Council Meeting
October 14-15, 2016
Mandalay Bay Resort and Convention Center
Las Vegas, NV

Minutes

The 45th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am, Friday, October 14, 2016, by Speaker James M. Cusick, MD, FACEP.

Seated at the head table were: James M. Cusick , MD, FACEP, speaker; John G. McManus, Jr., MD, MBA, FACEP, vice speaker; Dean Wilkerson, JD, MBA, CAE, Council secretary and executive director; and Jim Slaughter, JD, parliamentarian.

Dr. Cusick provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance.

Victoria Coan sang the National Anthem.

Scot Shepherd, MD, FACEP, president of the Las Vegas Chapter, welcomed councillors and other meeting attendees.

Melissa Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 325 councillors of the 394 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Mr. Eric Joy provided an overview of the Council meeting Web site and other technology enhancements.

David Wilcox, MD, FACEP, addressed the Council regarding the Emergency Medicine Foundation (EMF) Challenge.

Peter Jacoby, MD, FACEP, addressed the Council regarding the National Emergency Medicine Political Action Committee (NEMPAC) Challenge.

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2016 Council meeting:

Alabama	Lisa M Bundy, MD, FACEP Muhammad N Husainy, DO, FACEP Annalise Sorrentino, MD, FACEP
Alaska	Anne Zink, MD, FACEP
Arizona	Patricia A Bayless, MD, FACEP Paul Andrew Kozak, MD, FACEP Donald J Lauer, MD, MPH, FACEP J Scott Lowry, MD, FACEP Wendy Ann Lucid, MD, FACEP Craig Norquist, MD, FACEP Dale P Woolridge, MD, PhD, FACEP
Arkansas	Darren E Flamik, MD, FACEP Paul A Veach, MD, FACEP

Assoc of Academic Chairs of EM	Gabor David Kelen, MD, FACEP
California	John D Bibb, MD, FACEP Rodney W Borger, MD, FACEP John Dirk Coburn, MD Fred Dennis, MD, MBA, FACEP Carrieann E Drenten, MD Irv E Edwards, MD, FACEP Andrew N Fenton, MD, FACEP Marc Allan Futernick, MD, FACEP Vikant Gulati, MD, FACEP Ramon W Johnson, MD, FACEP Kevin M Jones, DO Roneet Lev, MD, FACEP Stephen J Liu, MD, FACEP John Thomas Ludlow, MD William K Mallon, MD Cameron J McClure, MD, FACEP Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Chi Lee Perlroth, MD, FACEP Maria Raven, MD, MPH, FACEP Vivian Reyes, MD, FACEP Nicolas Sawyer, MD Eric W Snyder, MD, FACEP Peter Erik Sokolove, MD, FACEP Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP Lori D Winston, MD, FACEP
Colorado	Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Kevin W McGarvey, MD Carla Elizabeth Murphy, DO, FACEP Eric B Olsen, MD, FACEP Lee Wilton Shockley, MD, FACEP Donald E Stader, MD, FACEP
Connecticut	Hynes M Birmingham, MD, FACEP Mark R Dziedzic, MD, FACEP Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP David E Wilcox, MD, FACEP
Council of EM Residency Directors)	Saadia Akhtar, MD
Delaware	Kathryn Groner, MD John T Powell, MD, MHCDS, FACEP
District of Columbia	Ethan A Booker, MD, FACEP Natalie L Kirilichin, MD Aisha T Liferidge, MD, FACEP
Emergency Medicine Residents' Association	Christian J Dameff, MD Nida F Degesys, MD

	Jasmeet Singh Dhaliwal, MD, MPH
	Ramnik S Dhaliwal, MD, JD
	Tiffany Jackson, MD
	Alicia Mikolaycik Kurtz, MD
	Matthew Rudy, MD
	Alison L Smith, MD, MPH
Florida	Andrew I Bern, MD, FACEP
	Jordan GR Celeste, MD
	Amy Ruben Conley, MD, FACEP
	Jay L Falk, MD, FACEP
	Kelly Gray-Eurom, MD, MMM, FACEP
	Larry Allen Hobbs, MD, FACEP
	Saundra A Jackson, MD, FACEP
	Steven B Kailes, MD, FACEP
	Michael Lozano, MD, FACEP
	Kristin McCabe-Kline, MD, FACEP
	Raymond Merritt, DO
	Ernest Page, II, MD, FACEP
	Sanjay Pattani, MD, FACEP
	Danyelle Redden, MD, FACEP
	Todd L Slesinger, MD, FACEP
	Kristine Staff, MD
	Joel B Stern, MD, FACEP
Georgia	Matthew R Astin, MD, FACEP
	James Joseph Dugal, MD, FACEP(E)
	Matthew Taylor Keadey, MD, FACEP
	Jeffrey F Linzer, Sr, MD, FACEP
	Matthew Lyon, MD, FACEP
	DW “Chip” Pettigrew, III, MD, FACEP
	Johnny L Sy, DO, FACEP
	Matthew J Watson, MD, FACEP
Government Services	James David Barry, MD, FACEP
	Marco Coppola, DO, FACEP
	Melissa L Givens, MD, FACEP
	Joshua Jacobson, DO
	Chad Kessler, MD, MHPE, FACEP
	Julio Rafael Lairet, DO, FACEP
	Linda L Lawrence, MD, FACEP
	Brett A Matzek, MD, FACEP
	David S McClellan, MD, FACEP
	Torree M McGowan, MD, FACEP
	Nadia M Pearson, DO, FACEP
	Christopher G Scharenbrock, MD, FACEP
	Gillian Schmitz, MD, FACEP
Hawaii	Jason K Fleming, MD, FACEP
	Richard M McDowell, MD, FACEP
Idaho	Nathan R Andrew, MD, FACEP
	Ken John Gramyk, MD, FACEP
Illinois	Christine Babcock, MD, FACEP
	E Bradshaw Bunney, MD, FACEP
	Shu Boung Chan, MD, FACEP

