Council Meeting
October 24-25, 2015
Boston Convention and Exhibitions Center
Boston, MA

Minutes

The 44th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:04 am, Saturday, October 24, 2015, by Speaker Kevin Klauer, DO, EJD, FACEP.

Seated at the head table were: Kevin Klauer, DO, EJD, FACEP, speaker; James Cusick, MD, FACEP, vice speaker; Dean Wilkerson, JD, MBA, CAE, Council secretary and executive director; and Jim Slaughter, JD, parliamentarian.

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

Carrie DeMoor, MD, FACEP, and Frederick Schiavone, MD, FACEP, sang the National Anthem.

Peter Smulowitz, MD, FACEP, president of the Massachusetts Chapter, welcomed councillors and other meeting attendees.

Melissa Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 301 councillors of the 375 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Dr. Klauer and 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 2015 Council meeting:

Alabama	Lisa M Bundy, MD, FACEP Melissa W. Costello, MD, FACEP Muhammad N Husainy, DO, FACEP
Alaska	Anne Zink, MD, FACEP
Arizona	Patricia A Bayless, MD, FACEP Paul Andrew Kozak, MD, FACEP J Scott Lowry, MD, FACEP Wendy Ann Lucid, MD, FACEP Ross B Rodgers, MD, FACEP Nicholas F Vasquez, MD, FACEP Dale P Woolridge, MD, PhD, FACEP
Arkansas	Darren E Flamik, MD, FACEP Paul A Veach, MD, FACEP

Association of Academic Chairs of Emergency Medicine	Gabor David Kelen, MD, FACEP
California	John O Anis, MD, FACEP Larry A Bedard, MD, FACEP Rodney W Borger, MD, FACEP John Dirk Coburn, MD 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 Roneet Lev, MD, FACEP Stephen J Liu, MD, FACEP John Thomas Ludlow, MD William K Mallon, MD, FACEP Cameron J McClure, MD, FACEP Valerie C Norton, MD, FACEP Michael B Osmundson, MD, FACEP Chi Lee Perlroth, MD, FACEP Vivian Reyes, MD, FACEP R Myles Riner, 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 Sybil Nedmchira Zachariah, MD
Colorado	Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Garrett S Mitchell, MD Carla Elizabeth Murphy, DO, FACEP Eric B Olsen, MD, FACEP Lee Wilton Shockley, MD, FACEP
Connecticut	Daniel Freess, MD, FACEP Frank Anthony Illuzzi, MD, FACEP David Peter John, MD, FACEP Morton Elliot Salomon, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP
Council of Emergency Medicine Residency Directors	Saadia Akhtar, MD
Delaware	Kathryn Groner, MD John T Powell, MD, RDMS, FACEP
District of Columbia	Guenevere Burke, MD Aisha T Liferidge, MD, FACEP Sunil I Madan, MD, FACEP
Emergency Medicine Residents' Association	Jordan GR Celeste, MD Ramnik S Dhaliwal, MD, JD Matthew Rudy, MD Alison L Smith, MD, MPH

Florida	Andrew I Bern, MD, FACEP Amy Ruben Conley, MD, FACEP Jay L Falk, MD, FACEP Kelly Gray-Eurom, MD, MMM, FACEP Larry Allen Hobbs, MD, FACEP Steven B Kailes, MD, FACEP Gary Lai, DO Michael Lozano, MD, FACEP Kristin McCabe-Kline, MD, FACEP Ashley Booth Norse, MD, FACEP Ernest Page, II, MD, FACEP Sanjay Pattani, MD, FACEP Tracy G Sanson, MD, FACEP Joel B Stern, MD, FACEP Joseph Adrian Tyndall, MD, FACEP L Kendall Webb, MD, FACEP
Georgia	James Joseph Dugal, MD, FACEP(E) Ralph Connell Griffin, Jr, MD, FACEP Earl A Grubbs, MD, FACEP Michael D Hagues, DO, FACEP Jeffrey F Linzer, Sr, 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 Laura Cookman, MD Leisa Rossello Deutsch, MD, MPH Antonia R Helbling, MD Chad Kessler, MD, MHPE, FACEP Julio Rafael Lairet, DO, FACEP David S McClellan, MD, FACEP Torree M McGowan, MD, FACEP John Gerard McManus, Jr, MD, FACEP Lee E Payne, MD, FACEP Nadia M Pearson, DO, FACEP Robert E Thaxton, MD, FACEP
Hawaii	Ann Malia Haleakala, MD, FACEP Richard M McDowell, MD, FACEP
Idaho	Nathan R Andrew, MD, FACEP Ken John Gramyk, MD, FACEP
Illinois	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 Jolie C Holschen, MD, FACEP Fred L Jacobs, MD, FACEP Valerie Jean Phillips, MD, FACEP Edward Phillip Sloan, MD, MPH, FACEP William P Sullivan, DO, JD, FACEP Nathan Seth Trueger, MD, MPH Deborah E Weber, MD, FACEP

Indiana	Michael D Bishop, MD, FACEP(E) Timothy A Burrell, MD, MBA, FACEP John T Finnell, II, MD, FACEP Jeffrey R Nickel, MD, FACEP James L Shoemaker, Jr, MD, FACEP Christopher S Weaver, MD, FACEP
Iowa	Kathryn K Dierks, DO, FACEP Ryan M Dowden, MD, FACEP Gary Thomas Hemann, DO, FACEP Michael E Takacs, MD, FACEP
Kansas	Dennis Michael Allin, MD, FACEP John F McMaster, 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, FACEP Jon Michael Cuba, MD, FACEP Phillip Luke LeBas, MD, FACEP Mark Rice, MD, FACEP
Maine	Garreth C Debiegun, MD, FACEP Charles F Pattavina, MD, FACEP
Maryland	Arjun S Chanmugam, MD, FACEP Drew C Fuller, MD, FACEP Yevgeniy Gincherman, MD, FACEP Hugh F Hill, III, MD, JD, FACEP Kathleen D Keeffe, MD, FACEP Orlee Israeli Panitch, MD, FACEP Matthew David Smith, 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 Kenneth Marshall, MD Matthew B Mostofi, DO, FACEP Mark D Pearlmutter, MD, FACEP Niels K Rathlev, MD, FACEP Brian Sutton, MD, FACEP
Michigan	Michael 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 James C Mitchiner, MD, MPH, FACEP Kevin Monfette, MD, FACEP David T Overton, MD, FACEP

	Paul R Pomeroy, Jr, MD, FACEP Larisa May Traill, MD, FACEP Bradley J Uren, MD, FACEP Mary Jo Wagner, MD, FACEP Gregory Link Walker, MD, FACEP Bradford L Walters, MD, FACEP James Michael Ziadeh, MD, FACEP
Minnesota	David M Larson, MD, FACEP David A Milbrandt, MD, FACEP David Nestler, MD, MS, FACEP Lane Patten, MD, FACEP Gary C Starr, MD, FACEP Thomas E Wyatt, MD, FACEP Andrew R Zinkel, MD, FACEP
Mississippi	Frederick B Carlton, Jr, MD, FACEP Lawrence Albert Leake, MD, FACEP
Missouri	Douglas Mark Char, MD, FACEP Jonathan Heidt, MD, FACEP Robert Francis Poirier, Jr., MD, FACEP Sebastian A Rueckert, MD, MBA, FACEP Larry Slaughter, MD, FACEP Christine Sullivan, MD, FACEP
Montana	Harry Eugene Sibold, MD, FACEP
Nebraska	Jason G Langenfeld, 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 Sarah Garlan Johansen, MD, FACEP
New Jersey	Victor M Almeida, DO, FACEP Robert M Eisenstein, MD, FACEP William Basil Felegi, DO, FACEP Rachelle Ann Greenman, MD, FACEP Anthony William Hartmann, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP Dennis Lucas McGill, MD, FACEP Mark S Rosenberg, DO, MBA, 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 Michael Cassara, DO, FACEP Justin Matthew Fuehrer, DO Theodore J Gaeta, DO, FACEP Sanjey Gupta, MD, FACEP

