity administering the program, the employees that give the epi, and the healthcare professional that prescribed and dispensed the drug. ACEP has information on the website with the 2016 proposed legislation in the states and it includes information about the adopted 2016 Epi Pen legislation. There is no legislation that addresses how to pay for epi. Currently, one company (Mylan, the makers of EpiPen) holds 90% of the US market on epi. The cost of an EpiPen has increased 400% since 2008. Senator Amy Klobuchar (D-MN) has called for a Judiciary Committee inquiry into the pricing and an investigation by the Federal Trade Commission and the company has faced a barrage of media criticism and complaints from patient advocates based on its pricing practices. The American Academy of Allergy, Asthma and Immunology introduced the Airline Access to Emergency Epinephrine Act (S1972).

Resolution 35 Emergency Department Detox Guidelines (as amended)

RESOLVED, That ACEP create clinical practice guidelines for treatment of patients presenting to the emergency department in opioid or benzodiazepine withdrawal; and be it further

RESOLVED, That ACEP create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.

Action: Assigned to the Clinical Policies Committee. This issue is included in the revision of the 2012 opioid clinical policy currently in progress. The critical questions have been finalized and literature searches completed. The literature is being obtained and grading will begin in the fall 2017. The revised clinical policy is expected to be finalized by 2018.

Resolution 36 Establishing State and National POLST/EOL Registries (as amended)

RESOLVED, That ACEP support the use of and implementation of POLST (or equivalent) programs as a means of honoring our patients' end of life wishes; and be it further

RESOLVED, That ACEP partner with organizations such as the American Medical Association, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, AARP, and all others it deems fit to advocate for and support the creation of state and/or a national POLST/EOL database(s) that can be accessed by emergency physicians and EMS responders in times of crisis and uncertainty around a patient's end-of-life care; and be it further

RESOLVED, That ACEP provide education for emergency physicians regarding the utilization of POLST forms and encourage ACEP members to become familiar with their state's POLST (or equivalent) program; and be it further

RESOLVED, That ACEP continue to promote advanced care and end-of-life planning and coordination as a best practice.

Action: This resolution is being addressed in ACEP's Strategic Plan: "Engage chapters and other medical organizations to promote Physician Orders for Life Sustaining Treatment (POLST) and other effective advance directive documents." Assigned third resolved to the Palliative Medicine Section.

Articles on POLST have been published in *ACEP Now* as well as other palliative care principles in the emergency department. A plan was developed to distribute POLST CME materials to chapters, encourage their use, and encourage advocacy efforts in states without adequate POLST laws.

The Palliative Medicine Section worked with the State Legislative/Regulatory Committee to address the assigned third resolved. Over the past several years ACEP has been increasingly engaged on issues of palliative medicine, end-of-life (EOL) care and advanced directives as they relate to emergency medicine. Many of ACEP's existing efforts were outlined in the background of the resolution. The collaborative work we sought to identify new opportunities for our organization to build on its educational efforts in the area of the POLST paradigm. The primary challenge in providing effective and targeted education for our membership is the significant state-to-state variability in the maturity of their POLST paradigm. Some states such as Oregon have a widely used POLST program that has been in place for many years while other states such as Arkansas do not have any sort of program in place. The National POLST Paradigm website provides a helpful map with some information about progress in each state (http://polst.org/programs-in-your-state/). However, even within categories on this map, there are major differences that would have a significant impact on providers. For example, both Indiana and Texas are categorized as "developing." In Indiana, POLST forms are widely available and seen regularly by EPs on shift, at least on a regional basis. In Texas, most EPs have no familiarity with the program or associated forms. To provide practice-relevant education to ACEP members would require tailoring such education to each state. For this reason some outreach efforts initially considered were believed to be impractical. For example, providing an article for each chapter to publish in their chapter newsletter (if they so wished) regarding the POLST paradigm was considered. However, each article would need to be written by someone personally familiar with the program in that state; the workgroup did not include that depth of expertise. A similar challenge exists for any programming reaching a nationwide audience, including lectures at ACEP's annual conference. To encourage physicians to learn about their own state programs, several articles have been published in *ACEP Now* about the POLST issue. In 2015, there were two articles about the complexities of the paradigm. Per our offer to provide additional materials for publication the editors may publish more information about this program in the future. EMRA's publication, *EM Resident,* published an article in the June/July 2016 issue, "*POLST: Guiding Providers in End of Life Care*." The article was co-authored by a member of the workgroup about the POLST paradigm, and was targeted at the new generation of emergency physicians. As an additional education outreach, information about the POLST paradigm was included in eCME course developed by ACEP. ACEP's MOC/MOL Subcommittee was tasked with development of an ABEM approved MOC Part IV PI-CME activity on palliative care. A workgroup member served as the content expert assigned to integrate information about POLST into the final product. One exciting outreach effort occurred at the 2016 Council meeting. A table was located outside the Council meeting with information and content experts available to discuss and answer questions about POLST.