	Cai Glushak, MD, FACEP
	David L Griffen, MD, PhD, FACEP
	John W Hafner, MD, FACEP
	George Z Hevesy, MD, FACEP
	Janet Lin, MD, FACEP
	Valerie Jean Phillips, MD, FACEP
	Henry Pitzele, MD, FACEP
	Yanina Purim-Shem-Tov, MD, FACEP
	William P Sullivan, DO, FACEP
	Nathan Seth Trueger, MD, MPH
Indiana	Sara Ann Brown, MD, FACEP
	John T Finnell, II, MD, FACEP
	John Thomas Rice, MD, FACEP
	James L Shoemaker, Jr, MD, FACEP
	Christopher S Weaver, MD, FACEP
	Lindsay M Weaver, MD, FACEP
Iowa	Ryan M Dowden, MD, FACEP
	Andrew Sean Nugent, MD, FACEP
	Rachael Sokol, DO, FACEP
	Michael E Takacs, MD, FACEP
Kansas	Chad Michael Cannon, MD, FACEP
	John M Gallagher, MD, FACEP
	Jeffrey G Norvell, MD, FACEP
Kentucky	David Wesley Brewer, MD, FACEP
	Royce Duane Coleman, MD, FACEP
	Melissa Platt, MD, FACEP
	Ryan Stanton, MD, FACEP
Louisiana	James B Aiken, MD, MHA, FACEP
	Jon Michael Cuba, MD, FACEP
	Phillip Luke LeBas, MD, FACEP
	Mark Rice, MD, FACEP
	Michael D Smith, MD, MBA, CPE, FACEP
Maine	Garreth C Debiegun, MD, FACEP
	James B Mullen, III, MD, FACEP
	Charles F Pattavina, MD, FACEP
Maryland	Jason D Adler, MD, FACEP
	Richard J Ferraro, MD, FACEP
	Kerry Forrestal, MD, FACEP
	Hugh F Hill, III, MD, JD, FACEP
	Kathleen D Keeffe, MD, FACEP
	Orlee Israeli Panitch, MD, FACEP
	Esteban Schabelman, MD, FACEP
Massachusetts	Brien Alfred Barnewolt, MD, FACEP
	Kate Burke, MD, FACEP
	Stephen K Epstein, MD, MPP, FACEP
	Jeffrey Hopkins, MD, FACEP
	Kathleen Kerrigan, MD, FACEP
	Matthew B Mostofi, DO, FACEP
	Mark D Pearlmutter, MD, FACEP

	Jesse Michael Schafer, MD
	Peter B Smulowitz, MD, FACEP
	Brian Sutton, MD, FACEP
Michigan	Michael J Baker, MD, FACEP
	Keenan M Bora, MD, FACEP
	Kathleen Cowling, DO, FACEP
	Nicholas Dyc, MD, FACEP
	Gregory Gafni-Pappas, DO, FACEP
	Rami R Khoury, MD, FACEP
	Robert T Malinowski, MD, FACEP
	Jacob Manteuffel, MD, FACEP
	James C Mitchiner, MD, MPH, FACEP
	Kevin Monfette, MD, FACEP
	David T Overton, MD, FACEP
	Paul R Pomeroy, Jr, MD, FACEP
	Luke Chris Saski, MD, FACEP
	Larisa May Traill, MD, FACEP
	Bradley J Uren, MD, FACEP
	Bradford L Walters, MD, FACEP
	Mildred J Willy, MD, FACEP
	James Michael Ziadeh, MD, FACEP
Minnesota	William G Heegaard, MD, FACEP
	David M Larson, MD, FACEP
	David A Milbrandt, MD, FACEP
	David Nestler, MD, MS, FACEP
	Gary C Starr, MD, FACEP
	Thomas E Wyatt, MD, FACEP
	Andrew R Zinkel, MD, FACEP
Mississippi	Melissa Wysong Costello, MD, FACEP
	Lawrence Albert Leake, MD, FACEP
Missouri	Douglas Mark Char, MD, FACEP
	Jonathan Heidt, MD, MHA, FACEP
	Thomas B Pinson, MD, FACEP
	Robert Francis Poirier, Jr., MD, MBA, FACEP
	Sebastian A Rueckert, MD, MBA, FACEP
	Christine Sullivan, MD, FACEP
Montana	Harry Eugene Sibold, MD, FACEP
Nebraska	Renee Engler, MD, FACEP
	Laura R Millemon, MD, FACEP
Nevada	Eric John Anderson, MD, FACEP
	Gregory Alan Juhl, MD, FACEP
	Scott Franklin Shepherd, MD, FACEP
New Hampshire	Reed Brozen, MD, FACEP
	Matthew Alexander Roginski, MD
New Jersey	Victor M Almeida, DO, FACEP
	Robert M Eisenstein, MD, FACEP
	William Basil Felegi, DO, FACEP
	Jenice Forde-Baker, MD, FACEP

	Anthony William Hartmann, MD, FACEP
	Steven M Hochman, MD, FACEP
	Marjory E Langer, MD, FACEP
	Alexis M LaPietra, DO
	J Mark Meredith, MD, FACEP
New Mexico	Eric Michael Ketcham, MD, FACEP
	Tony B Salazar, MD, FACEP
New York	Brahim Ardolic, MD, FACEP
	Samuel Francis Bosco, MD, FACEP
	Jay Miller Brenner, MD, FACEP
	Jeremy T Cushman, MD, FACEP
	Jason Zemmel D'Amore, MD, FACEP
	Mathew Foley, MD, FACEP
	Theodore J Gaeta, DO, FACEP
	Sanjey Gupta, MD, FACEP
	Michael Gary Guttenberg, DO, FACEP
	Abbas Husain, MD, FACEP
	Stuart Gary Kessler, MD, FACEP
	Penelope Chun Lema, MD, FACEP
	Joshua B Moskovitz, MD, MPH, FACEP
	Nestor B Nestor, MD, FACEP
	Salvatore R Pardo, MD, FACEP
	Jennifer Pugh, MD, FACEP
	Jeffrey S Rabrich, DO, FACEP
	Christopher C Raio, MD, FACEP
	Gary S Rudolph, MD, FACEP
	James Gerard Ryan, MD, FACEP
	Frederick M Schiavone, MD, FACEP
	Trent T She, MD
	Virgil W Smaltz, MD, MPA, FACEP
	Jeffrey J Thompson, MD, FACEP
	Asa “Peter” Viccellio, MD, FACEP
North Carolina	Gregory J Cannon, MD, FACEP
	Jennifer Casaletto, MD, FACEP
	Charles W Henrichs, III, MD, FACEP
	Jeffrey Allen Klein, MD, FACEP
	Thomas Lee Mason, MD, FACEP
	Abhishek Mehrotra, MD, FACEP
	Bret Nicks, MD, FACEP
	Jennifer L Raley, MD, FACEP
	Stephen A Small, MD, FACEP
	Michael J Utecht, MD, FACEP
North Dakota	K J Temple, MD, FACEP
Ohio	Eileen F Baker, MD, FACEP
	Saurin P Bhatt, MD
	Dan Charles Breece, DO, FACEP
	Laura Michelle Espy-Bell, MD
	Purva Grover, MD, FACEP
	Gary R Katz, MD, MBA, FACEP
	Erika Charlotte Kube, MD, FACEP
	Thomas W Lukens, MD, PhD, FACEP
	John L Lyman, MD, FACEP