	Michael Gary Guttenberg, DO, FACEP
	Raymond Iannaccone, MD, FACEP
	Stuart Gary Kessler, MD, FACEP
	David C Lee, MD, FACEP
	Penelope Chun Lema, MD, FACEP
	Daniel G Murphy, MD, MBA, FACEP
	Nestor B Nestor, MD, FACEP
	David H Newman, MD, FACEP
	William F Paolo, MD, FACEP
	Salvatore R Pardo, MD, FACEP
	Louise A Prince, MD, FACEP
	Christopher C Raio, MD, FACEP
	Gary S Rudolph, MD, FACEP
	Frederick M Schiavone, MD, FACEP
	Todd L Slesinger, MD, FACEP
	Virgil W Smaltz, MD, MPA, FACEP
	Asa "Peter" Viccellio, MD, FACEP
North Carolina	Gregory Cannon, MD, FACEP
	Jennifer Casaletto, MD, FACEP
	Charles W Henrichs, III, MD, FACEP
	David Kammer, MD, FACEP
	Jeffrey Allen Klein, MD, FACEP
	Thomas Lee Mason, MD, FACEP
	Abhishek Mehrotra, MD, FACEP
	Bret Nicks, 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
	Thomas E Carter, DO, FACEP
	Purva Grover, MD, FACEP
	Mary E Hancock, MD, FACEP
	Gary R Katz, MD, MBA, 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
	Nicole Ann Veitinger, DO, FACEP
Oklahoma	Jeffrey Michael Goodloe, MD, FACEP
	Cecilia Guthrie, MD, FACEP
	James Raymond Kennedye, MD, MPH, FACEP
Oregon	Michael Henstrom, MD, FACEP
	David P Lehrfeld, MD
	John C Moorhead, MD, FACEP
	Evangeline Sokol, MD, FACEP
Pennsylvania	Michael A Bohrn, MD, FACEP
	Merle Andrea Carter, MD, FACEP
	Ankur A Doshi, MD, FACEP

	Todd Fijewski, MD, FACEP Maria Koenig Guyette, MD, FACEP Jacob Kleinman, MD Scott Jason Korvek, MD, FACEP Chadd K Kraus, DO, DrPH, MPH Vishnu M Patel, MD Ericka Powell, MD, FACEP Shawn M Quinn, DO Ralph James Riviello, MD, FACEP Anna Schwartz, MD, FACEP Natasha Singh, MD Arvind Venkat, MD, FACEP Robert R Whipkey, 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	Keith Thomas Borg, MD, PhD, FACEP Thomas H Coleman, MD, FACEP Stephen A D Grant, MD, FACEP Frank C Smeeks, MD, FACEP
South Dakota	Donald J Kosiak, Jr, MD, FACEP
Tennessee	Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Sudave D Mendiratta, MD, FACEP Thomas R Mitchell, MD, FACEP Karolyn K Moody, DO, MPH
Texas	Carrie de Moor, MD, FACEP Nathan Deal, MD Diana L Fite, MD, FACEP Juan Francisco Fitz, MD, FACEP Angela F Gardner, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Alison Haddock, MD, FACEP Justin P Hensley, MD, FACEP Shkelzen Hoxhaj, MD, MPH, FACEP Doug Duart Jeffrey, MD, FACEP Heidi C Knowles, MD, FACEP Heather S Owen, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP Richard Dean Robinson, MD, FACEP Melanie T Stanzer, DO Gerad A Troutman, MD, FACEP Hemant H Vankawala, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, FACEP
Utah	Jim V Antinori, MD, FACEP John R Dayton, MD, FACEP Stephen Carl Hartsell, MD, FACEP

Vermont	Joshua Harris, MD
Virginia	Pamela P Bensen, MD, MS, FACEP Kelly Foley, MD, FACEP David Matthew Kruse, MD, FACEP Bruce M Lo, MD, MBA, RDMS, FACEP Jeremiah O'Shea, MD, FACEP Mark Robert Sochor, MD, FACEP Sara F Sutherland, MD, MBA, 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 Christopher S Goode, MD, FACEP Thomas Marshall, MD, FACEP
Wisconsin	Howard Jeffery Croft, MD, FACEP William D Falco, MD, MS, FACEP William C Haselow, MD, FACEP Jeffrey J Pothof, MD, FACEP Brian Sharp, MD, FACEP
Wyoming	Benjamin E Beasley, MD, FACEP

Sections of Membership

Air Medical Transport	Mischa P Mirin, MD, FACEP
American Association of Women Emergency Physicians	Parveen K Parmar, MD
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	William Colwell Dalsey, MD, FACEP
Disaster Medicine	Roy L Alson, MD, PhD, FACEP
Dual Training	Michael C Bond, MD, FACEP
Emergency Medical Informatics	R Carter Clements, MD, FACEP
Emergency Medical Services-Prehospital Care	Sabina A Braithwaite, MD, FACEP
Emergency Med Practice Management & Health Policy	Ronald J Brace, MD, FACEP
Emergency Medicine Research	Nidhi Garg, MD
Emergency Medicine Workforce	Donald L Lum, MD, FACEP
Emergency Ultrasound	Jason Fields, MD, FACEP

Forensic Medicine	Lawrence J R Goldhahn, MD, FACEP
Freestanding Emegency Centers	Michael Joseph Sarabia, MD, FACEP
Geriatric Emergency Medicine	Marianna Karounos, DO
International Emergency Medicine	Hani Osama Mowafi, 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	Robert R Turelli, Jr, MD, FACEP
Rural Emergency Medicine	Harry L Wingate, 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	Bruce J Derrick, MD
Wellness	Laura H McPeake, MD, FACEP
Wilderness Medicine	Susanne J Spano, MD, FACEP
Young Physicians	Mitesh Rao, MD

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)
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)
Nicholas J. Jouriles, MD, FACEP (OH)
Brian F. Keaton, MD, FACEP (OH)
Linda L. Lawrence, MD, FACEP (GS)
John B. McCabe, MD, FACEP (NY)
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)
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, 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 25-26, 2014, Council meeting and approved the actions of the Steering Committee taken at their January 20, 2015, and May 6, 2015, meetings.

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

Dr. Klauer reported that eight late resolutions were received and reviewed by the Steering Committee. Six were memorial resolutions and were and accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. The other two late resolutions were not accepted for submission to the Council.

Dr. Klauer presented the Nominating Committee report. Three members were nominated for President-Elect: Paul D. Kivela, MD, MBA, FACEP; Robert E. O'Connor, MD, MPH, FACEP; and Rebecca B. Parker, MD, FACEP. Dr. Klauer called for floor nominations. There were no floor nominees. The nominations were then closed.

Six members were nominated for four positions on the Board of Directors: Vidor E. Friedman, MD, FACEP; William P. Jaquis, MD, FACEP; Christopher S. Kang, MD, FACEP; Mark S. Rosenberg, DO, MBA, FACEP; Bradley J. Uren, MD, FACEP; and James M. Williams, DO, MS, FACEP. Dr. Klauer called for floor nominations. There were no floor nominees. The nominations were then closed.

Dr. Cusick was the only nominee for Speaker of the Council. Dr. Klauer called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. Cusick was declared as the 2015-17 speaker of the Council. He then addressed the Council.

Four members were nominated for Council Vice Speaker: Sabina A. Braithwaite, MD, FACEP; Gary Katz, MD, MBA, FACEP; John G. McManus, Jr. MD, MBA, FACEP; and Robert C. Solomon, MD, FACEP. Dr. Klauer called for floor nominations. There were no floor nominees. The nominations were then closed.

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

2015 Council Resolutions

The Council recessed at 9:45 am for the Reference Committee hearings. The resolutions considered by the 2015 Council appear below as submitted.

RESOLUTION 1

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

RESOLUTION 2

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

RESOLUTION 3

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

RESOLUTION 4

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

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

RESOLUTION 5

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

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

RESOLUTION 6

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

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
    A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
    B. Satisfaction of at least three of the following individual criteria during their professional career:
        1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
        2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
        3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
        4. active involvement in emergency medicine administration or departmental affairs;
        5. active involvement in an emergency medical services system;
        6. research in emergency medicine;
        7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
        8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
        9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
        10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.
4. ~~Provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.~~

RESOLUTION 7

RESOLVED, The ACEP Bylaws Article X – Officers/Executive Director, Section 8 – President-Elect, be amended to read:

Any member of the Board of Directors excluding the president, president-elect, ~~and~~ immediate past president**, speaker of the Council, and immediate past speaker,** shall be eligible for election to the position of president-elect by the Council. The president-elect shall be a member of the Board of Directors. The president-elect's term of office shall begin at the conclusion of the meeting at which the election as president-elect occurs and shall end with succession to the office of president. The president-elect shall be elected by a majority vote of the councilors present and voting at the annual meeting of the Council. The president-elect shall succeed to the office of president at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

RESOLUTION 8

RESOLVED, That the "Election Procedures" section of the Council Standing Rules, be amended to read:

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 tie 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, & Elections Committee chair will report the results to the speaker. **The speaker shall announce to the Council the actual vote totals of each election without attribution.**

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, & 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.