ACEP's MOC/MOL Subcommittee will complete development of a new MOC Part IV activity on palliative care, which will also address POLST, in 2017-18.

The Ethics Committee worked with the Palliative Medicine Section to develop the "Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy." The guidelines were approved by the Board in April 2017.

Resolution 37 Intravenous Ketamine for Pain Management in the ED (as amended)

RESOLVED, That ACEP collaborate with the Emergency Nurses Association, the American Association of Emergency Nurse Practitioners, the Society of Emergency Medicine Physician Assistants, and other emergency care provider organizations to develop a joint position statement endorsing the use of sub-dissociative ketamine under the same procedures and policies as other analgesic agents administered by nursing staff in the emergency department setting; and be it further

RESOLVED, That the position statement developed by ACEP and the other stakeholders on the use of sub-dissociative ketamine be distributed to all state nursing boards.

Action: Assigned to the Emergency Medicine Practice Committee and to include representatives from ENA, AAENP, SEMPA, and others as appropriate.

The committee considered addressing the use of sub-dissociative ketamine in the "Optimizing the Treatment of Acute Pain in the Emergency Department" policy statement, but determined that a separate policy is needed in addition to an information paper or PREP. The committee plans to complete the drafts for consideration by the Board in October 2017.

Resolution 38 Patient Satisfaction Scores in Safe Prescribing (as amended)

RESOLVED, That ACEP opposes any non-evidence based financial incentives predicated on patient satisfaction scores; and be it further

RESOLVED, That ACEP work with stakeholders to create a quality measure that is related to safe prescribing of controlled medications; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Action: The first resolved is a policy statement. Assigned to the Emergency Medicine Practice Committee to review ACEP's current policy statements regarding patient satisfaction surveys/scores and determine if any revisions are needed or whether an additional policy statement should be developed. Assigned second resolved to the Quality & Patient Safety Committee. Assigned third resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee revised the policy statement, "Patient Satisfaction Surveys" with the new title "Patient Experience of Care Surveys." The policy was approved by the Board in June 2016.

The AMA Section Council on Emergency Medicine has supported and advocated ACEP's position in discussions about ED-PEC and HCAHPS as patient satisfaction scores that need revision.

Resolution 41 Procedural Credentialing Requirements (as amended)

RESOLVED, That ACEP work within its several committees and sections charged with quality, emergency medicine practice, and rural emergency medicine to research and recommend such credentialing models to maintain the rural/underserved presence without undue hardship on ED physicians or result in a greater lack of board certified/board eligible emergency physicians in these areas; and be it further

RESOLVED, That ACEP develop a policy statement and information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas; and be it further

RESOLVED, That ACEP work with hospital accreditation bodies, the Centers for Medicare & Medicaid Services, the American Hospital Association, and related state hospital, regulatory, and certification organizations to recommend appropriate credentialing standards for ED physicians and facilities in rural/underserved areas.

Action: The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to explore development of a policy statement and other information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas and to work with the Rural Emergency Medicine Section and other committees as needed. The Board approved revisions to the policy statement, "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" in April 2017 and also reviewed the revised .

Resolution 42 Prolonged Emergency Department Boarding (as amended)

RESOLVED, That ACEP seek out and 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; and be it further

RESOLVED, 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.

