American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2016 Annual ACEP Council Meeting

Reference Committee Reports

Saturday, October 15, 2016

ORDER OF DEBATE

Reference Committee A – Dr. Cusick Presiding

Reference Committee C – Dr. McManus Presiding

Reference Committee B – Dr. Cusick Presiding

DEFINITIONS OF AVAILABLE COUNCIL ACTIONS

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

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

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

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

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

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2016 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Michael J. Gerardi, MD, FAAP, FACEP *New Jersey Chapter*	
2	In Memory of Kenneth L. DeHart, MD, FACEP *South Carolina College of Emergency Physicians*	
3	Unanimous Consent - Council Standing Rules Amendment *Council Steering Committee*	A
4	Legacy Fellows – Housekeeping Change - Bylaws Amendment *Bylaws Committee* *Board of Directors*	A
5	Young Physician Position on the ACEP Board of Directors *Young Physicians Section*	A
6	Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians *Careers in Emergency Medicine Section*	A
7	Diversity in Emergency Medicine Leadership *Pennsylvania College of Emergency Physicians*	A
8	Opposition to Required High Stakes Secured Examination for Maintenance of Certification *Texas College of Emergency Physicians*	A
9	Accreditation Standards for Freestanding Emergency Centers *Freestanding Emergency Centers Section*	B
10	Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use *Larry Bedard, MD, FACEP* *Jerome Hoffman, MD, FACEP* *Robert Solomon, MD, FACEP*	B
11	CMS Recognition of Independently Licensed Freestanding Emergency Centers *Texas College of Emergency Physicians*	B
12	Collaboration with Non-Medical Entities on Quality and Standards *Missouri College of Emergency Physicians*	B
13	Crowding Kills *Massachusetts College of Emergency Physicians* *Peter Viccellio, MD, FACEP*	B

Resolution #	Subject/Submitted by	Reference Committee
14	Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients Boarding in EDs *Washington Chapter* *California Chapter*	B
15	Enactment of Narrow Networks Requirements *Illinois College of Emergency Physicians*	B
16	Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. *Freestanding Emergency Centers Section* *Rural Emergency Medicine Section*	B
17	Insurance Collection of Beneficiary Deductibles *Connecticut College of Emergency Physicians* *Daniel Freess, MD, FACEP* *Greg Shangold, MD, FACEP*	B
18	Opposition to CMS Mandating Treatment Expectations *Texas College of Emergency Physicians*	B
19	Single-Payer Health Insurance *Larry Bedard, MD, FACEP* *Kathleen Cowling, DO, FACEP* *Gregory Gafni-Pappas, DO, FACEP* *Gregory Larkin, MD, FACEP* *Jacob Manteuffel, MD, FACEP* *James Mitchiner, MD, FACEP* *Charles Pattavina, MD, FACEP* *Megan Ranney, MD, FACEP* *Robert Solomon, MD, FACEP* *Nicholas Vasquez, MD, FACEP* *Peter Viccellio, MD, FACEP* *Bradford Walters, MD, FACEP*	B
20	Support & Advocacy for 24/7 Hyperbaric Medicine Availability *Undersea & Hyperbaric Medicine Section*	B
21	Best Practices for Harm Reduction Strategies, Including Warm Handoffs, in the ED *Pennsylvania College of Emergency Physicians*	C
22	Court Ordered Forensic Evidence Collection in the ED *Texas College of Emergency Physicians*	C
23	Medical Assisted Therapy for Patients with Substance Use Disorders in the ED *Pennsylvania College of Emergency Physicians*	C
24	Mental Health Boarding Solutions *Massachusetts College of Emergency Physicians* *Peter Viccellio, MD, FACEP*	C

Resolution #	Subject/Submitted by	Reference Committee
25	Military Medics Integration into Civilian EMS *Missouri College of Emergency Physicians*	C
26	Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians *Emergency Ultrasound Section* *New York Chapter*	C
27	Pediatric Surgery Centers *California Chapter* *Washington Chapter*	C
28	Reimbursement for Opioid Counseling *Pennsylvania College of Emergency Physicians*	C
29	The Opioid Epidemic – A Leadership Role for ACEP *Larry Bedard, MD, FACEP* *Richard Bukata, MD, FACEP* *Jerome Hoffman, MD, FACEP* *James Mitchiner, MD, FACEP* *Charles Pattavina, MD, FACEP* *Michael Salomon, MD* *Peter Viccellio, MD, FACEP*	C
30	Treatment of Marijuana Intoxication in the ED *Illinois College of Emergency Physicians*	C