	Catherine Anna Marco, MD, FACEP Daniel R Martin, MD, FACEP Michael McCrea, MD, FACEP Matthew J Sanders, DO, FACEP Ryan Squier, MD, FACEP Nicole Ann Veitinger, DO, FACEP
Oklahoma	Jeffrey Michael Goodloe, MD, FACEP Jeffrey Johnson, MD James Raymond Kennedye, MD, MPH, FACEP
Oregon	Robert D Barriatua, MD, FACEP David P Lehrfeld, MD John C Moorhead, MD, FACEP Hans T Notenboom, MD, FACEP Erin Schneider, MD
Pennsylvania	Kirby Black, MD Erik Blutinger, MD Deborah Brooks, MD Merle Andrea Carter, MD, FACEP Ankur A Doshi, MD, FACEP Joshua Enyart, DO Todd Fijewski, MD, FACEP Maria Koenig Guyette, MD, FACEP Marilyn Joan Heine, MD, FACEP Scott Jason Korvek, MD, FACEP Vishnu M Patel, MD Ericka Powell, MD, FACEP Shawn M Quinn, DO, FACEP Anna Schwartz, MD, FACEP Michael A Turturro, MD, FACEP Arvind Venkat, MD, FACEP Gary David Zimmer, MD, FACEP
Puerto Rico	Luis A Serrano, MD, FACEP Ivonne Velez-Acevedo, MD, FACEP
Rhode Island	Achyut B Kamat, MD, FACEP Melanie J Lippmann, MD, FACEP Jessica Smith, MD, FACEP
Society of Academic Emergency Medicine	Kathleen J Clem, MD, FACEP
South Carolina	Thomas H Coleman, MD, FACEP Allison Leigh Harvey, MD, FACEP Dietrich Jehle, MD, FACEP L Wade Manaker, MD, FACEP Frank C Smeeks, MD, FACEP
South Dakota	Scott Gregory Vankeulen, MD
Tennessee	Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Sarah Hoper, MD, JD, FACEP Thomas R Mitchell, MD, FACEP Karolyn K Moody, DO, MPH

Texas	Sara Andrabi, MD Carrie de Moor, MD, FACEP Justin W Fairless, DO, FACEP Angela Siler Fisher, MD, FACEP Diana L Fite, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Alison Haddock, MD, FACEP Justin P Hensley, MD, FACEP Heidi C Knowles, MD, FACEP John Bruce Moskow, MD, FACEP Heather S Owen, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Richard Dean Robinson, MD, FACEP Chet D Schrader, MD, FACEP Nicholas P Steinour, MD, FACEP Gerad A Troutman, MD, FACEP Hemant H Vankawala, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, FACEP
Utah	James V Antinori, MD, FACEP Bennion D Buchanan, MD, FACEP John R Dayton, MD, FACEP Stephen Carl Hartsell, MD, FACEP
Vermont	Joshua Harris, MD
Virginia	Brian C Dawson, MD, FACEP Bruce M Lo, MD, MBA, RDMS, FACEP Cameron K Olderog, MD, FACEP Jeremiah O'Shea, MD, FACEP Joran Sequeira, MD Mark Robert Sochor, MD, FACEP Sara F Sutherland, MD, MBA, FACEP Stephen J Wolf, MD, FACEP
Washington	Cameron Ross Buck, MD, FACEP Enrique R Enguidanos, MD, FACEP John Matheson, MD, FACEP Nathaniel R Schlicher, MD, JD, FACEP Patrick Solari, MD, FACEP Jennifer L'Hommedieu Stankus, MD, JD, FACEP Liam Yore, MD, FACEP
West Virginia	Frederick C Blum, MD, FACEP Thomas Marshall, MD, FACEP
Wisconsin	Howard Jeffery Croft, MD, FACEP William D Falco, MD, MS, FACEP William C Haselow, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP
Wyoming	Waseem A Khawaja, MD, FACEP

Sections of Membership

Air Medical Transport	Gaston Ariel Costa, MD
Amer Assoc of Women Emergency Physicians	E Lea Walters, MD, FACEP
Careers in Emergency Medicine	Sullivan K Smith, MD, FACEP
Critical Care Medicine	Ayan Sen, MD, FACEP
Cruise Ship Medicine	Sydney W Schneidman, MD, FACEP
Democratic Group Practice	David F Tulsiak, MD, FACEP
Disaster Medicine	Roy L Alson, MD, PhD, FACEP
Dual Training	Michael C Bond, MD, FACEP
Emergency Medical Informatics	Jeffrey A Nielson, MD, FACEP
Emergency Medical Services-Prehospital Care	Gina Piazza, DO, FACEP
EM Practice Management & Health Policy	Jonathan F Thomas, MD
Emergency Medicine Research	Nidhi Garg, MD, FACEP
Emergency Medicine Workforce	Guy Nuki, MD
Emergency Ultrasound	Robert M Bramante, MD, FACEP
Forensic Medicine	Lawrence J R Goldhahn, MD, FACEP
Freestanding Emegency Centers	Michael Joseph Sarabia, MD, FACEP
Geriatric Emergency Medicine	Marianna Karounos, DO, FACEP
International Emergency Medicine	Elizabeth L DeVos, MD, FACEP
Medical Humanities	David P Sklar, MD, FACEP
Observation Services	Carol L Clark, MD, MBA, FACEP
Palliative Medicine	Kate Aberger, MD, FACEP
Pediatric Emergency Medicine	Madeline Matar Joseph, MD, FACEP
Quality Improvement & Patient Safety	Jeffrey J Pothof, MD, FACEP
Rural Emergency Medicine	Darrell L Carter, MD, FACEP
Sports Medicine	Christopher Aaron Gee, MD, MPH, FACEP
Tactical Emergency Medicine	Howard K Mell, MD, MPH, CPE, FACEP
Telemedicine	Hartmut Gross, MD, FACEP
Toxicology	Jennifer Hannum, MD, FACEP

Trauma & Injury Prevention	Gregory Luke Larkin, MD, MPH, FACEP
Undersea & Hyperbaric Medicine	Richard Walker, III, MD, FACEP
Wellness	Susan Theresa Haney, MD, FACEP
Wilderness Medicine	Susanne J Spano, MD, FACEP
Young Physicians	Leisa Rossello Deutsch, MD, MPH, FACEP

In addition to the credentialed councillors, the following past leaders attended all or part of the Council meeting and were not serving as councillors:

Past Presidents

Nancy J. Auer, MD, FACEP (WA)
Larry A. Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Michael L. Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
Gregory L. Henry, MD, FACEP (MI)
J. Brian Hancock, MD, FACEP (MI)
John C. Johnson, MD, FACEP (IN)
Nicholas J. Jouriles, MD, FACEP (OH)
Brian F. Keaton, MD, FACEP (OH)
Linda L. Lawrence, MD, FACEP (GS)
Alex M. Rosenau, DO, FACEP (PA)
Robert W. Schafermeyer MD, FACEP (NC)
Sandra M. Schneider, MD, FACEP (TX)
David C. Seaberg, MD, CPE, FACEP (TN)
Richard L. Stennes, MD, MBA, FACEP (CA)
Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)
Marco Coppola, DO, FACEP (GS)
Mark L. DeBard, MD, FACEP (OH)
Peter J. Jacoby, MD, FACEP (CT)
Kevin M. Klauer, DO, FACEP (OH)
Todd B. Taylor, MD, FACEP (TN)
Arlo F. Weltge, MD, MPH, FACEP (TX)
Dennis C. Whitehead, MD, FACEP (MI)

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The Council Standing Rules were distributed to the councillors prior to the meeting and were not read aloud. The rules are listed as distributed.