Action: Assigned to the Emergency Medicine Practice Committee to include in their current objective "Revise and update the 2008 paper "Emergency Department Crowding High-Impact Solutions" and explore new innovations to address boarding in the ED" and include participation and review by other organizations/stakeholders.

Representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians worked with the committee to revise the.

information paper. The revised paper was reviewed by the Board in June 2016 and distributed to members and stakeholder organizations. Additional resources are available on the ACEP Website

Resolution 43 Required CME Burden (as amended)

RESOLVED, That ACEP, in order to promote high quality, safe, and efficient emergency medicine care address the fact that requiring a significant amount of concentrated continuing medical education in specific areas annually will lead to reduced ongoing education in other clinical areas important to the practice of emergency medicine (such as Pediatrics, Infectious Disease, Gastroenterology, Endocrinology, etc.), resulting in the unintended consequence of reducing physician readiness to care for the ED patients not included in the Time Critical Diagnosis initiative; and be it further

RESOLVED, That ACEP work with organizations such as the American Hospital Association, the American Heart Association, and related state hospital organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to be able to readily care for all emergency department patients without costly and redundant requirements, unless found to be necessary for individual physicians based on assessment and oversight by the ED medical director.

Action: Assigned to the Emergency Medicine Practice Committee. The policy statement, "CME Burden," was approved by the Board in April 2016.

Resolution 45 Telemedicine Appropriate Support and Controls

RESOLVED, That ACEP investigate and evaluate the positive, negative, and potential unintended consequences of telemedicine; and be it further

RESOLVED, That ACEP develop appropriate policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Action: Assigned to the Emergency Medicine Practice Committee to incorporate into their current work in developing a policy statement on telemedicine in conjunction with the Emergency Telemedicine Section.

The Emergency Medicine Practice Committee developed the policy statement, "Emergency Medicine Telemedicine," that was approved by the Board in January 2016. The Ethics Committee developed the policy statement, "Ethical Use of Telemedicine in Emergency Care," that was approved by the Board in June 2016.

Resolution 46 Transitioning Out of Medical Practice

RESOLVED, That ACEP dedicate member resources towards the study and education of how best to transition out of the clinical practice of Emergency Medicine.

Action: Assigned to the Well-Being Committee. Review the Emergency Medicine Practice Committee's recently completed paper on careers outside of the emergency department and determine if any additional information and resources should be developed.

The Well-Being Committee reviewed the Emergency Medicine Practice Committee's information paper on this topic and added information on opportunities in education, subspecialties, and event medicine. The Board reviewed the revised information paper, "Hospital Employment and Careers Outside the ED," in June 2016.

Resolution 47 In Memory of Marshall T. Morgan, MD

RESOLVED, That the American College of Emergency Physicians honors Marshall T. Morgan, MD, for his thoughtful, professional demeanor, his superb patient care skills, true compassion for all those he encountered, and his exemplary leadership in emergency medicine and the house of medicine.

Action: A framed resolution was prepared and sent to the family of Dr. Morgan.

Resolution 48 In Memory of Richard P. O'Brien, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted communicator and self-described "radio enthusiast," Richard P. O'Brien, MD, FACEP, and extends condolences and gratitude to his family and friends for his service to the specialty of emergency medicine and to patient care.

Action: A framed resolution was prepared and sent to the family of Dr. O'Brien.

Resolution 49 In Memory of Leah Anne Davis, DO

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor the contributions made by Leah Anne Davis, DO, as one of the future leaders in Emergency Medicine; and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to her family, friends, and colleagues our sympathy, great sense of sadness and loss, our gratitude for having been able to share a part of her life, and for her service to the specialty of Emergency Medicine

Action: A framed resolution was prepared and sent to the family of Dr. Davis.

Resolution 50 In Memory of Marvin Leibovich, MD, FACEP

RESOLVED, That the American College of Emergency Physicians fondly honors Marvin Leibovich, MD, FACEP, as one of the pioneers and leaders in the specialty of emergency medicine; and be it further

RESOLVED, That national ACEP join with the Arkansas Chapter in extending our memorium and gratitude to Dr. Leibovich for a life well lived in the service of others.