RESOLUTION 9

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

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

RESOLUTION 10

RESOLVED, That ACEP evaluate the feasibility of changing all members to one of two standardized renewal dates, one which will be in January 1 and the other in July 1, with the individual member being able to choose which renewal month they prefer.

RESOLUTION 11

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

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

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

RESOLUTION 12

RESOLVED, That ACEP develop an organized, searchable database of all prior Council resolutions submitted for discussion, designed for use by the ACEP membership, to include the relevant background material, adopted amendments, final disposition of each resolution, and any references to subsequent ACEP action as a result of the resolution.

RESOLUITON 13

RESOLVED, That ACEP evaluate the expanding role and cost for pharmaceutical drugs affecting the practice of emergency medicine and identify and collaborate, where appropriate, with pharmaceutical manufacturers and other

interested parties to best assure an appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and report back to the ACEP Council on a periodic basis.

RESOLUTION 14

RESOLVED, That ACEP endorse and support local ordinances and state laws that require police officers to wear body-worn cameras.

RESOLUTION 15

RESOLVED, That ACEP endorse and support the CARERS Act of 2015; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine submit a resolution to the AMA to endorse and support the CARERS Act of 2015.

RESOLUTION 16

RESOLVED, That ACEP believes that the federal and state governments should decriminalize the possession of small amounts of marijuana for personal use for people aged 21 and older; and be it further

RESOLVED, That ACEP believes that state and the federal government should legalize, regulate, and tax marijuana for adult use.

RESOLUTION 17

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

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

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

RESOLUTION 18

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

RESOLUTION 19

RESOLVED, That ACEP create a policy statement supporting that all funding distributed to institutions for the purpose of graduate medical education be used solely for that purpose; and be it further

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

RESOLUTION 20

RESOLVED, That ACEP develop a policy statement on the effects that group purchasing has on medication shortages and use of orphan devices in emergency departments; and be it further

RESOLVED, That ACEP work with stakeholders such as the American Medical Association to develop model legislation that protects physicians and pharmacists from liability as a result of the inability to provide adequate equipment or pharmaceuticals to diagnose and treat emergency patients; and be it further

RESOLVED, That ACEP create a list of "never events" as it relates to orphan devices and drug shortages.

RESOLUTION 21

RESOLVED, That ACEP create a recommended standard minimum amount of information to be contained in the Healthcare Information Exchanges; and be it further

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

RESOLUTION 22

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

wishes on an online advance directive registry; and be it further

RESOLVED, That ACEP support the creation and distribution of educational materials on advance directives to distribute at states' Department of Motor Vehicle offices, tested on license application examinations, and mailed or electronically distributed to individuals obtaining and renewing drivers licenses; and be it further

RESOLVED, That ACEP advocate that individuals over 18 applying for or renewing a driver license or identification card be given the option to indicate whether they have an advance directive; and be it further

RESOLVED, That ACEP advocate for states' Department of Motor Vehicles to create an advance directive icon to be available for placement on the front of the license for individuals who declare that they have an advance directive during license registration or renewal; and be it further

RESOLVED, That ACEP supports legislation for and innovations to further integrate advance directive information with state driver license and identification cards in efforts to promote greater accessibility, usability, and awareness of advance directives.

RESOLUTION 23

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

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

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

RESOLUTION 24

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

RESOLUTION 25

RESOLVED, That ACEP create a white paper elucidating the barriers this rule creates to appropriate care, the costs it creates for the system, and the costs it transfers to the patients; and be it further

RESOLVED, That ACEP partner with the American Medical Association and other healthcare organizations to author a white paper and work together to eliminate the Medicare 3-Day Rule; and be it further

RESOLVED, That ACEP make elimination of the Medicare 3-Day Rule a top legislative priority for the coming year.

RESOLUTION 26

RESOLVED, That ACEP supports banning the production, sale, distribution or possession of powdered alcohol for personal consumption use; and be it further

RESOLVED, That ACEP request that the FDA ban powdered alcohol; and be it further

RESOLVED, That ACEP request the Alcohol and Tobacco Tax Trade Bureau (TTB) to reverse its decision on Palcohol; and be it further

RESOLVED, That ACEP endorse and support S.728/H.R. 1717, which would ban the production, sale, distribution or possessions of powdered alcohol; and be it further

RESOLVED, That ACEP support legislation to ban the production, sale, distribution, or possession of powdered alcohol on a state level for personal consumption use.

RESOLUTION 27

RESOLVED, That ACEP issue a statement declaring that insurance companies and other payers reimburse emergency physicians for ultrasound studies and services that they perform and interpret as part of patient care in the Emergency Department; and be it further

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

RESOLUTION 28

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

RESOLVED, That ACEP devote increased resources to monitor the state-by-state status and changes in law concerning the standards for fair payment of Emergency Physicians and establish a single point of contact at the

national level as a resource for assisting all chapters; and be it further

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

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

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

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

RESOLUTION 29

RESOLVED, That ACEP supports the requirement that pharmaceutical companies coordinate with hospitals to pay for appropriate hospital-located drug "take-back" programs; and be it further

RESOLVED, That ACEP endorses and supports local ordinances, state, and national laws that require drug "take-back" programs; and further be it

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

RESOLUTION 30

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

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

RESOLUTION 31

RESOLVED, That ACEP communicate its appreciation to ABEM for its efforts to be sensitive to the practicing emergency physician in interpreting ABMS mandates; and be it further

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

RESOLVED, That ACEP develop policy that specifically opposes efforts of the American Board of Medical Specialties and its specialty boards to become independent sole source and for profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy particularly when not sensitive to the needs of practicing physicians.

RESOLUTION 32

RESOLVED, That ACEP appoint an internal task force to establish a list of imaging findings that should be communicated in real-time and in a closed-loop manner by the radiologist to the emergency provider, weighing the benefit of immediate communication of critical information against the risk of excessive interruptions in provider workflow; and be it further

RESOLVED, That ACEP work with the American College of Radiology to develop a joint best practice guideline regarding imaging findings that should be communicated in real-time and in a closed-loop manner by the radiologist to the emergency provider, weighing the benefit of immediate communication of critical information against the risk of excessive interruptions in provider workflow.

RESOLUTION 33

RESOLVED, That ACEP refine the policy statement, "Freestanding Emergency Departments," to include differentiation between freestanding EDs and urgent care centers or create a separate policy statement defining an

urgent care center to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and costs to make informed decisions when seeking care; and be it further

RESOLVED, That ACEP work with the Centers for Medicare & Medicaid Services and related state hospital, regulatory, and certification organizations to advocate for appropriate credentialing standards for these entities to ensure the patients may fully understand the care to be expected when presenting to each.

RESOLUTION 34

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

RESOLVED, Based upon available information, that ACEP develop appropriate policy to support public awareness, cost effective timely access, and liability protection for public and health care provider administration, and collaboration with other interested organizations, for use of epinephrine for anaphylaxis outside of health care settings.

RESOLUTION 35

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

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

RESOLUTION 36

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

RESOLVED, That ACEP create a task force charged with promoting POLST/EOL registries, explore the cost and regulatory barriers to creating such databases, seek funding options both internally and externally for the creation of POLST/EOL databases and considers either setting up a database or identifying partners that can set up POLST/EOL databases for the benefit of our members and the American public; and be it further

RESOLVED, That the POLST/EOL Registries task force report back to the Council in 2016 with actionable items that the Council, Board, and ACEP can pursue to bring about POLST and end of life databases; and be it further

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

RESOLUTION 37

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

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

RESOLUTION 38

RESOLVED, That ACEP opposes any non-evidence based financial incentives for patient satisfaction scores related to the provision of controlled substance prescriptions; and be it further

RESOLVED, That ACEP work with CMS and/or the National Quality Forum (NQF) to create a quality measure that is related to safe prescribing of controlled medications; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine submit a resolution to the AMA regarding patient satisfaction scores and safe prescribing.

RESOLUTION 39

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

RESOLVED, That ACEP opposes the use of patient satisfaction surveys for physician credentialing or for

emergency medicine practice financial incentives or dis-incentives.