Council Standing Rules

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

If the number of alternate councillors is insufficient to fill all councillor positions for a particular chapter, section, or EMRA, then a member of that sponsoring body may be seated as a councillor pro-tem by either the concurrence of an officer of the sponsoring body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the

speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, chapters, and sections, etc. are responsible for abiding by the campaign rules.

Cellular Phones, Pagers, and Computers

Cellular phones, pagers, and computers must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of computers for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by chapter and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate status. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

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

Debate should not exceed two minutes for each recognized individual unless special permission has been granted. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the chair, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.
When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, and Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tire for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, and Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, and Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committees shall consider activity and involvement in the College, the Council, and chapter or sections when considering the slate of candidates.

Nominations

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

A prospective floor candidate or an individual who intends to nominate a candidate from the floor may make this intent known in advance by notifying the Council secretary in writing. Upon receipt of this notification, the

candidate becomes a "declared floor candidate" and has all the rights and responsibilities of committee nominated candidates. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *Sturgis, 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 Personal Privilege and Voting Immediately.***

Past Presidents and Past Speakers Seating

Past presidents and past speakers of the College are invited to sit with their respective chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Personal Privilege

Any councillor may call for a "point of personal privilege" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege" to interject debate is out of order.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

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

Resolutions must be submitted in writing by at least two members or by chapters, sections, committees, or the Board of Directors. A letter of endorsement from the sponsoring body is required if submitted by a chapter, section, or committee.

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.

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

• Regular Non-Bylaws Resolutions

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

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

• Bylaws Resolutions

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

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

• Late Resolutions

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

• Emergency Resolutions

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting.
Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The motion to "vote immediately" applies only to the immediately pending matter, therefore, motions to "vote immediately on all pending matters" is out of order.

The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, voting cards, standing or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue.

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The councillors reviewed and accepted the minutes of the October 24-25, 2015, Council meeting and approved the actions of the Steering Committee taken at their January 26, 2016, and May 15, 2016, meetings.

Dr. Cusick called for submission of emergency resolutions. None were submitted.

Dr. Cusick reported that two late resolutions were received and reviewed by the Steering Committee. One late resolution was withdrawn and the other late resolution was accepted and assigned to Reference Committee C.

Dr. Cusick presented the Nominating Committee report. Four members were nominated for President-Elect: Hans R. House MD, MACM, FACEP; Paul D. Kivela, MD, MBA, FACEP; Robert E. O'Connor, MD, MPH, FACEP; and John J. Rogers, MD, CPE, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Seven members were nominated for four positions on the Board of Directors: James J. Augustine, MD, FACEP; John T. Finnell, MD, FACEP; Kevin M. Klauer, DO, EJD, FACEP; Debra G. Perina, MD, FACEP; Gillian R. Schmitz, MD, FACEP; Matthew J. Watson, MD, FACEP; and James M. Williams, DO, MS, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Dr. McManus explained the Candidate Forum procedures. The candidates then made their opening statements to the Council.

2016 Council Resolutions

The Council recessed at 9:15 am for the Reference Committee hearings. The resolutions considered by the 2016 Council appear below as submitted.

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Michael J. Gerardi, MD,

FACEP, for his exemplary service, leadership, and commitment to the College, the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, MD, FACEP, as one of the leaders in Emergency Medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Kenneth L. DeHart, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

RESOLUTION 3

RESOLVED, That the "Unanimous Consent" section of the Council Standing Rules be amended to read:

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. **The requestor, when recognized by the chair, may give a one-minute summary of the reason for extraction to enable the Council to determine the "merits of extraction." The Reference Committee chair will then read the summary of the testimony from the Reference Committee Report. Without debate, a one-third affirmative vote of the councillors present and voting is required to remove the item from the Unanimous Consent Agenda. This process will be repeated for each item requested to be removed from the Unanimous Consent Agenda.** Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

RESOLUTION 4

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be amended to read:

"Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. **Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status.** Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

RESOLUTION 5

RESOLVED, That the 2016 ACEP Council supports the establishment of a full voting designated young physician position on the ACEP Board of Directors.

RESOLUTION 6

RESOLVED, That the ACEP Board of Directors pursue an appropriate avenue to study and determine if any specific issues posed to Senior/Late Career Emergency Physicians exist, and that if there is a need to address issues related to Senior/Late Career Emergency Physicians, to address those issues in an appropriate manner to be determined by the ACEP Board and that a report on this matter shall be delivered to the 2017 ACEP Council.

RESOLUTION 7

RESOLVED, That the ACEP Board of Directors develop strategies to increase diversity within the ACEP Council and its leadership and report back to the Council on effective means of implementation.

RESOLUTION 8

RESOLVED, That ACEP oppose mandatory, required, high stakes secured examination for Maintenance of Certification (MOC) in Emergency Medicine; and be it further

RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

RESOLUTION 9

RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further

RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

RESOLUTION 10

RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

RESOLUTION 11

RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further

RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

RESOLUTION 12

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medical care, clinical and non-clinical, reach out and build coalitions with non-medical organizations involved in developing quality standards to achieve objective and meaningful advances in quality in the eyes of our patients, institutions, and payers; and be it further

RESOLVED, That the American College of Emergency Physicians, in conjunction with non-medical organizations involved in developing quality standards, define the costs of providing the highest levels of quality care, to quality/safety reflects reimbursement and reimbursement reflects quality/safety.

RESOLUITON 13

RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further

RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders 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; and be it further

RESOLVED, That ACEP reaffirms its support of:

1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge (before 11 am) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital

RESOLUTION 14

RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs; and be it further

RESOLVED, That ACEP endorse integration of a dashboard for reporting and tracking of behavioral health patients boarding in EDs in electronic health record systems as a means for linking to broader priority systems, for communicating the impact of boarded behavioral health patients, and to further collaborate with all appropriate health care and government stakeholders.