Action: A framed resolution was prepared and sent to the family of Dr. Leibovich.

Resolution 51 In Memory of Michael G. Hughes, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes with gratitude and honor the contributions made by Michael G. Hughes, MD, FACEP, to the specialty of emergency medicine in Massachusetts and in his service to our country's armed forces; and be it further

RESOLVED, That ACEP extends to the family, friends, and colleagues of Dr. Hughes our sympathy, our great sense of sadness and loss, and our gratitude for having been able to share a part of his life

Action: A framed resolution was prepared and sent to the family of Dr. Hughes.

Resolution 52 Commendation for David Blunk

RESOLVED, That the American College of Emergency Physicians formally commends David Blunk for his dedicated efforts, leadership, and mentoring at both the state and local levels as the Executive Director of the Pennsylvania College of Emergency Physicians.

Action: A framed resolution was presented to Mr. Blunk.

Council Standing Rules Resolution

Resolution 9 Electronic Submission of Resolution Amendments

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

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

Action: The Council Standing Rules were updated.

Referred Resolutions

Resolution 18 ER is for Emergencies

RESOLVED, That ACEP work with the American Medical Association and other interested parties to study the possibility of expanding the "ER is for Emergencies" program to a national scale.

Action: Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution and to consult with the AMA Section Council on Emergency Medicine as needed.

The committee sought advice from the Washington Chapter and members of the AMA Section Council on Emergency Medicine. Since October 2015, some internal changes have occurred within the Washington State Medical Association (WSMA) regarding the issue. By acquiescing to the WA-ACEP desire to bring this EM-specific issue to ACEP first and the resulting referral to the ACEP Board, the momentum was lost within the WSMA to bring the issue

before the AMA. The AMA Section Council on Emergency Medicine representatives also noted that this is a specialty-specific issue and is not the usual type of resolution brought before the AMA without specific requests or action items expected by the AMA. Additionally, it was discussed that other states (specifically, Oregon) have used the Washington experience to tailor initiatives to their state without specifically adopting the "ER is for Emergencies" program, but instead adapting components of the "Seven Best Practices" that were believed to be most effective in their particular climate. In October 2016, the Board approved the committee's recommendation to take no further action at this time and continue to promote the spirit of the resolution by supporting state chapters with similar initiatives.

Resolution 24 Interstate Medical Licensure Compact Legislation and Opposition to National Medical License

RESOLVED, That ACEP evaluate the proposed state legislative language, often referred to as the "Interstate Medical Licensure Compact," allowing reciprocity by state physician licensing boards for board certified physicians, for its potential effect on emergency physicians' practice and the potential for unintended consequences.

Action: Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee identified resources and in October 2016 the Board approved the committee's recommendation to distribute the information to members and chapters.

There have been ongoing discussions about how to improve the process of allowing physicians to practice in more than one state. In response to these discussions, the Interstate Medical Licensure Compact (IMLC) is a voluntary pathway that streamlines the ability for a physician to obtain a license in multiple states, while still allowing state medical boards to retain their regulatory oversight capacity. Currently, the process to obtain licensure in multiple states remains cumbersome. For initial licensure, basic standards remain uniform on a national level. However, states have implemented their own additional requirements for granting and renewing medical licenses for physicians. These include variable timetables for licensure renewal, CME requirements including formal course work, and potential face-to-face interviews with members of the state medical board.[2] State agencies can then take many months to process their applications. In 2013, the Federation of State Medical Boards (FSMB) House of Delegates adopted a resolution to help improve the process of license portability. This initiative, known as the Interstate Medical Licensure Compact (IMLC), received support from the American Medical Association House of Delegates in 2014. Currently, 17 states have enacted legislation to enable the state to participate in the IMLC, and 10 additional states have introduced legislation to advance the measure. The IMLC is a **voluntary** option designed to streamline the current process and make it easier for physicians to obtain full, unrestricted licenses to practice in multiple states. The IMLC reduces the administrative and cost barriers previously faced by physicians providing in-person care in multiple states. The IMLC is also an important mechanism that will support physicians who are interested in using telemedicine technologies while ensuring that the state where the patient receives care is able to provide oversight and ensure accountability with state medical practice laws and standards of care. The Interstate Medical Licensure Compact Commission is the entity charged with administering the IMLC. The Commission held several public meetings from October 2015 to August 2016, published a rule open to comment, and developed the IMLC's technical and data infrastructure. The interstate medical licensure compact was launched April 6, 2017.