RESOLUTION 40

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

RESOLVED, That ACEP supports state legislative and regulatory efforts to support the adoption of the POLST paradigm; and be it further

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

RESOLUTION 41

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

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

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

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RESOLUTION 42

RESOLVED, That ACEP seek out and work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety; and be it further

RESOLVED, That ACEP promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

RESOLUTION 43

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

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

RESOLUTION 44

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

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

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

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

RESOLUTION 45

RESOLVED, That ACEP investigate and evaluate the positive, negative, and potential unintended

consequences of telemedicine; and be it further

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

RESOLUTION 46

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

RESOLUTION 47 (This late resolution was accepted by the Council.)

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

RESOLUTION 48 (This late resolution was accepted by the Council.)

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

RESOLUTION 49 (This late resolution was accepted by the Council.)

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

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

RESOLUTION 50 (This late resolution was accepted by the Council.)

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

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

RESOLUTION 51 (This late resolution was accepted by the Council.)

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

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

RESOLUTION 52 (This late resolution was accepted by the Council.)

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

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Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 5-12 were referred to Reference Committee A. Liam T. Yore, MD, FACEP, chaired Reference Committee A and other members were: J. Dave Barry, MD, FACEP; Sara A. Brown, MD, FACEP; Hammad Husainy, DO, FACEP; Todd L. Slesinger, MD, FACEP; Leslie Moore, JD; and Dan Sullivan.

Resolutions 13-30 were assigned to Reference Committee B. L. Anthony Cirillo, MD, FACEP, chaired Reference Committee B and other members were: Gregory Cannon, MD, FACEP; Alison Haddock, MD, FACEP; Kristin McCabe-Kline, MD; Mildred Willy, MD, FACEP; Anne Zink, MD, FACEP; Stacie Jones, MPH; and Barbara Tomar, MHA.

Resolutions 31-46 were referred to Reference Committee C. Ralph J. Riviello, MD, FACEP, chaired

Reference Committee C and other members were: Douglas Char, MD, FACEP; Jeffrey Linzer, MD, FACEP; Donald Lum, MD, FACEP; Tony Salazar, MD, FACEP; James Thompson, MD, FACEP; Mary Anne Mitchell, ELS; Margaret Montgomery, RN, MSN; and Sandy Schneider, MD, FACEP.

At 1:00 pm a Town Hall Meeting was held. The topic was "Mergers and Acquisitions: Medical Shark Tank." Ricardo Martinez, MD, FACEP, served as the moderator and the discussants were Brent Asplin, MD, FACEP; Savoy Brummer, MD, FACEP; Ray Iannaccone, MD, FACEP; and Jay Kaplan, 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. Klauer introduced the Board of Directors and honored guests and then addressed the Council.

Dr. Klauer reviewed the procedure for the adoption of the 2015 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Cusick then presented the memorial resolutions to the colleagues of Leah Anne Davis, DO; Michael G. Hughes, MD, FACEP; Marvin Leibovich, MD, FACEP; Richard P. O'Brien, MD, FACEP; Marshall T. Morgan, MD; and Stanley M. Zydlo, Jr., MD, FACEP. The Council adopted the memorial resolutions by observing a moment of silence.

Dr. Klauer announced that the commendation resolutions would be presented during the Council luncheon on Sunday, October 25, 2015.

Barry N. Heller, MD, FACEP, reported on activities of the American Board of Emergency Medicine. Catherine A. Marco, MD, FACEP, reported on the professionalism in emergency medicine survey.

John J. Rogers, MD, CPE, FACEP, presented the secretary-treasurer's report.

Matthew Rudy, MD, addressed the Council regarding the activities of the Emergency Medicine Residents' Association.

Vidor E. Friedman, 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.

Steven Stack, MD, FACEP, president of the American Medical Association, addressed the Council.

Michael J. Gerardi, 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 6:23 pm for the candidate reception and reconvened at 8:04 am on Sunday, October 25, 2015.

Dr. Costello reported that 364 councillors of the 375 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.

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 9.
Not for adoption: Resolution 8 and Resolution 10.

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

The committee recommended that Resolution 5 be adopted.

It was moved THAT RESOLUTION 5 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 6 be adopted.

It was moved THAT RESOLUTION 6 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 7 not be adopted.

It was moved THAT RESOLUTION 7 BE ADOPTED.

The authors of Resolution 7 requested to withdraw the resolution. Without any objections, the resolution was withdrawn.

It was moved THAT THE RULES BE SUSPENDED FOR A 10-MINUTE DISCUSSION OF THE CONCEPT OF RESOLUTION 7. The motion was not adopted.

It was moved THAT THE RULES BE SUSPENDED TO APPOINT A TASK FORCE TO DISCUSS THE CONCEPT OF RESOLUTION 7. The motion was not adopted.

The committee recommended that Resolution 11 not be adopted.

It was moved THAT RESOLUTION 11 BE ADOPTED.

It was moved THAT RESOLUTION 11 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved THAT THE WORD "CENSURE" BE REPLACED BY THE WORD "ADMONISHMENT." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 12 be adopted.

It was moved THAT AMENDED RESOLUTION 12 BE ADOPTED:

RESOLVED, THAT ACEP ~~DEVELOP AN ORGANIZED, SEARCHABLE~~ **IMPROVE THE EXISTING** DATABASE OF ALL PRIOR COUNCIL RESOLUTIONS SUBMITTED FOR DISCUSSION, DESIGNED FOR USE BY THE ACEP MEMBERSHIP, TO INCLUDE THE RELEVANT BACKGROUND MATERIAL, ADOPTED AMENDMENTS, FINAL DISPOSITION OF EACH RESOLUTION, AND ANY REFERENCES TO SUBSEQUENT ACEP ACTION SUCH AS A RESULT OF THE RESOLUTION**, TO IMPROVE SEARCH FUNCTIONALITY, AND TO PUBLICIZE THIS TOOL TO FUTURE COUNCILLORS.** The motion was adopted.

There was no testimony offered on the Affiliate Membership Feasibility Study or the Compensation Committee Report.

REFERENCE COMMITTEE C

Dr. Riviello 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: Amended Resolution 31, Amended Resolution 32, Amended Resolution 33, Amended Resolution 34, Amended Resolution 35, Amended Resolution 37, Amended Resolution 39, Amended Resolution 41, Amended Resolution 42, Amended Resolution 43, Resolution 45, and Resolution 46.

Amended Resolution 31, Amended Resolution 33, Amended Resolution 34, Amended Resolution 35, and Amended Resolution 39 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 32(15)

~~RESOLVED, THAT ACEP APPOINT AN INTERNAL TASK FORCE TO ESTABLISH A LIST OF IMAGING FINDINGS THAT SHOULD BE COMMUNICATED IN REAL-TIME AND IN A CLOSED-LOOP MANNER BY THE RADIOLOGIST TO THE EMERGENCY PROVIDER, WEIGHING THE BENEFIT OF IMMEDIATE COMMUNICATION OF CRITICAL INFORMATION AGAINST THE RISK OF EXCESSIVE INTERRUPTIONS IN PROVIDER WORKFLOW; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH THE AMERICAN COLLEGE OF RADIOLOGY TO DEVELOP A JOINT BEST PRACTICE GUIDELINE REGARDING IMAGING FINDINGS THAT SHOULD BE COMMUNICATED IN REAL-TIME AND IN A CLOSED-LOOP MANNER BY THE RADIOLOGIST TO THE EMERGENCY PROVIDER, WEIGHING THE BENEFIT OF IMMEDIATE COMMUNICATION OF CRITICAL INFORMATION AGAINST THE RISK OF EXCESSIVE INTERRUPTIONS IN PROVIDER WORKFLOW.

AMENDED RESOLUTION 37(15)

RESOLVED, THAT ACEP COLLABORATE WITH THE EMERGENCY NURSES ASSOCIATION**, THE AMERICAN ASSOCIATION OF EMERGENCY NURSE PRACTITIONERS, THE SOCIETY OF EMERGENCY MEDICINE PHYSICIAN ASSISTANTS, AND OTHER EMERGENCY CARE PROVIDER ORGANIZATIONS** TO DEVELOP A JOINT POSITION STATEMENT ENDORSING THE USE OF SUB-DISSOCIATIVE KETAMINE UNDER THE SAME PROCEDURES AND POLICIES AS OTHER ANALGESIC AGENTS ADMINISTERED BY NURSING STAFF IN THE EMERGENCY DEPARTMENT SETTING; AND BE IT FURTHER

RESOLVED, THAT THE POSITION STATEMENT DEVELOPED BY ACEP AND THE ~~EMERGENCY NURSES ASSOCIATION~~ **OTHER STAKEHOLDERS** ON THE USE OF SUB-DISSOCIATIVE KETAMINE BE DISTRIBUTED TO ALL STATE NURSING BOARDS.