RESOLUTION 15

RESOLVED, That ACEP shall create a study of the impact of narrow networks laws and potential solutions that address balance billing issues without increasing the burden on the patient; and be it further

RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks does not affect a physician's ability to receive fair reimbursement for providing medical care.

RESOLUTION 16

RESOLVED, That ACEP develop a report or information paper supporting the use of Freestanding Emergency Centers as an alternative care model for the replacement of Emergency Departments in Critical Access and Rural Hospitals that have closed, or are in imminent risk of closure, to maintain access to emergency care in the underserved and rural regions of the United States.

RESOLUTION 17

RESOLVED, That ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patient's deductibles after the insurance company pays the physician the full negotiated rate; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates that advocates for a national law requiring health care insurance companies to collect patient's deductibles after the insurance company pays the physician the full negotiated rate.

RESOLUTION 18

RESOLVED, That ACEP oppose the overstep of CMS mandated reporting standards that require potential harm to patients without the recognition of appropriate physician assessment and evidence based goal directed care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and the public the dangers of CMS overstep of physician responsibility to patients for quality indicators and actively work to communicate to hospitals the need and options to recognize appropriate physician treatment while avoiding unnecessary harm to patients.

RESOLUTION 19

RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

RESOLUTION 20

RESOLVED, That the American College of Emergency Physicians work with the Undersea & Hyperbaric Medical Society (UHMS) and the Divers Alert Network (DAN) to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide timely and appropriate treatment to patients in need.

RESOLUTION 21

RESOLVED, That ACEP develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and be it further

RESOLVED, That ACEP provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

RESOLUTION 22

RESOLVED, That ACEP study the moral and ethical responsibilities of emergency physicians within the context of court ordered forensic collection of evidence in the context of patient refusal of consent, and if appropriate,

develop policy to support emergency physician's professional responsibilities when in conflict with court ordered forensic collection of evidence and or medical treatment.

RESOLUTION 23

RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further

RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction and maintenance programs (including methadone, buprenorphine) from the Emergency Department.

RESOLUTION 24

RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further

RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further

RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and the National Academy of Medicine to develop community and hospital based benchmark performance metrics for ED mental health flow and linking inpatient psychiatric facilities acceptance of patients to licensure.

RESOLUTION 25

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training and assessment for national registry testing and certification in recognition of the current level of training and experience of military medical specialist providers in our nation's service.

RESOLUTION 26

RESOLVED, That ACEP supports users of clinical ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of clinical ultrasound by non-radiology specialists and the billing for such services; and be it further

RESOLVED, That ACEP continue to support emergency physicians working to develop and implement clinical ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

RESOLUTION 27

RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further

RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

RESOLUTION 28

RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further

RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

RESOLUTION 29

RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further

RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further

RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including such innovative treatments as allowing school nurses and other trained school personnel to administer Naloxone, "safe injection sites," and needle exchange programs.

RESOLUTION 30

RESOLVED, That ACEP investigate the scope of treatment of marijuana intoxication in the ED that has legal implications; and be it further

RESOLVED, That ACEP determines if there are state or federal laws that provide guidance to emergency physicians in the treatment of marijuana intoxication in the ED; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee or task force to answer clinically relevant questions that address the need to care for ED patients with possible marijuana (or other drug) intoxication; and be it further

RESOLVED, That ACEP investigate how other medical specialties address the treatment of marijuana intoxication in other clinical settings; and be it further

RESOLVED, That ACEP provide the resources necessary to coordinate the treatment of marijuana intoxication in the ED.

RESOLUTION 31 (This late resolution was accepted by the Council for submission.)

RESOLVED, That ACEP actively oppose the FDA approval of sublingual formulations of synthetic fentanyl analogs, including sufentanil, via direct testimony or other means that the Board may find suitable; and be it further

RESOLVED**,** That ACEP create a report detailing the risks, benefits, and alternatives to the use of narcotic analgesics that, by their specific route of administration or formulation, carry a higher risk of misuse or abuse than other similarly classified drugs, in EMS and Emergency Medicine.

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Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 3-8 were referred to Reference Committee A. Chad Kessler, MD, FACEP, chaired Reference Committee A and other members were: James R. Kennedye, MD, MPH, FACEP; Heidi C. Knowles, MD, FACEP; Paul R. Pomeroy, Jr., MD, FACEP; Anne Zink, MD, FACEP; Leslie Moore, JD; and Dan Sullivan.

Resolutions 9-20 were assigned to Reference Committee B. Nathaniel R. Schlicher, MD, JD, FACEP, chaired Reference Committee B and other members were: Jordan GR Celeste, MD, FACEP; William B. Felegi, DO, FACEP; Heather A. Heaton, MD; Donald L. Lum, MD, FACEP; Tony B. Salazar, MD, FACEP; Harry Monroe; and Barbara Tomar, MHA.

Resolutions 21-31 were referred to Reference Committee C. Kelly Gray-Eurom, MD, MMM, FACEP, chaired Reference Committee C and other members were: Sabina A. Braithwaite, MD, FACEP; Gregory Cannon, MD, FACEP; Nathaniel T. Hibbs, DO, FACEP; Ramon W. Johnson, MD, FACEP; Harry E. Sibold, MD, FACEP; Margaret Montgomery, RN, MSN; and Sandy Schneider, MD, FACEP.

At 1:00 pm a Town Hall Meeting was held. The topic was "Alternate Delivery Models and Their Impact on Emergency Medicine." Marco Coppola, DO, FACEP, served as the moderator and the discussants were Paolo Coppola, MD, FACEP; Hartmut Gross, MD, FACEP; Howard Mell, MD, FACEP; and Gerad Troutman, MD, FACEP.

The Candidate Forum began at 2:30 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:15 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. Cusick introduced the Board of Directors and honored guests and then addressed the Council.

Dr. Cusick reviewed the procedure for the adoption of the 2016 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then presented the memorial resolution to the colleagues of Kenneth L. DeHart, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting 2016 and adopted the memorial resolution by observing a moment of silence.

Dr. Cusick announced that the commendation resolution would be presented during the Council luncheon on

Saturday, October 15, 2016.

Michael L Carius, MD, FACEP, reported on activities of the American Board of Emergency Medicine.

William P. Jaquis, MD, FACEP, presented the secretary-treasurer's report.

Ramnik Dhaliwal, MD, JD, addressed the Council regarding the activities of the Emergency Medicine Residents' Association.

Brooks Bock, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

Peter Jacoby, MD, FACEP, addressed the Council regarding the activities of NEMPAC and the 911 Network.

Jay A. Kaplan, MD, FACEP, president, addressed the Council. He reflected on his past year as ACEP president and highlighted the successes of the College.