Late Resolutions

Resolution #	Subject/Submitted by	Reference Committee
31	Opposing the Development of Sublingual Sufentanil *Howard Mell, MD, MPH, FACEP* *Megan Ranney, MD, MPH, FACEP*	

2016 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 3-8, Compensation Committee Report

Chad Kessler, MD, MPHE, FACEP (GS), Chair
James R. Kennedye, MD, MPH, FACEP (OK)
Heidi C. Knowles, MD, FACEP (TX)
Paul R. Pomeroy, Jr., MD, FACEP (MI)
Anne Zink, MD, FACEP (AK)

Leslie Moore, JD
Dan Sullivan

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2016 Council Meeting

Report of REFERENCE COMMITTEE A

Presented by: Chad Kessler, MD, MPHE, FACEP, Chair

Mr. Speaker and Councillors:

Reference Committee A gave careful consideration to the several items referred to it and submits the following report:

(1) Unanimous Consent Agenda

For adoption:

- **AMENDED RESOLUTION 6(16): Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians**
- **AMENDED RESOLUTION 7(16): Diversity in Emergency Medicine Leadership**

AMENDED RESOLUTION 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 6(16) be adopted.

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.

Testimony

There was significant testimony on this resolution, all in favor of adoption. Testimony concurred in the assumption that issues do exist that need to be studied and addressed. Hospitals are already testing the cognitive and other capabilities of aging physicians, and ABMS and other medical societies are also interested in this issue. It would be to emergency physicians' advantage to have ACEP move decisively and rapidly on this issue and provide guidance rather than have external organizations judge ACEP members' competency. Additional testimony stressed that the issue is not about just setting standards, but rather is about developing a process whereby aging physicians can acquire and maintain skills needed to deliver competent care. ACEP's leadership in this process will enable it to set the debate, answer the attendant questions, and develop the appropriate "fitness to practice" criteria.

AMENDED RESOLUTION 7(16) Diversity in Emergency Medicine Leadership

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 7(16) be adopted.

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.

Testimony

There was abundant testimony unanimously in favor of the resolution. A number of chapters provided testimony suggesting that increasing diversity at the chapter level will increase diversity at the Council level, and thereby the leadership of the College. Testimony from the California Chapter indicated their membership has benefitted from intentional efforts to increase diversity in their leadership. The Pennsylvania and Texas Chapters also testified to their respective chapter commitments to increasing diversity among their leadership. It was noted that diversity includes issues related not only to ethnicity and gender, but also to those of age and persons with disabilities. Current Board members affirmed support of increasing diversity within all positions of leadership. The proposed amended resolution reflects the emphasis that this is a grassroots effort to include chapter and section components of the Council as well as the Council as a larger body.

End of Consent Agenda

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(2) RESOLUTION 3(16) Unanimous Consent – Council Standing Rules Amendment

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 3(16) not be adopted.

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.

101 **Testimony**
102
103 A majority of the testimony was against adoption, although there was acknowledgment that the
104 resolution is intended to create a more efficient process, respect the time of the Council and the efforts of
105 the reference committees. Those expressing support further testified that because this resolution requires the
106 Council to provide its support, it exemplifies the democratic process. Those in favor of the resolution
107 emphasized that many times items are pulled off the consent agenda when the outcome is clear; this practice
108 wastes Council time.
109
110 Those opposed argued that limiting the ability of Council members to remove items from the
111 Consent Agenda is undemocratic and stifles debate. Historically, select resolutions have been removed from
112 the Consent Agenda by a single individual, whose testimony to the Council body has reversed the
113 recommendation of the Reference Committee. These historical precedents argue against adoption of the
114 resolution.
115