AMENDED RESOLUTION 41(15)

RESOLVED, THAT ACEP WORK WITHIN ITS SEVERAL COMMITTEES AND SECTIONS CHARGED WITH QUALITY, EMERGENCY MEDICINE PRACTICE, AND RURAL EMERGENCY MEDICINE TO RESEARCH AND RECOMMEND SUCH CREDENTIALING MODELS TO MAINTAIN THE RURAL/UNDERSERVED PRESENCE WITHOUT UNDUE HARDSHIP ON ED PHYSICIANS OR RESULT IN A GREATER LACK OF BOARD CERTIFIED/BOARD ELIGIBLE EMERGENCY PHYSICIANS IN THESE AREAS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT AND INFORMATION FOR DISSEMINATION REGARDING APPROPRIATE EMERGENCY MEDICINE CREDENTIALING MODELS FOR RURAL/UNDERSERVED AREAS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH ~~THE JOINT COMMISSION~~ **HOSPITAL ACCREDITATION BODIES**, THE CENTERS FOR MEDICARE & MEDICAID SERVICES, THE AMERICAN HOSPITAL ASSOCIATION, AND RELATED STATE HOSPITAL, REGULATORY, AND CERTIFICATION ORGANIZATIONS TO RECOMMEND APPROPRIATE CREDENTIALING STANDARDS FOR ED PHYSICIANS AND FACILITIES IN RURAL/UNDERSERVED AREAS.

AMENDED RESOLUTION 42(15)

RESOLVED, THAT ACEP SEEK OUT AND WORK WITH OTHER ORGANIZATIONS AND STAKEHOLDERS TO DEVELOP MULTI-SOCIETY POLICIES THAT ESTABLISH CLEAR DEFINITIONS FOR BOARDING AND CROWDING AND LIMIT THE NUMBER OF HOURS AND VOLUME OF BOARDERS TO ALLOW FOR CONTINUED PATIENT ACCESS AND PATIENT SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE **TO OTHER ORGANIZATIONS AND STAKEHOLDERS KNOWN SOLUTIONS TO MITIGATE BOARDING AND CROWDING, INCLUDING BUT NOT LIMITED TO SMOOTHING OF ELECTIVE ADMISSIONS, INCREASING WEEKEND DISCHARGES, DISCHARGE OF PATIENTS BEFORE NOON, FULL AVAILABILITY OF ANCILLARY SERVICES SEVEN DAYS A WEEK, AND IMPLEMENTATION OF A FULL-CAPACITY PROTOCOL AND PROMOTE** LEGISLATION AT THE STATE AND NATIONAL LEVEL THAT LIMITS AND DISCOURAGES THE PRACTICE OF EMERGENCY DEPARTMENT BOARDING AS A SOLUTION TO HOSPITAL CROWDING.

AMENDED RESOLUTION 43(15)

RESOLVED, THAT ACEP, IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICINE CARE ADDRESS THE FACT THAT REQUIRING ~~THIS~~ **A SIGNIFICANT** AMOUNT OF CONCENTRATED CONTINUING MEDICAL EDUCATION IN SPECIFIC AREAS ANNUALLY WILL LEAD TO REDUCED ONGOING EDUCATION IN OTHER CLINICAL AREAS IMPORTANT TO THE PRACTICE OF EMERGENCY MEDICINE (SUCH AS PEDIATRICS, INFECTIOUS DISEASE, GASTROENTEROLOGY, ENDOCRINOLOGY, ETC.), RESULTING IN THE UNINTENDED CONSEQUENCE OF REDUCING PHYSICIAN READINESS TO CARE FOR THE ED PATIENTS NOT INCLUDED IN THE TIME CRITICAL DIAGNOSIS INITIATIVE; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH ORGANIZATIONS SUCH AS THE AMERICAN HOSPITAL ASSOCIATION, THE AMERICAN HEART ASSOCIATION, AND RELATED STATE HOSPITAL ORGANIZATIONS, REGULATORY BODIES, AND CREDENTIALING AGENCIES TO PROVIDE RESOURCES, SUPPORT, AND UNDERSTANDING OF THE COMPREHENSIVENESS OF BOARD CERTIFIED/ELIGIBLE EMERGENCY PHYSICIANS TO BE ABLE TO READILY CARE FOR ALL EMERGENCY DEPARTMENT PATIENTS WITHOUT COSTLY AND REDUNDANT REQUIREMENTS, UNLESS FOUND TO BE NECESSARY FOR INDIVIDUAL PHYSICIANS BASED ON ASSESSMENT AND OVERSIGHT BY THE ED MEDICAL DIRECTOR.

The committee recommended that AMENDED RESOLUTION 31 BE ADOPTED.

It was moved THAT AMENDED RESOLTUION 31 BE ADOPTED.

RESOLVED, THAT ACEP COMMUNICATE ITS APPRECIATION TO ABEM FOR ITS EFFORTS TO BE SENSITIVE TO THE PRACTICING EMERGENCY PHYSICIAN IN INTERPRETING THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) MANDATES; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP POLICY SUPPORTING THE AMERICAN BOARD OF MEDICAL SPECIALTIES MAINTENANCE OF CERTIFICATION AS APPROPRIATE SUPPORT FOR STATE MEDICAL LICENSE MAINTENANCE OF LICENSURE, BUT ACTIVELY OPPOSE MANDATES THAT REQUIRE OR LINK MAINTENANCE OF CERTIFICATION AS **THE ONLY** REQUIREMENT~~S~~ FOR ONGOING MAINTENANCE OF LICENSURE; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP POLICY THAT SPECIFICALLY OPPOSES EFFORTS OF ~~THE AMERICAN BOARD OF MEDICAL SPECIALTIES AND ITS~~ SPECIALTY BOARDS TO BECOME THE INDEPENDENT SOLE SOURCE AND FOR PROFIT AUTONOMOUS ENTITIES MANDATING CONTINUING EDUCATION CREDIT AND UNCONTROLLED FIDUCIARY AND FINANCIAL AUTONOMY ~~PARTICULARLY WHEN NOT SENSITIVE TO THE NEEDS OF~~ ~~PRACTICING~~ **FOR EMERGENCY** PHYSICIANS.

It was moved THAT THE WORD “REQUIREMENT” BE REPLACED WITH THE WORD “PATHWAY.” The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 33 be adopted.

It was moved THAT AMENDED RESOLUTION 33 BE ADOPTED:

RESOLVED, THAT ACEP ~~REFINE THE POLICY STATEMENT, “FREESTANDING EMERGENCY DEPARTMENTS,” TO INCLUDE DIFFERENTIATION BETWEEN FREESTANDING~~

~~EDS AND URGENT CARE CENTERS OR~~ CREATE A ~~SEPARATE~~ POLICY STATEMENT DEFINING AN URGENT CARE CENTER **IN ORDER** TO PROTECT PATIENTS BY ENSURING ACCURATE CONSUMER INFORMATION AS TO PROVIDER QUALIFICATIONS, RESOURCES AVAILABLE, AND COSTS TO MAKE INFORMED DECISIONS WHEN SEEKING CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~WORK WITH THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND RELATED STATE HOSPITAL, REGULATORY, AND CERTIFICATION ORGANIZATIONS~~ **CONSIDER WORKING WITH STATE AND FEDERAL STAKEHOLDERS** TO ADVOCATE FOR APPROPRIATE ~~CREDENTIALING~~ **REGULATORY** STANDARDS FOR URGENT CARE CENTERS ~~THESE ENTITIES~~.

It was moved THAT THE WORD "CONSIDER" IN THE SECOND RESOLVED BE DELETED AND THE WORD "WORKING" BE REPLACED WITH THE WORD "WORK." The motion was adopted.

It was moved THAT THE WORD "COSTS" BE REPLACED WITH THE WORD "VALUE." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 34 be adopted.