The Council recessed at 5:30 pm for the candidate reception and reconvened at 8:00 am on Saturday, October 15, 2016.

Dr. Costello reported that 386 councillors of the 394 eligible for seating had been credentialed. She then introduced the members of the Tellers, Credentials, & Elections Committee, reviewed the electronic voting procedures, and conducted a test of the keypads using demographic and survey questions.

Mr. Wilkerson addressed the Council and then showed a video of the new ACEP headquarters building.

REFERENCE COMMITTEE A

Dr. Kessler presented the report of Reference Committee A. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 6 and Amended Resolution 7

The Council adopted the resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 6

RESOLVED, THAT THE ACEP BOARD OF DIRECTORS ~~PURSUE AN APPROPRIATE AVENUE~~ **CREATE A TASK FORCE** TO STUDY ~~AND DETERMINE IF ANY~~ **ISSUES** SPECIfiC ~~ISSUES POSED~~ TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS. ~~EXIST, AND THAT IF THERE IS A NEED TO ADDRESS ISSUES RELATED TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS, TO ADDRESS THOSE ISSUES IN AN APPROPRIATE MANNER TO BE DETERMINED BY THE ACEP BOARD AND THAT A REPORT ON THIS MATTER SHALL BE DELIVERED~~ **THE TASK FORCE SHALL MAKE RECOMMENDATIONS REGARDING IDENTIFIED ISSUES TO THE BOARD, WHICH SHALL DELIVER AN UPDATE ON THIS MATTER** TO THE 2017 ACEP COUNCIL.

AMENDED RESOLUTION 7

RESOLVED, THAT THE ACEP BOARD OF DIRECTORS **WORK IN A COORDINATED EFFORT WITH THE COMPONENT BODIES OF THE COUNCIL TO** DEVELOP STRATEGIES TO INCREASE DIVERSITY WITHIN THE ~~ACEP~~ COUNCIL AND ITS LEADERSHIP AND REPORT BACK TO THE COUNCIL ON EFFECTIVE MEANS OF IMPLEMENTATION.

The committee recommended that Resolution 3 not be adopted.

It was moved THAT RESOLUTION 3 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 4 be adopted.

It was moved THAT RESOLUTION 4 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 5 not be adopted.

It was moved THAT RESOLUTION 5 BE ADOPTED.

It was moved THAT THE WORDS "FULL VOTING" BE DELETED. The motion was not adopted.

The main motion was then voted on and was not adopted

The committee recommended that Resolution 8 not be adopted.

It was moved THAT RESOLUTION 8 BE ADOPTED.

It was moved THAT RESOLUTION 8 BE DIVIDED. The motion was adopted.

It was moved THAT THE FIRST RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP ~~OPPOSE MANDATORY, REQUIRED, HIGH STAKES SECURED EXAMINATION~~ **WORK WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE (ABEM TO FURTHER DEVELOP ALTERNATIVE WAYS TO ASSESS MEDICAL KNOWLEDGE OTHER THAN BY A HIGH-STAKES STANDARDIZED TEST** FOR MAINTENANCE OF CERTIFICATION (MOC) IN EMERGENCY MEDICINE. The motion was adopted.

The amended main motion was then voted on and was not adopted.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 8 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

Dr. Gray-Eurom presented the report of Reference Committee C. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 21, Resolution 22, Amended Resolution 25, Amended Resolution 26, Resolution 27, and Resolution 28.

Resolution 21 was extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 25

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICINE CARE, SUPPORT CURRENT STATE AND FEDERAL INITIATIVES FOR ACCELERATED TRAINING ~~AND ASSESSMENT FOR NATIONAL REGISTRY TESTING AND CERTIFICATION IN RECOGNITION OF THE~~ **TO ALLOW TRANSITION OF CURRENT MILITARY PRE-HOSPITAL PERSONNEL TO THE CIVILIAN SECTOR AND WHICH RECOGNIZE THE** CURRENT LEVEL OF TRAINING AND EXPERIENCE OF MILITARY MEDICAL SPECIALIST PROVIDERS IN OUR NATION'S SERVICE.

AMENDED RESOLUTION 26

RESOLVED, THAT ACEP SUPPORTS USERS OF ~~CLINICAL~~ **EMERGENCY** ULTRASOUND WITH A STATEMENT DECLARING OPPOSITION TO THE USE OF EXCLUSIVE IMAGING CONTRACTS TO LIMIT THE USE OF ~~CLINICAL~~ **EMERGENCY** ULTRASOUND BY NON-RADIOLOGY SPECIALISTS AND THE BILLING FOR SUCH SERVICES; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO SUPPORT EMERGENCY PHYSICIANS WORKING TO DEVELOP AND IMPLEMENT ~~CLINICAL~~ **EMERGENCY** ULTRASOUND PROGRAMS WHO FACE OPPOSITION IN HOSPITALS WHERE RADIOLOGISTS OR OTHERS HOLD EXCLUSIVE IMAGING CONTRACTS.

The committee recommended that RESOLUTION 21 BE ADOPTED.

It was moved THAT 21 BE ADOPTED.

Without objection, the title of the resolution was amended by deleting the words "including warm handoffs."

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 23 be adopted.

It was moved THAT AMENDED RESOLUTION 23 BE ADOPTED:

RESOLVED, THAT ACEP REVIEW THE EVIDENCE ON ED-INITIATED TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS TO PROVIDE EMERGENCY PHYSICIAN EDUCATION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION ~~AND MAINTENANCE~~ PROGRAMS **SUCH AS** ~~(INCLUDING METHADONE~~, BUPRENORPHINE~~),~~,FROM THE EMERGENCY DEPARTMENT.

Without objection, the title was amended by replacing the word "medical" with the word "medication."

It was moved THAT THE WORDS "SUCH AS" AND THE WORD "BUPRENORPHINE" BE DELETED. The motion was adopted.

It was moved THAT THE SECOND RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION PROGRAMS AND THE DEVELOPMENT OF CLINICAL POLICY GUIDELINES REGARDING OPIOUD WITHDRAWAL MANAGEMENTIN THE EMERGENCY DEPARTMENT. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 24 be adopted.