116
117 **(3) RESOLUTION 4(16) Legacy Fellows – Housekeeping Change – Bylaws Amendment**
118
119 RECOMMENDATION:
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121 Mr. Speaker, your Reference Committee recommends that Resolution 4(16) be adopted.
122
123 RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be
124 amended to read:
125
126 "Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. **Members**
127 **previously designated as ACEP Fellows under any prior criteria shall retain Fellow status.**
128 Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election,
129 and reasons for termination of Fellows shall be determined by the Board of Directors.
130
131 **Testimony**
132
133 The limited testimony on this resolution was unanimously in favor.
134

135
136 **(4) RESOLUTION 5(16) Young Physician Position on the ACEP Board of Directors**
137
138 RECOMMENDATION:
139
140 Mr. Speaker, your Reference Committee recommends that Resolution 5(16) not be adopted.
141
142 RESOLVED, That the 2016 ACEP Council supports the establishment of a full voting designated
143 young physician position on the ACEP Board of Directors.
144
145 **Testimony**
146
147 Lengthy debate ensued regarding this resolution, with the testimony evenly split among the
148 speakers. Those in favor of the resolution stated that young physicians are routinely unable to serve on the
149 Board because of the current requirements for membership. Bringing on young physicians will create
150 generational diversity and bring a different energy to the Board, which is healthy for the College. They
151 emphasized that we risk losing these younger physicians if we do not engage them. Furthermore, other
152 medical associations, including the American Medical Association, have already instituted with success a
153 seat for young physicians. Merely having a representative from EMRA at the Board of Directors meetings
154 is not equivalent to having a young physician member of the Board. Young physicians constitute a group
155 with substantially different needs, experiences, and interests than residents.
156

157 Those in opposition stated that a young physician may not have the experience needed to fill a seat
158 on the Board and emphasized that the criteria for Board membership should not cater to one particular
159 demographic within the College. Others stated that granting this seat is tantamount to age discrimination
160 and that if the requirements for Board service are too onerous, the requirements should be revised rather
161 than creating exceptions that cater to a special interest group. Furthermore, the Council is the correct venue
162 for an underrepresented group to find its voice in the College rather than creating a special seat on the
163 Board. It was suggested that creating a non-voting seat on the Board may provide a solution to this problem.
164

165
166 **(5) RESOLUTION 8(16) Opposition to Required High Stakes Secured Examination for Maintenance**
167 **of Certification**
168
169 RECOMMENDATION:
170
171 Mr. Speaker, your Reference Committee recommends that Resolution 8(16) not be adopted.
172
173 RESOLVED, That ACEP oppose mandatory, required, high stakes secured examination for
174 Maintenance of Certification (MOC) in Emergency Medicine; and be it further
175
176 RESOLVED, That ACEP work with members, other interested organizations, and interested
177 certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow
178 individual practitioners options to demonstrate or verify their content knowledge for continued practice in
179 Emergency Medicine.
180
181 **Testimony**
182
183 There was significant debate on this topic with passionate testimony on both sides of the resolution.
184 Those in favor shared that while they appreciate the work of ABEM, they were tasked with representing
185 their membership who would be in support of changing the high stakes nature of the MOC exam. Reasons
186 for this change included testimony regarding the cost, the high stakes nature of the exam, and impact to
187 other subspecialty board certifications.
188
189 Those in opposition to the resolution spoke of the close relationship between ACEP and ABEM, the
190 changes ABEM has already made to the recertification process (including to make it less high stakes), the
191 importance of having a high standard for physician competence and not "racing to the bottom," the risk of
192 creating a void of certification and the importance of self regulation. There was testimony regarding the
193 history of the MOC, and the importance of a high standard for the public as well.
194
195 Of note, the authors of the resolution recommended changing the word "interested" certifying body
196 to "equivalent" certifying body.
197

198
199 Mr. Speaker, this concludes the report of Reference Committee A. I would like to thank James R.
200 Kennedye, MD, MPH, FACEP; Heidi C. Knowles, MD, FACEP; Paul R. Pomeroy, Jr., MD, FACEP; Anne
201 Zink, MD, FACEP; Leslie Moore, JD; and Dan Sullivan for their excellent work in developing these
202 recommendations.