Resolution 28 Standards for Fair Payment of Emergency Physicians

RESOLVED, That ACEP develop a set of standards for fair payment for Emergency Physician services, and compliance with which to be included in the next edition of America's Emergency Environment, A State by State Report Card;" and be it further

RESOLVED, That ACEP devote increased resources to monitor the state-by-state status and changes in law concerning the standards for fair payment of Emergency Physicians and establish a single point of contact at the national level as a resource for assisting all chapters; and be it further

RESOLVED, That ACEP shall work with other **medical** specialties~~, ambulatory services,~~ and hospitals to develop Model Fair Payment Legislation and then devote resources to promoting adoption in every state; and be it further

~~RESOLVED, That ACEP shall use its influence with the National Emergency Medicine Political Action Committee to devote resources to developing state-by-state influence upon each state's legislative and regulatory process; and be it further~~

RESOLVED, That ACEP work with the Emergency Medicine Foundation to research, publish, and disseminate the detrimental effects of legislation that limits the rights of emergency physicians to fairly bill and collect, and to develop effective educational materials explaining the facts concerning emergency physician billing and collection, for use at the national and local level in educating legislators, regulators, policy-makers, and the public; and be it further

RESOLVED, That ACEP ~~and the Emergency Medicine Action Fund develop and support~~ **explore the development of** a national "strike team" that can be deployed by ACEP leadership to help chapters in states where emergency physicians are facing an immediate legislative threat to the fair payment process.

Action: This resolution was addressed primarily through the work of the ACEP/EDPMA Task Force on Reimbursement Issues. It was also assigned to the Reimbursement Committee, State Legislative/Regulatory Committee, and Federal Government Affairs Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

In the summer of 2015, ACEP President Dr. Michael Gerardi appointed an ACEP/EDPMA Joint Task Force to study reimbursement issues. The subgroup working on balance billing issues considered concerns created by narrow networks with regard to those issues. The task force, working in conjunction with ACEP's State Legislative/Regulatory Committee and Reimbursement Committee, produced a series of studies, "Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services" and "Situation Report: Balance Billing Legislation." Those documents were approved by the Board in April 2016. Additional resources are available on the ACEP website, including a fact sheet on fair coverage.

In December 2015, network adequacy and out of network reimbursement was an issue included on the agenda of a national call for state chapter leaders and lobbyists. In the 2015-16 fiscal year, the State Legislative/Regulatory Committee recommended, and the Board approved, Public Policy Grants for the Georgia and Florida chapters to address these issues and ACEP staff and member experts provided consultative services to assist numerous other chapters dealing with out of network payment legislation or regulation. Beginning in January 2016, ACEP leaders and staff began holding meetings with the American Society of Anesthesiologists about collaborating on network adequacy and balance billing issues at the state level. The collaboration subsequently expanded to include other hospital-based specialties and the AMA. Work toward building out this coalition is ongoing with plans to be operating collaboratively in 2017.