It was moved THAT AMENDED RESOLUTION 24 BE ADOPTED:

RESOLVED, THAT ACEP PARTNER WITH STAKEHOLDERS INCLUDING THE AMERICAN PSYCHIATRIC ASSOCIATION, THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, **THE** NATIONAL ALLIANCE OF MENTAL ILLNESS, AND OTHER INTERESTED PARTIES, TO DEVELOP MODEL PRACTICES FOCUSED ON BUILDING BED CAPACITY, ENHANCING ALTERNATIVES, AND REDUCING THE LENGTH OF STAY FOR MENTAL HEALTH PATIENTS IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP AND SHARE THESE ED MENTAL HEALTH BEST PRACTICES DESIGNED TO REDUCE ED MENTAL HEALTH VISITS, REDUCE ED MENTAL HEALTH BOARDING, AND IMPROVE THE OVERALL CARE OF PATIENTS WHO BOARD IN OUR EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH ~~THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND THE NATIONAL ACADEMY OF MEDICINE~~ **APPROPRIATE STAKEHOLDERS** TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND ~~LINKING~~ INPATIENT

PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS ~~TO LICENSURE~~.

It was moved THAT THE THIRD RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP WORK WITH **THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND OTHER APPROPRIATE STAKEHOLDERS** TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND ~~LINKING INPATIENT~~ PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS ~~TO LICENSURE~~. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 35 be adopted.

It was moved THAT AMENDED RESOLUTION 29 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THE TRAINING AND EQUIPPING OF ALL FIRST RESPONDERS, INCLUDING POLICE, FIRE, AND EMS PERSONNEL TO USE INJECTABLE AND NASAL SPRAY NALOXONE; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THAT APPROPRIATELY TRAINED PHARMACISTS BE ABLE TO DISPENSE NALOXONE WITHOUT PRESCRIPTION; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A COMPREHENSIVE POLICY ON THE PREVENTION AND TREATMENT OF THE OPIOID USE DISORDER EPIDEMIC INCLUDING ~~SUCH~~ INNOVATIVE TREATMENTS. ~~AS ALLOWING SCHOOL NURSES AND OTHER TRAINED SCHOOL PERSONNEL TO ADMINISTER NALOXONE, "SAFE INJECTION SITES," AND NEEDLE EXCHANGE PROGRAMS.~~ The motion was adopted.

The committee recommended that Resolution 30 not be adopted.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP INVESTIGATE THE SCOPE OF TREATMENT OF ~~MARIJUANA INTOXICATION~~ **POSSIBLE COMPLICATIONS OF CANNABINOID USE**IN THE ED THAT ~~HAS~~ **HAVE** LEGAL IMPLICATIONS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP DETERMINES IF THERE ARE STATE OR FEDERAL LAWS THAT PROVIDE GUIDANCE TO EMERGENCY PHYSICIANS IN THE TREATMENT OF MARIJUANA INTOXICATION IN THE ED; AND BE IT FURTHER~~

RESOLVED, THAT THE BOARD OF DIRECTORS ASSIGN AN APPROPRIATE COMMITTEE OR TASK FORCE TO ANSWER CLINICALLY RELEVANT QUESTIONS THAT ADDRESS THE NEED TO CARE FOR ED PATIENTS WITH POSSIBLE ~~MARIJUANA (OR OTHER DRUG) INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE**; AND BE IT FURTHER

RESOLVED, THAT ACEP INVESTIGATE HOW OTHER MEDICAL SPECIALTIES ADDRESS THE TREATMENT OF ~~MARIJUANA INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE** IN OTHER CLINICAL SETTINGS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE THE RESOURCES NECESSARY TO COORDINATE THE TREATMENT OF ~~MARIJUANA INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE** IN THE ED.

It was moved THAT THE RESOLUTION 30 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 31 be adopted.

It was moved THAT AMENDED RESOLUTION 31 BE ADOPTED:

RESOLVED, THAT ACEP ACTIVELY OPPOSE THE FDA APPROVAL OF SUBLINGUAL FORMULATIONS OF SYNTHETIC FENTANYL ANALOGS, INCLUDING SUFENTANIL, VIA DIRECT TESTIMONY OR OTHER MEANS THAT THE BOARD MAY FIND SUITABLE.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP CREATE A REPORT DETAILING THE RISKS, BENEFITS, AND ALTERNATIVES TO THE USE OF NARCOTIC ANALGESICS THAT, BY THEIR SPECIFIC ROUTE OF ADMINISTRATION OR FORMULATION, CARRY A HIGHER RISK OF MISUSE OR ABUSE THAN OTHER SIMILARLY CLASSIFIED DRUGS, IN EMS AND EMERGENCY MEDICINE.~~ The motion was adopted.

The Council recessed at 11:30 am for the awards luncheon and reconvened at 1:00 pm on Saturday, October 15, 2016.

REFERENCE COMMITTEE B

Dr. Schlicher presented the report of Reference Committee B. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 9, Resolution 11, Amended Resolution 12, Amended Resolution 13, Amended Resolution 14, Amended Resolution 15, Amended Resolution 16, Amended Resolution 17, Resolution 19 and Resolution 20.

For referral: Resolution 10.

Amended Resolution 12, Resolution 13, and Amended Resolution 17 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 14

RESOLVED, THAT THE ACEP PROMOTE THE DEVELOPMENT AND APPLICATION OF THROUGHPUT QUALITY DATA MEASURES AND DASHBOARD REPORTING FOR BEHAVIORAL HEALTH PATIENTS ~~BOARDED~~ IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENDORSE INTEGRATION OF A DASHBOARD FOR REPORTING AND TRACKING OF BEHAVIORAL HEALTH PATIENTS BOARDING IN EDS IN ELECTRONIC HEALTH RECORD SYSTEMS AS A MEANS FOR LINKING TO BROADER PRIORITY SYSTEMS, FOR COMMUNICATING THE IMPACT OF BOARDED BEHAVIORAL HEALTH PATIENTS, AND TO FURTHER COLLABORATE WITH ALL APPROPRIATE HEALTH CARE AND GOVERNMENT STAKEHOLDERS.

AMENDED RESOLUTION 15

RESOLVED, THAT ACEP SHALL CREATE A STUDY OF THE IMPACT OF NARROW NETWORKS LAWS AND POTENTIAL SOLUTIONS THAT ADDRESS BALANCE BILLING ISSUES WITHOUT INCREASING THE BURDEN ON THE PATIENT; AND BE IT FURTHER

RESOLVED, THAT ACEP DEDICATE RESOURCES AND SUPPORT TO ENSURE ANY PROPOSED LEGISLATION REGARDING NARROW NETWORKS ~~DOES NOT AFFECT~~ **PROTECTS** ~~A PHYSICIAN'S ABILITY TO RECEIVE~~ **FAIR PAYMENT** FOR ~~PROVIDING~~ **EMERGENCY** MEDICAL CARE.