2016 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 21-30

Kelly Gray-Eurom, MD, MMM, FACEP (FL), Chair
Sabina A. Braithwaite, MD, FACEP (MO)
Gregory Cannon, MD, FACEP (NC)
Nathaniel T. Hibbs, DO, FACEP (CO)
Ramon W. Johnson, MD, FACEP (CA)
Harry E. Sibold, MD, FACEP (MT)

Margaret Montgomery, RN, MSN
Sandy Schneider, MD, FACEP

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2016 Council Meeting

Report of REFERENCE COMMITTEE C

Presented by: Kelly Gray-Eurom, MD, MMM, FACEP, Chair

Mr. Speaker and Councillors:

Reference Committee C gave careful consideration to the several items referred to it and submits the following report:

(1) Unanimous Consent Agenda

For adoption:

- **RESOLUTION 21(16): Best Practices for Harm Reduction Strategies, Including Warm Handoffs, in the ED**
- **RESOLUTION 22(16): Court Ordered Forensic Evidence Collection in the ED**
- **AMENDED RESOLUTION 25(16): Military Medics Integration into Civilian EMS**
- **AMENDED RESOLUTION 26(16): Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians**
- **RESOLUTION 27(16): Pediatric Surgery Centers**
- **RESOLUTION 28(16): Reimbursement for Opioid Counseling**

RESOLUTION 21(16): Best Practices for Harm Reduction Strategies, Including Warm Handoffs, in the ED

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 21(16) be adopted.

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.

Testimony

There was limited testimony provided on the resolution. There was agreement that resources for providers are limited and that there is a need for more education.

RESOLUTION 22(16): Court Ordered Forensic Evidence Collection in the ED

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 22(16) be adopted.

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 physicians' professional responsibilities when in conflict with court-ordered forensic collection of evidence and or medical treatment.

Testimony

Testimony was overwhelmingly provided in favor of adoption. Many expressed that the physician's duty is to the patient and that liability concerns could arise if forensic collection of evidence became mandated. All comments in opposition were primarily raised for clarification.

AMENDED RESOLUTION 25(16): Military Medics Integration into Civilian EMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 25(16) be adopted.

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.

Testimony

Testimony was overwhelmingly in support of this resolution. Language was added to eliminate referring to a single certifying body.

AMENDED RESOLUTION 26(16): Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 26(16) be adopted.

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.

Testimony

There was unanimous support for the resolution and the proposed amendment to change "clinical ultrasound" to "emergency ultrasound." It was noted that ultrasound is part of residency training, yet there is no mechanism for billing for these services in many institutions.

RESOLUTION 27(16): Pediatric Surgery Centers

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 27(16) be adopted.

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.

Testimony

Testimony was overwhelmingly in support of the resolution. It was noted that this document was created without ACEP input. It was also noted that the recommendations were not evidence based. Several individuals testified that their institutions were already implementing these guidelines. Care of children is a core component of emergency care.

RESOLUTION 28(16): Reimbursement for Opioid Counseling

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 28(16) be adopted.

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.

Testimony

The majority of the testimony was in favor of the resolution and that physicians should be reimbursed for counseling. Testimony was heard that the code should allow for any professional personnel to perform the service. It was noted that similar codes have a time-based requirement for the length of counseling.

End of Consent Agenda

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(2) AMENDED RESOLUTION 23(16): Medical Assisted Therapy for Patients with Substance Use Disorders in the ED

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 23(16) 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.

Testimony

Testimony was divided; concerns were raised that this could lead to a mandate for treatment or establish a standard of care, and that emergency physicians would be required to provide this treatment. Testimony was given that there is a lack of resources available in many communities for patient follow up and referral. Supporters of the resolution noted that the resolution did not include a mandate and that it would allow physicians to choose this as a

treatment option for their patients. Additional comments were made that there is medical evidence in support of this treatment.

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(3) AMENDED RESOLUTION 24(16): Mental Health Boarding Solutions

<u>RECOMMENDATION</u>:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 24(16) 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~~.