It was moved THAT AMENDED RESOLUTION 34 BE ADOPTED:

RESOLVED, THAT ACEP, IN CONJUNCTION WITH OTHER INTERESTED ORGANIZATIONS, EVALUATE STATE EFFORTS TO PROVIDE TIMELY ACCESS TO EPINEPHRINE FOR ANAPHYLAXIS, INCLUDING CURRENT STATE LEGISLATION THAT INCLUDES LIABILITY PROTECTION FOR APPROPRIATE USE, PUBLIC EDUCATION, AWARENESS AND TIMELY ACCESS, INCLUDING COST EFFECTIVE MECHANISMS FOR AVAILABILITY OF DEVICES THAT MAY BE USED FOR BYSTANDER OR SELF-ADMINISTRATION, AND REPORT BACK TO THE COUNCIL IN 2016; AND BE IT FURTHER

RESOLVED, BASED UPON AVAILABLE INFORMATION, THAT ACEP DEVELOP APPROPRIATE POLICY TO SUPPORT PUBLIC AWARENESS, COST EFFECTIVE TIMELY ACCESS, AND LIABILITY PROTECTION FOR PUBLIC AND HEALTH CARE PROVIDER ADMINISTRATION, AND COLLABORATION WITH OTHER INTERESTED ORGANIZATIONS, FOR USE OF EPINEPHRINE FOR ANAPHYLAXIS OUTSIDE OF **EMERGENCY** HEALTH CARE SETTINGS.

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

RESOLVED, BASED UPON AVAILABLE INFORMATION, THAT ACEP DEVELOP APPROPRIATE POLICY TO SUPPORT PUBLIC AWARENESS, COST EFFECTIVE TIMELY ACCESS, ~~AND~~ LIABILITY PROTECTION FOR PUBLIC AND HEALTH CARE PROVIDER ADMINISTRATION, AND COLLABORATION WITH OTHER INTERESTED ORGANIZATIONS, FOR **THE SAFE AND EVIDENCED-BASED** USE OF EPINEPHRINE FOR ANAPHYLAXIS OUTSIDE OF **EMERGENCY** HEALTH CARE SETTINGS. The motion was not adopted.

It was moved THAT THE SECOND RESOLVED BE DELETED. 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 35 BE ADOPTED:

RESOLVED, THAT ACEP CREATE CLINICAL PRACTICE GUIDELINES FOR ~~DETOXIFICATION~~ **TREATMENT** OF PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT IN OPIOID OR BENZODIAZEPINE WITHDRAWAL; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE A PRACTICE RESOURCE TO EDUCATE EMERGENCY PROVIDERS ABOUT THE SCIENCE OF **ACUTE** OPIOID AND BENZODIAZEPINE ADDICTION..

It was moved THAT THE WORD "ACUTE" BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted

The committee recommended that Substitute Resolution 36, which includes language from Resolution 40, be adopted and that in the event that Substitute Resolution 36 is adopted, Resolution 40 would not be considered.

It was moved THAT SUBSTITUTE RESOLUTION 36 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT THE USE OF AND IMPLEMENTATION OF POLST (OR EQUIVALENT) PROGRAMS AS A MEANS OF HONORING OUR PATIENTS' END OF LIFE WISHES; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH ORGANIZATIONS SUCH AS THE AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE, HOSPICE AND PALLIATIVE NURSES ASSOCIATION, AARP, AND ALL OTHERS IT DEEMS FIT TO ADVOCATE FOR AND SUPPORT THE CREATION OF STATE AND/OR A NATIONAL POLST/EOL DATABASE(S) THAT CAN BE ACCESSED BY EMERGENCY PHYSICIANS IN TIMES OF CRISIS AND UNCERTAINTY AROUND A PATIENT'S END-OF-LIFE CARE; AND BE IT FURTHER

~~RESOLVED, THAT ACEP CREATE A TASK FORCE CHARGED WITH PROMOTING POLST/EOL REGISTRIES, EXPLORE THE COST AND REGULATORY BARRIERS TO CREATING SUCH DATABASES, SEEK FUNDING OPTIONS BOTH INTERNALLY AND EXTERNALLY FOR THE CREATION OF POLST/EOL DATABASES AND CONSIDERS EITHER SETTING UP A DATABASE OR IDENTIFYING PARTNERS THAT CAN SET UP POLST/EOL DATABASES FOR THE BENEFIT OF OUR MEMBERS AND THE AMERICAN PUBLIC; AND BE IT FURTHER~~

~~RESOLVED, THAT THE POLST/EOL REGISTRIES TASK FORCE REPORT BACK TO THE COUNCIL IN 2016 WITH ACTIONABLE ITEMS THAT THE COUNCIL, BOARD, AND ACEP CAN PURSUE TO BRING ABOUT POLST AND END OF LIFE DATABASES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP PROVIDE EDUCATION FOR EMERGENCY PHYSICIANS REGARDING THE UTILIZATION OF POLST FORMS AND ENCOURAGE ACEP MEMBERS TO BECOME FAMILIAR WITH THEIR STATE'S POLST (OR EQUIVALENT) PROGRAM; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO PROMOTE ADVANCED CARE AND END-OF-LIFE PLANNING AND COORDINATION AS A BEST PRACTICE.

It was moved THAT THE SECOND RESOLVED BE DELETED. The motion was not adopted.

It was moved THAT THE WORDS "THAT ACEP CREATE A TASK FORCE CHARGED WITH PROMOTING POLST/EOL REGISTRIES" IN THE THIRD RESOLVED BE RETAINED AND THAT THE FOURTH RESOLVED BE RETAINED. The motion was not adopted.

It was moved THAT THE WORDS "EMS RESPONDERS" BE INSERTED AFTER THE WORDS "ACCESSED BY EMERGENCY PHYSICIANS AND" IN THE SECOND RESOLVED. The motion was adopted.

The amended main motion was then voted on and adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 2:15 pm on Sunday, October 25, 2015.

REFERENCE COMMITTEE C (Continued)

The committee recommended that Amended Resolution 38 be adopted.

It was moved THAT AMENDED RESOLUTION 38 BE ADOPTED:

RESOLVED, THAT ACEP OPPOSES ANY NON-EVIDENCE BASED FINANCIAL INCENTIVES ~~FOR~~ **PREDICATED ON** PATIENT SATISFACTION SCORES ~~RELATED TO THE~~

~~PROVISION OF CONTROLLED SUBSTANCE PRESCRIPTIONS~~; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~WORK WITH CMS AND/OR THE NATIONAL QUALITY FORUM (NQF) TO~~ CREATE A QUALITY MEASURE THAT IS RELATED TO SAFE PRESCRIBING OF CONTROLLED MEDICATIONS; AND BE IT FURTHER

RESOLVED, THAT THE AMA SECTION COUNCIL ON EMERGENCY MEDICINE ~~SUBMIT A RESOLUTION~~ **SUPPORT AND ADVOCATE OUR POSITION** TO THE AMA REGARDING PATIENT SATISFACTION SCORES AND SAFE PRESCRIBING.

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

RESOLVED, THAT ACEP ~~WORK WITH CMS AND/OR THE NATIONAL QUALITY FORUM (NQF) TO~~ **WORK WITH STAKEHOLDERS TO** CREATE A QUALITY MEASURE THAT IS RELATED TO SAFE PRESCRIBING OF CONTROLLED MEDICATIONS. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 39 be adopted.

It was moved THAT AMENDED RESOLUTION 39 BE ADOPTED:

~~RESOLVED, THAT ACEP ACKNOWLEDGES THAT HIGHER PATIENT SATISFACTION SCORES ARE ASSOCIATED WITH MANY INDICATORS OF POOR QUALITY OF MEDICAL CARE, MANY FACTORS UNRELATED TO MEDICAL CARE, AND MANY COMPONENTS OF MEDICAL CARE NOT UNDER PHYSICIAN CONTROL; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ~~OPPOSES~~ **REAFFIRM ITS OPPOSITION TO** THE USE OF PATIENT SATISFACTION SURVEYS FOR PHYSICIAN CREDENTIALING OR FOR EMERGENCY MEDICINE PRACTICE FINANCIAL INCENTIVES OR DISINCENTIVES, **CONSISTENT WITH CURRENT ACEP POLICY**.

It was moved THAT THE SECOND RESOLVED BE AMENDED BY ADDITION OF THE WORDS "THAT HAVE NOT BEEN VALIDATED" AFTER THE WORD "SURVEYS." The motion was adopted.

It was moved THAT AMENDED RESOLUTION 39 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 44 be referred to the Board.

It was moved THAT RESOLTUION 44 BE REFERRED TO THE BOARD. The motion was adopted.

REFERENCE COMMITTEE B

Dr. Cirillo 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: Amended Resolution 13, Resolution 17, Amended Resolution 19, Amended Resolution 20, Amended Resolution 21, Resolution 23, Amended Resolution 26, Amended Resolution 27, Amended Resolution 28, Amended Resolution 29, and Resolution 30.

Not for adoption: Resolution 14 and Resolution 15.