AMENDED RESOLUTION 16

RESOLVED, THAT ACEP DEVELOP A REPORT OR INFORMATION PAPER ~~SUPPORTING~~ **ANALYZING** THE USE OF FREESTANDING EMERGENCY CENTERS AS AN ALTERNATIVE CARE MODEL ~~FOR THE REPLACEMENT OF~~ **TO MAINTAIN ACCESS TO EMERGENCY CARE IN AREAS WHERE** EMERGENCY DEPARTMENTS IN CRITICAL ACCESS AND RURAL HOSPITALS THAT HAVE CLOSED, OR ARE IN ~~IMMINENT RISK OF CLOSURE, TO MAINTAIN ACCESS TO EMERGENCY CARE IN THE UNDERSERVED AND RURAL REGIONS OF THE UNITED STATES~~ **THE PROCESS OF CLOSING**.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 12 BE ADOPTED:

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ~~IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICAL CARE, CLINICAL AND NON-CLINICAL,~~ REACH OUT AND BUILD COALITIONS WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING **NON-CLINICAL** QUALITY STANDARDS ~~TO ACHIEVE OBJECTIVE AND MEANINGFUL ADVANCES IN QUALITY IN THE EYES OF OUR PATIENTS, INSTITUTIONS, AND PAYERS; AND BE IT FURTHER~~ **THAT INCLUDE AN EVALUATION OF THE COST OF PROVIDING THE HIGHEST LEVEL QUALITY OF CARE.**

~~RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN CONJUNCTION WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING QUALITY STANDARDS, DEFINE THE COSTS OF PROVIDING THE HIGHEST LEVELS OF QUALITY CARE, TO QUALITY/SAFETY REFLECTS REIMBURSEMENT AND REIMBURSEMENT REFLECTS QUALITY/SAFETY.~~

It was moved THAT RESOLUTION 12 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED.

RESOLVED, THAT ACEP REQUEST THAT THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) UNDER SECTION 319 OF THE PUBLIC HEALTH SERVICE (PHS) ACT DETERMINES THAT EMERGENCY DEPARTMENT BOARDING AND HALLWAY CARE IS AN IMMEDIATE THREAT TO THE PUBLIC HEALTH AND PUBLIC SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE UNITED STATES PUBLIC HEALTH SERVICE, THE JOINT COMMISSION, AND OTHER APPROPRIATE STAKEHOLDERS 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; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~REAFFIRMS ITS SUPPORT OF~~ **PUBLICLY PROMOTE THE FOLLOWING AS SUSTAINABLE SOLUTIONS TO HOSPITAL CROWDING WHICH HAVE THE HIGHEST IMPACT ON PATIENT SAFETY, HOSPITAL CAPACITY, ICU AVAILABILITY, AND COSTS**:

1. SMOOTHING OF ELECTIVE ADMISSIONS AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
2. EARLY DISCHARGE (BEFORE 11 AM) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
3. ENHANCED WEEKEND DISCHARGES AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
4. THE REQUIREMENT FOR A GENUINE INSTITUTIONAL SOLUTION TO BOARDING WHEN THERE IS NO HOSPITAL CAPACITY, WHICH MUST INCLUDE BOTH PROVIDING ADDITIONAL STAFF AS NEEDED AND REDISTRIBUTING THE MAJORITY OF ED BOARDERS TO OTHER AREAS OF THE HOSPITAL.
5. THE CONCEPT OF A TRUE 24/7 HOSPITAL.

Without objection, the title of the resolution was amended to read: "Emergency Department Boarding and Crowding is a Public Health Emergency."

Without objection, item 2. was amended to read: "EARLY DISCHARGE **STRATEGIES** (~~BEFORE~~ **E.G.,** 11 AM **DISCHARGES, SCHEDULED DISCHARGES, STAGGERED DISCHARGES**) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY."

The amended main motion was then voted on and was adopted.

The committee recommended that Amended Resolution 17 be adopted.

It was moved THAT AMENDED RESOLUTION 17 BE ADOPTED:

RESOLVED, THAT ACEP ADD TO ITS LEGISLATIVE AGENDA AS A PRIORITY TO ADVOCATE FOR HEALTH CARE INSURANCE COMPANIES TO BE REQUIRED TO COLLECT PATIENTS' DEDUCTIBLES **FOR EMTALA-RELATED CARE** AFTER THE INSURANCE COMPANY PAYS THE PHYSICIAN ~~THE FULL NEGOTIATED RATE~~; AND BE IT FURTHER

RESOLVED, THAT ACEP SUBMIT A RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES THAT ADVOCATES FOR A NATIONAL LAW REQUIRING HEALTH CARE INSURANCE COMPANIES TO COLLECT PATIENT~~'S~~ DEDUCTIBLES AFTER THE INSURANCE COMPANY PAYS THE PHYSICIAN FOR ~~THE FULL NEGOTIATED RATE~~ **EMTALA RELATED CARE**.

It was moved THAT AMENDED RESOLUTION 17 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 18 be adopted.

It was moved THAT AMENDED RESOLUTION 18 BE ADOPTED.

RESOLVED, THAT ACEP ~~OPPOSE THE OVERSTEP OF~~ **WORK WITH** CMS **REGARDING** MANDATED REPORTING STANDARDS THAT ~~REQUIRE~~ **MAY RESULT IN** ~~POTENTIAL~~ HARM TO PATIENTS WITHOUT THE RECOGNITION OF ~~APPROPRIATE PHYSICIAN ASSESSMENT~~ ~~AND~~ EVIDENCE BASED~~, GOAL DIRECTED~~ CARE OF INDIVIDUAL PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ACTIVELY COMMUNICATE TO MEMBERS AND ~~THE PUBLIC~~ **HOSPITALS** THE DANGERS ~~OF CMS OVERSTEP OF~~ ~~PHYSICIAN RESPONSIBILITY TO PATIENTS FOR~~ **THAT** QUALITY INDICATORS **COULD PRESENT HARM TO POTENTIAL PATIENTS,** AND ~~ACTIVELY WORK TO COMMUNICATE TO HOSPITALS THE NEED AND OPTIONS TO RECOGNIZE APPROPRIATE PHYSICIAN TREATMENT WHILE AVOIDING UNNECESSARY HARM TO PATIENTS.~~ **THE IMPORTANCE OF PHYSICIAN AUTONOMY IN TREATMENT**. The motion was adopted.

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Dr. Parker, president-elect, addressed the Council.

Dr. Costello reported that 392 of the 394 councillors eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Klauer and Dr. Schmitz were elected to a three-year term. Dr. Augustine and Dr. Perina were re-elected to a three-year term.

The Tellers, Credentials, & Elections Committee conducted the president-elect election. Dr. Kivela was elected.

There being no further business, Dr. Cusick adjourned the 2016 Council meeting at 3:00 pm on Saturday, October 15, 2016. The next meeting of the ACEP Council is scheduled for October 27-28, 2017, at the Marriott Marquis Hotel in Washington, DC.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary

Approved by,

James M. Cusick, MD FACEP
Council Speaker