Testimony

Testimony was overall in favor of the first and second Resolveds. Concern was raised about the third Resolved because stating specific organizations limits the number of stakeholders that could be involved. There were also concerns regarding the linking of licensure. The language was amended to address these concerns.

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(4) AMENDED RESOLUTION 29(16): The Opioid Epidemic – A Leadership Role for ACEP

<u>RECOMMENDATION</u>:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 29(16) 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.~~

Testimony

Testimony was in overwhelming support of the first two Resolveds. Many opposed the third Resolved as written. Concern was raised about specific interventions, particularly safe injection sites and needle exchange programs. Concerns were raised that the emergency department might become the site for such services. Therefore, the third Resolved was amended to reflect these concerns.

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(5) RESOLUTION 30(16): Treatment of Marijuana Intoxication in the ED

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 30(16) not be adopted.

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.

Testimony

Testimony highlighted that this was a complicated issue. During the discussion, questions were raised whether the resolution would also include synthetic cannabinoids. However, inclusion of these agents would significantly change the scope of the resolution. There was also testimony that requiring a task force would utilize considerable resources of the College. Referral to the Board was considered; however, there was no clarity about what was being referred. Additionally, there is limited evidence-based information to support a clinical policy. While all considered the issue to be important, the resolution lacks sufficient clarity and specificity.

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(6) AMENDED RESOLUTION 31(16): Opposing the Development of Sublingual Sufentanil

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 31(16) 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.~~

Testimony

Testimony was in strong support for the first Resolved. It was noted that FDA testimony on this product will take place in the next several months. Due to the fact that this was a late resolution, no background information was developed. It is therefore unclear what information currently exists and what resources the College would need to develop an extensive information paper.

Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank 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; Sandy Schneider, MD, FACEP; and Loren Rives, MNA for their excellent work in developing these recommendations.

2016 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 9-20

Nathaniel R. Schlicher, MD, JD, FACEP (WA), Chair
Jordan GR Celeste, MD, FACEP (FL)
William B. Felegi, DO, FACEP (NJ)
Heather A. Heaton, MD (EMPMHP)
Donald L. Lum, MD, FACEP (EM Workforce)
Tony B. Salazar, MD, FACEP (NM)

Harry Monroe
Barbara Tomar, MHA

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2016 Council Meeting

Report of REFERENCE COMMITTEE B

Presented by: Nathaniel R. Schlicher, MD, JD, MBA, FACEP, Chair

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Mr. Speaker and Councillors:

Reference Committee B gave careful consideration to the several items referred to it and submits the following report:

(1) Unanimous Consent Agenda

For adoption:

- **RESOLUTION 9(16): Accreditation Standards for Freestanding Emergency Centers**
- **RESOLUTION 11(16): CMS Recognition of Independently Licensed Freestanding Emergency Centers**
- **AMENDED RESOLUTION 12(16): Collaboration with Non-Medical Entities on Quality and Standards**
- **AMENDED RESOLUTION 13(16): Crowding Kills**
- **AMENDED RESOLUTION 14(16): Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs**
- **AMENDED RESOLUTION 15(16): Enactment of Narrow Networks Requirements**
- **AMENDED RESOLUTION 16(16): Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S.**
- **AMENDED RESOLUTION 16(16): Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients Boarding in EDs**
- **AMENDED RESOLUTION 17(16): Insurance Collection of Beneficiary Deductibles**
- **RESOLUTION 19(16): Health Care Financing Taskforce**
- **RESOLUTION 20(16): Support & Advocacy for 24/7 Hyperbaric Medicine Availability**

For referral:

- **RESOLUTION 10(16): Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use**

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(2) RESOLUTION 9(16): Accreditation Standards for Freestanding Emergency Centers

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 9(16) be adopted.

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.

Testimony

Testimony was heard suggesting that adoption of this resolution is needed to protect the interest of the integrity of emergency medicine as freestanding emergency centers continue to proliferate. Entities outside emergency medicine have shown interest in establishing accreditation standards. Opponents expressed concerns about

ACEP expanding its scope into becoming an accrediting organization. In response, it was argued that emergency medicine needs to take on this role or it will be done by others outside the specialty.