For referral: Resolution 18 and Resolution 24.

Amended Resolution 13, Resolution 15, Resolution 18, Amended Resolution 21, Amended Resolution 26, Amended Resolution 28, and Resolution 30 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 19

~~RESOLVED, THAT ACEP CREATE A POLICY STATEMENT SUPPORTING THAT ALL FUNDING DISTRIBUTED TO INSTITUTIONS FOR THE PURPOSE OF GRADUATE MEDICAL EDUCATION BE USED SOLELY FOR THAT PURPOSE; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH THE AGENCIES THAT PROVIDE GRADUATE MEDICAL EDUCATION FUNDING TO CREATE MEASURES TO ENSURE THAT ALL INSTITUTIONS THAT RECEIVE GRADUATE MEDICAL EDUCATION FUNDING BE REQUIRED TO MAINTAIN PUBLICLY AVAILABLE RECORDS OF THE DISTRIBUTION AND UTILIZATION OF THESE FUNDS.

AMENDED RESOLUTION 20

~~RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT ON THE EFFECTS THAT GROUP PURCHASING HAS ON MEDICATION SHORTAGES AND USE OF ORPHAN DEVICES IN THE EMERGENCY DEPARTMENTS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP STUDY THE EFFECTS ON PATIENT CARE FROM THE LACK OF AVAILABILITY OF APPROPRIATE MEDICATIONS AND MEDICAL EQUIPMENT DUE TO GROUP PURCHASING PRACTICES, MEDICATION SHORTAGES, AND ORPHAN PRODUCT RESTRICTIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH STAKEHOLDERS SUCH AS THE AMERICAN MEDICAL ASSOCIATION TO DEVELOP MODEL LEGISLATION THAT PROTECTS PHYSICIANS ~~AND PHARMACISTS~~ FROM LIABILITY AS A RESULT OF THE INABILITY TO PROVIDE ~~ADEQUATE EQUIPMENT~~ **OPTIMAL CARE DUE TO LACK OF APPROPRIATE MEDICAL DEVICES** OR PHARMACEUTICALS TO DIAGNOSE AND TREAT EMERGENCY PATIENTS.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP CREATE A LIST OF "NEVER EVENTS" AS IT RELATES TO ORPHAN DEVICES AND DRUG SHORTAGES~~

AMENDED RESOLUTION 27

RESOLVED, THAT ACEP ~~ISSUE~~ **DEVELOP** A STATEMENT DECLARING THAT INSURANCE COMPANIES AND OTHER PAYERS REIMBURSE EMERGENCY PHYSICIANS FOR ULTRASOUND STUDIES AND SERVICES THAT THEY PERFORM AND INTERPRET AS ~~PART OF~~ **SEPARATE AND IDENTIFIABLE PROCEDURES WHILE PROVIDING** PATIENT CARE **SERVICES** IN THE EMERGENCY DEPARTMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT EFFORTS TO REDUCE PAYMENT DENIALS FOR APPROPRIATELY PERFORMED AND DOCUMENTED CLINICAL ULTRASONOGRAPHY.

AMENDED RESOLUTION 29

RESOLVED, THAT ACEP SUPPORTS THE ~~REQUIREMENT THAT PHARMACEUTICAL COMPANIES COORDINATE WITH HOSPITALS TO PAY FOR APPROPRIATE HOSPITAL-LOCATED~~ **DEVELOPMENT OF** DRUG "TAKE-BACK" PROGRAMS **AT NO COST TO PATIENTS**; AND BE IT FURTHER

~~RESOLVED, THAT ACEP ENDORSES AND SUPPORTS LOCAL ORDINANCES, STATE, AND NATIONAL LAWS THAT REQUIRE DRUG "TAKE-BACK" PROGRAMS; AND FURTHER BE IT~~

RESOLVED, THAT THE AMA SECTION COUNCIL ON EMERGENCY MEDICINE ~~SUBMIT~~ **CONSIDER SUBMITTING** A RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION TO SUPPORT DRUG "TAKE-BACK" PROGRAMS.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED:

RESOLVED, THAT ACEP EVALUATE THE EXPANDING ROLE AND COST FOR ~~PHARMACEUTICAL DRUGS~~ **PHARMACEUTICALS** AFFECTING THE PRACTICE OF EMERGENCY MEDICINE AND IDENTIFY AND COLLABORATE, WHERE APPROPRIATE, WITH ~~PHARMACEUTICAL MANUFACTURERS AND OTHER INTERESTED PARTIES~~ **INTERESTED PARTIES/STAKEHOLDERS, INCLUDING PHARMACEUTICAL MANUFACTURERS AND OTHERS** TO BEST ASSURE AN APPROPRIATE, COST-EFFECTIVE, SUSTAINABLE, ACCESS TO EMERGENCY CARE TREATMENTS AND IDENTIFY METHODS TO BEST FACILITATE

DISSEMINATION OF FACTUAL AND DATA DRIVEN INFORMATION ABOUT ALTERNATIVE USES OF MEDICATIONS AND DEVELOP APPROPRIATE POLICIES TO SUPPORT THIS EFFORT AND REPORT BACK TO THE ACEP COUNCIL ~~ON A PERIODIC BASIS~~ **NEXT YEAR**.

It was moved THAT THE WORDS "NEXT YEAR" BE REPLACED WITH THE WORDS "IN 2016." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 15 not be adopted.

It was moved THAT RESOLUTION 15 BE ADOPTED.

It was moved THAT RESOLUTION 15 BE AMENDED BY ADDITION OF A NEW FIRST RESOLVED TO READ:

RESOLVED, THAT ACEP RESPECTS AND SUPPORTS THE FIRST AMENDMENT RIGHT OF ALL PHYSICIANS, BASED ON THEIR TRAINING, EDUCATION, AND EXPERIENCE, TO RECOMMEND MEDICINAL CANNABIS FOR PATIENTS. The motion was not adopted.

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

The committee recommended that Resolution 16 not be adopted.

It was moved THAT RESOLUTION 16 BE ADOPTED.

It was moved THAT RESOLUTION 16 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY MEDICINE SUPPORTS FURTHER RESEARCH INTO THE MEDICAL AND SOCIETAL IMPACTS OF MARIJUANA; AND BE IT FURTHER

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS FORMALLY TAKES NO STANCE AS TO THE LEGAL STATUS OF MARIJUANA, AND BELIEVES THAT THE APPROPRIATE DETERMINATION AS TO THE LEGALIZATION OF MARIJUANA IS BEST DONE AT THE STATE AND FEDERAL LEVEL. The motion was not adopted.

It was moved THAT RESOLUTION 16 BE DIVIDED. The motion was not adopted.

The main motion was then voted and was not adopted.

The committee recommended that Resolution 18 be referred to the Board of Directors.

It was moved THAT RESOLUTION 18 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved THAT RESOLUTION 18 BE AMENDED TO READ:

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION AND OTHER INTERESTED PARTIES TO STUDY THE POSSIBILITY OF EXPANDING THE ~~"ER IS FOR EMERGENCIES"~~ **COORDINATING CARE FOR THE PRUDENT LAYPERSON** PROGRAM TO A NATIONAL SCALE BASED OFF OF THE WASHINGTON STATE SEVEN BEST PRACTICES PROGRAM.

It was moved THAT RESOLUTION 18 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 21 be adopted.

It was moved THAT AMENDED RESOLUTION 21 BE ADOPTED.

RESOLVED, That ACEP create a recommended standard ~~minimum amount~~ of information to be contained in the Healthcare Information Exchanges; and be it further

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

It was moved THAT AMENDED RESOLUTION 21 BE FURTHER AMENDED TO READ:

RESOLVED, THAT ACEP CREATE A RECOMMENDED STANDARD ~~MINIMUM AMOUNT OF~~ **FOR ED** INFORMATION **SUMMARY** ~~TO BE~~ CONTAINED IN ~~THE~~ HEALTHCARE INFORMATION EXCHANGES; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE OR IDENTIFY, AND PROMOTE THE STANDARD THAT ALLOWS FOR NOTIFICATION(IN THE ED ELECTRONIC HEALTH RECORD)OF THE EXISTENCE OF APPLICABLE HEALTHCARE INFORMATION EXCHANGE DATA; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE THE STANDARDIZED REQUIREMENTS TO THE HEALTHCARE INFORMATION EXCHANGES CURRENTLY IN THE PROCESS OF DEVELOPMENT. The motion was adopted.