ACEP filed suit against the federal government in May 2016. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency. According to the lawsuit, insurance companies have failed to provide fair coverage for their insured patients. They have forced health care providers out of their health plans by offering reimbursement that barely covers the cost of care and constructed narrow networks that offer little coverage for emergency care in many parts of the country. The lawsuit is still pending. A motion for summary judgement was filed on November 18, 2016. The government filed its Cross Motion for Summary Judgement and Opposition to Summary Judgement on December 9, 2016. ACEP filed its response by January 20, 2016. The U.S. District Court for the District of Columbia partially granted ACEP's Motion for Summary Judgment on August, 31, 2017, and denied the Government's counter motion regarding its lawsuit against the federal government to contest a regulation that impedes emergency physicians from receiving accurate usual and customary payment for out-of-network services. The court remanded the matter back to the to the Centers for Medicare & Medicaid Services for further explanation of the regulation, saying that comments submitted to the federal departments (Departments of Health & Human Services, Labor, and Treasury) during its development expressed "concerns about the rule – for example, that the methods it used to set payments were not transparent and could be manipulated by insurers. Many of these commenters proposed using a transparent database to set payments instead. The Departments all but ignored these comments and proposals." The ruling does not invalidate the regulation, but it is a clear step in the right direction and it forces the Government to respond to ACEP's concerns in a substantive manner. The Parties (ACEP and the federal Departments) have been ordered to file a "joint status report" by October 30, 2017. This does not mean the Departments must respond by then, but that the Court will review and make a determination regarding its next steps from that point forward. The court has the right to move on to review the substantive issues raised by ACEP (i.e., that the entire rule is a violation of the Administrative Procedures Act and the Affordable Care Act) at that point. ACEP is now developing a strategy to emphasize our concerns with the new Administration pending a response from the agencies. The Departments will, at some point, file their response and may request additional comments or not. They may revise the regulation, or leave it as is.

ACEP provided funding to the Florida, Georgia, and Texas chapters in 2016 to support their efforts on out-of-network/balance billing legislation. The Emergency Medicine Action Fund has provided additional funding to the Georgia Chapter.

ACEP continues to hold strategy meetings on out-of-network/balance billing with multiple stakeholders.

The AMA House of Delegates adopted the following resolution at the June 2017 annual meeting:

> "RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care."

The AMA sent a letter on June 29, 2017, asking Anthem to rescind the policy citing federal patient

protections under prudent layperson, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

Another resolution adopted by the AMA in June, which originated from ACEP, brought together a large coalition of stakeholders from multiple states and specialties to protect out-of-network coverage for patients. The resolution calls for the AMA to join ACEP and the Physicians for Fair Coverage coalition to fight the surprise insurance gaps patients are experiencing while providing fair payment to emergency physicians.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

Resolution 30 Use of Body Cameras Worn by Law Enforcement in the ED

RESOLVED, That ACEP modify and extend its current policy statement "Recording Devices in the Emergency Department" to promote and endorse the expectation of patient privacy and limitations on recording devices by law enforcement personnel, visitors, and other individuals or organizations, during the provision of healthcare to patients in the emergency department; and be it further

RESOLVED, That ACEP promote a position that institutions and physicians should restrict the use of recording devices during patient care and in areas in which discussions containing confidential, HIPAA-protected patient information are likely to occur within the Emergency Department.

Action: Assigned to the Ethics Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee revised the policy statement, "Recording Devices in the Emergency Department" that was approved by the Board in January 2017.

Resolution 39 Patient Satisfaction Scores in Emergency Medicine

~~RESOLVED, That ACEP acknowledges that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, and many components of medical care not under physician control; and be it further~~

RESOLVED, That ACEP ~~opposes~~ **reaffirm its opposition to** the use of patient satisfaction surveys **that have not been validated** for physician credentialing or for emergency medicine practice financial incentives or disincentives, **consistent with current ACEP policy**.

Action: Assigned to the Emergency Medicine Practice Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

The committee revised the policy statement, "Patient Satisfaction Surveys" with the new title "Patient Experience of Care Surveys." It was approved by the Board in June 2016.

Resolution 44 State Medical Board Review of Emergency Medicine Practice

RESOLVED, That ACEP survey and summarize member experience with potential inappropriate or onerous review of Emergency Medicine practice by state licensing boards; and be it further

RESOLVED, That state medical licensing board peer review of emergency medicine practice should be by board certified emergency physicians practicing in similar circumstances utilizing recognized standards of care; and be it further

RESOLVED, That ACEP evaluate the implications of developing policy to support state licensing board review of egregious expert medical testimony, including, but not limited to, simplified "out of state" physicians "certificates" to provide authority over expert medical testimony; and be it further

RESOLVED, That ACEP develop policy to support state licensing board review and sanctioning of physicians providing egregious standards of care for testimony in medical liability cases.

Action: Assigned to the Medical-Legal Committee for review and to provide a recommendation to the Board regarding further action on this resolution. Their work continued in the 2016-17 committee year and a recommendation is expected for the October 2017 Board meeting.