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(3) RESOLUTION 10(16): Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 10(16) be referred to the Board of Directors

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.

Testimony

Testimony noted the change from past resolutions related to this issue, in that this resolution calls for decriminalization as opposed to legalization of marijuana. However, that did not change concerns of some speakers that ACEP should not support decriminalization, even if not inviting legalization of marijuana. At the same time, physician groups such as ACEP will continue to be drawn into issues considered to be more social, rather than medical issues, and the Board may want to consider these types of issues in future strategic planning.

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(4) RESOLUTION 11(16): CMS Recognition of Independently Licensed Freestanding Emergency Centers

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 11(16) be adopted.

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.

Testimony

Testimony revealed that physician owned freestanding emergency centers often see Medicare patients but cannot be paid for them when not affiliated with a hospital. CMS recognition and payment for services would enable centers to be established in non-affluent areas.

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(5) AMENDED RESOLUTION 12(16): Collaboration with Non-Medical Entities on Quality and Standards

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 12(16) 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.~~

Testimony

Testimony reflected an interest in engaging with non-medical organizations that develop quality standards that can affect hospital-based practice and equipment, but there were concerns about the need to define the costs of providing the highest levels of quality care.

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(6) AMENDED RESOLUTION 13(16): Crowding Kills

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 13(16) 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.

Testimony

Testimony contended that the federal government has been slow to react to this issue, and it is important for emergency physicians to provide solutions with results that can be measured.

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(7) AMENDED RESOLUTION 14(16): Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients ~~Boarding~~ in EDs

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that AMENDED RESOLUTION 14(16) be adopted.

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.

Testimony

Testimony pointed to the great extent of this problem for emergency departments. Though dashboard reporting is complex, it is greatly needed. Testimony suggested including all behavioral health patients, not just boarded patients.

(8) AMENDED RESOLUTION 15(16): Enactment of Narrow Networks Requirements

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 15(16) be adopted.

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.

Testimony

Testimony reflected widely held concerns that ACEP needs to study the impact on access and payment as insurers continue to narrow the numbers and types of physicians in their networks, and the College needs to weigh in strongly on legislation regarding narrow networks.

(9) AMENDED RESOLUTION 16(16): Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 16(16) be adopted.

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.**

Testimony

Testimony supported the need to explore the use of freestanding emergency departments to rural areas lacking the availability of access to emergency care, particularly given the closures of rural critical care hospitals. It was noted that Congressional legislation has been filed supporting such development.

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(10) AMENDED RESOLUTION 17(16): Insurance Collection of Beneficiary Deductibles

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 17(16) 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**.

Testimony

Testimony strongly supported the resolution in pointing out that the insurance industry shouldn't place physicians in the middle of their contractual relationships with their enrollees.

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(11) AMENDED RESOLUTION 19(16): ~~Single-Payer Health Insurance~~ Health Care Financing Task Force

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 19(16) be adopted.

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.

Testimony

The preponderance of testimony supported the Board appointing a Healthcare Financing Task Force that was directed by the 2014 Council meeting. In that vein, it was determined that the title of the Resolution should be changed.

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(12) RESOLUTION 20(16): Support & Advocacy for 24/7 Hyperbaric Medicine Availability

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 20(16) be adopted.

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.

Testimony

Testimony supported working with other hyperbaric organizations, and particularly since this is an emergency medicine subspecialty. ACEP should advocate for issues related to access and quality of hyperbaric services. It was noted that this may not be feasible in some areas.

End of Consent Agenda

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(13) AMENDED RESOLUTION 18(16): Opposition to CMS Mandating Treatment Expectations

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 18(16) 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.**

Testimony

Strongly worded testimony reflected concern about significant danger to patients of ill-designed and mandated use of specific measures for treatment of certain patient conditions. Testimony noted problems arise when federal requirements do not keep up with the treatment science. Though many members are involved in work groups assisting federal efforts to develop quality measures, everyone testifying believed strongly that ACEP should resist CMS dictating adherence to potentially dangerous standards.

Mr. Speaker, this concludes the report of Reference Committee B. I would like to thank 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, for their excellent work in developing these recommendations.