It was moved THAT THE WORD "CREATE" IN THE FIRST RESOLVED BE REPLACED WITH THE WORD "IDENTIFY" AND THE WORDS "CREATE OR" IN THE SECOND RESOLVED BE REPLACED WITH THE WORDS "WORK WITH RELEVANT STAKEHOLDERS TO." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 22 be adopted.

It was moved THAT AMENDED RESOLUTION 22 BE ADOPTED:

RESOLVED, THAT ACEP **SUPPORT EFFORTS TO** ENCOURAGE ADULTS OF ALL AGES AND STATES OF HEALTH TO TALK WITH FAMILY, FRIENDS, SPIRITUAL ADVISORS, HEALTH PROFESSIONALS, AND PHYSICIANS ABOUT ADVANCE DIRECTIVES AND TO RECORD AND KEEP **THESE WISHES** UPDATED**.** ~~THESE WISHES ON AN ONLINE ADVANCE DIRECTIVE REGISTRY; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP SUPPORT THE CREATION AND DISTRIBUTION OF EDUCATIONAL MATERIALS ON ADVANCE DIRECTIVES TO DISTRIBUTE AT STATES' DEPARTMENT OF MOTOR VEHICLE OFFICES, TESTED ON LICENSE APPLICATION EXAMINATIONS, AND MAILED OR ELECTRONICALLY DISTRIBUTED TO INDIVIDUALS OBTAINING AND RENEWING DRIVERS LICENSES; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ADVOCATE THAT INDIVIDUALS OVER 18 APPLYING FOR OR RENEWING A DRIVER LICENSE OR IDENTIFICATION CARD BE GIVEN THE OPTION TO INDICATE WHETHER THEY HAVE AN ADVANCE DIRECTIVE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ADVOCATE FOR STATES' DEPARTMENT OF MOTOR VEHICLES TO CREATE AN ADVANCE DIRECTIVE ICON TO BE AVAILABLE FOR PLACEMENT ON THE FRONT OF THE LICENSE FOR INDIVIDUALS WHO DECLARE THAT THEY HAVE AN ADVANCE DIRECTIVE DURING LICENSE REGISTRATION OR RENEWAL; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP SUPPORTS LEGISLATION FOR AND INNOVATIONS TO FURTHER INTEGRATE ADVANCE DIRECTIVE INFORMATION WITH STATE DRIVER LICENSE AND IDENTIFICATION CARDS IN EFFORTS TO PROMOTE GREATER ACCESSIBILITY, USABILITY, AND AWARENESS OF ADVANCE DIRECTIVES.~~ The motion was adopted.

The committee recommended that Resolution 25 not be adopted.

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

The committee recommended that Amended Resolution 26 be adopted.

It was moved THAT AMENDED RESOLUTION 26 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORTS BANNING THE PRODUCTION, SALE, DISTRIBUTION OR POSSESSION OF POWDERED ALCOHOL FOR PERSONAL CONSUMPTION USE; AND BE IT FURTHER

RESOLVED, THAT ACEP REQUEST THAT THE FDA BAN POWDERED ALCOHOL; AND BE IT FURTHER

RESOLVED, THAT ACEP REQUEST THE ALCOHOL AND TOBACCO TAX TRADE BUREAU (TTB) TO REVERSE ITS DECISION ON PALCOHOL; AND BE IT FURTHER

~~RESOLVED, THAT ACEP ENDORSE AND SUPPORT S.728/H.R. 1717, WHICH WOULD BAN THE PRODUCTION, SALE, DISTRIBUTION OR POSSESSIONS OF POWDERED ALCOHOL; AND BE IT FURTHER~~

RESOLVED, THAT ACEP SUPPORT LEGISLATION TO BAN THE PRODUCTION, SALE, DISTRIBUTION, OR POSSESSION OF POWDERED ALCOHOL ON A STATE LEVEL FOR PERSONAL CONSUMPTION USE.

It was moved THAT THE SECOND AND THIRD RESOLVEDS BE DELETED. The motion was adopted.

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

The committee recommended that Amended Resolution 28 be adopted.

It was moved THAT AMENDED RESOLUTION 28 BE ADOPTED:

RESOLVED, THAT ACEP DEVELOP A SET OF STANDARDS FOR FAIR PAYMENT FOR EMERGENCY PHYSICIAN SERVICES, AND COMPLIANCE WITH WHICH TO BE INCLUDED IN THE NEXT EDITION OF AMERICA'S EMERGENCY ENVIRONMENT, A STATE BY STATE REPORT CARD;" AND BE IT FURTHER

RESOLVED, THAT ACEP DEVOTE INCREASED RESOURCES TO MONITOR THE STATE-BY-STATE STATUS AND CHANGES IN LAW CONCERNING THE STANDARDS FOR FAIR PAYMENT OF EMERGENCY PHYSICIANS AND ESTABLISH A SINGLE POINT OF CONTACT AT THE NATIONAL LEVEL AS A RESOURCE FOR ASSISTING ALL CHAPTERS; AND BE IT FURTHER

RESOLVED, THAT ACEP SHALL WORK WITH OTHER **MEDICAL** SPECIALTIES~~, AMBULATORY SERVICES,~~ AND HOSPITALS TO DEVELOP MODEL FAIR PAYMENT LEGISLATION AND THEN DEVOTE RESOURCES TO PROMOTING ADOPTION IN EVERY STATE; AND BE IT FURTHER

~~RESOLVED, THAT ACEP SHALL USE ITS INFLUENCE WITH THE NATIONAL EMERGENCY MEDICINE POLITICAL ACTION COMMITTEE TO DEVOTE RESOURCES TO DEVELOPING STATE-BY-STATE INFLUENCE UPON EACH STATE'S LEGISLATIVE AND REGULATORY PROCESS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH THE EMERGENCY MEDICINE FOUNDATION TO RESEARCH, PUBLISH, AND DISSEMINATE THE DETRIMENTAL EFFECTS OF LEGISLATION THAT LIMITS THE RIGHTS OF EMERGENCY PHYSICIANS TO FAIRLY BILL AND COLLECT, AND TO DEVELOP EFFECTIVE EDUCATIONAL MATERIALS EXPLAINING THE FACTS CONCERNING EMERGENCY PHYSICIAN BILLING AND COLLECTION, FOR USE AT THE NATIONAL AND LOCAL LEVEL IN EDUCATING LEGISLATORS, REGULATORS, POLICY-MAKERS, AND THE PUBLIC; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~AND THE EMERGENCY MEDICINE ACTION FUND DEVELOP AND SUPPORT~~ **EXPLORE THE DEVELOPMENT OF** A NATIONAL "STRIKE TEAM" THAT CAN BE DEPLOYED BY ACEP LEADERSHIP TO HELP CHAPTERS IN STATES WHERE EMERGENCY PHYSICIANS ARE FACING AN IMMEDIATE LEGISLATIVE THREAT TO THE FAIR PAYMENT PROCESS.

It was moved THAT AMENDED RESOLUTION 28 BE FURTHER AMENDED BY ADDITION OF A NEW FOURTH RESOLVED TO READ:

RESOLVED, THAT ACEP SHOULD PROMOTE, AT THE STATE AND FEDERAL LEVEL, THE ELIMINATION OF THE PRACTICE OF SENDING BALANCE BILLS TO PATIENTS WHO

PRESENT TO THE EMERGENCY DEPARTMENT OF AN IN-NETWORK FACILITY, IN EXCHANGE FOR THE ADOPTION OF A FAIR OUT-OF-NETWORK BENEFIT STANDARD BASED ON THE LESSER OF THE PROVIDER'S CHARGES OR AN AGREED UPON, SPECIFIED, PERCENTILE OF USUAL AND CUSTOMARY CHARGES; AND BE IT FURTHER

The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 28 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 30 be adopted.

It was moved THAT RESOLUTION 30 BE ADOPTED.

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

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

Dr. Costello reported that 373 of the 375 councillors eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the vice speaker election. Dr. McManus was elected.

Congressman Raul Ruiz, MD (D-CA) addressed the Council.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Kang and Dr. Rosenberg were elected to a three-year term. Dr. Friedman and Dr. Jaquis were re-elected to a three-year term.

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

There being no further business, Dr. Klauer adjourned the 2015 Council meeting at 5:59 pm on Sunday, October 25, 2015. The next meeting of the ACEP Council is scheduled for October 14-15, 2016, at Mandalay Bay Convention Resort in Las Vegas, NV.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary

Approved by,

Kevin M. Klauer, DO, EJD, FACEP
Council Speaker