COUNCIL MEETING

October 24-25, 2020

Virtual Meeting
The American College of Emergency Physicians is a national not-for-profit professional organization that exists to support quality emergency medical care and to promote the interest of emergency physicians. The College is not organized to and may not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.

The College provides a forum for exchange of ideas in a variety of settings including its annual meeting, educational programs, committee meetings, and Board meetings. The Board of Directors of the College recognizes the possibility that the College and its activities could be viewed by some as an opportunity for anti-competitive conduct. Therefore, the Board is promulgating this policy statement to clearly and unequivocally support the policy of competition served by the antitrust laws and to communicate the College's uncompromising policy to comply strictly in all respects with those laws.

While recognizing the importance of the principle of competition served by the antitrust laws, the College also recognizes the severity of the potential penalties that might be imposed on not only the College but its members as well in the event that certain conduct is found to violate the antitrust laws. Should the College or its members be involved in any violation of federal/state antitrust laws, such violation can involve both civil as well as criminal penalties that may include imprisonment for up to 3 years as well as fines up to $350,000 for individuals and up to $10,000,000 for the College plus attorney fees. In addition, damage claims awarded to private parties in a civil suit are tripled for antitrust violations. Given the severity of such penalties, the Board intends to take all necessary and proper measures to ensure that violations of the antitrust laws do not occur.

In order to ensure that the College and its members comply with the antitrust laws, the following principles will be observed:
• The American College of Emergency Physicians or any committee, section, chapter, or activity of the College shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms and conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at College meetings or other activities.

• There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers, any supplier or purchaser or group of suppliers or purchasers of health care products or services, any actual or potential competitor or group of actual potential competitors, any patients or group of patients, or any private or governmental reimbursers.

• There will be no discussions about allocating or dividing geographic or service markets, customers, or patients.

• There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.

• There will be no discussions about discouraging entry into or competition in any segment of the health care market.

• There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.

• Certain activities of the College and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state, or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) of a governmental body; or 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a “sham” to cover anticompetitive conduct.

• Speakers at committees, educational meetings, or other business meetings of the College shall be informed that they must comply with the College's antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the College or its legal counsel.

• Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

At informal discussions at the site of any College meeting all participants are expected to observe the same standards of personal conduct as are required of the College in its compliance.
Conflict of Interest

Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, Annals Editor, staff, and others acting on behalf of the College have a fiduciary duty to the College, including the duties of loyalty, diligence, and confidentiality.

Those in positions of responsibility must act in utmost good faith on behalf of the College. In accepting their positions, they promise to give the College the benefit of their work and best judgment. They should exercise the powers conferred solely in the interest of the College and should not use their role or position for their own personal interest or that of any other organization or entity. Even the perception of conflict can potentially compromise the confidence and trust of ACEP members and the public in the stewardship of its leaders.

Conflicts of interest arise when participants in positions of responsibility have personal, financial, business, or professional interests or responsibilities that may interfere with their duties on behalf of ACEP. The immediacy and seriousness of various conflicts of interest situations may vary. Of basic importance is the degree to which the interest would tend one toward bias or pre-disposition on an issue or otherwise compromise the interests of the College.

A conditional, qualified, or potential conflict of interest can arise when the outside interest is not substantial or does not relate significantly to any contemplated action of the College. For example, a person might hold a minor financial interest in a company wishing to do business with the College. Disclosure is ordinarily sufficient to deal with this type of potential conflict of interest, provided that there is no expectation that one's duty to the College would be affected.

Direct conflicts of interest arise, for example, when an individual engages in a personal transaction with the College or holds a material interest or position of responsibility in an organization involved in a specific transaction with the College or that may have interests at variance or in competition with the College. The appropriate and necessary course of action in such cases is to disclose the conflict and recuse oneself, during the deliberations and the vote on the issue.
In rare circumstances, an individual may have such a serious, ongoing, and irreconcilable conflict, where the relationship to an outside organization so seriously impedes one's ability to carry out the fiduciary responsibility to the College, that resignation from the position with the College or the conflicting entity is appropriate.

Dealing effectively with actual, perceived, or potential conflicts of interest is a shared responsibility of the individual and the organization. The individual and organizational roles and responsibilities with regard to conflicts of interest follow.

A. General

1. All individuals who serve in positions of responsibility within the College need not only to avoid conflicts of interest, but also to avoid the appearance of a conflict of interest. This responsibility pertains to Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, Annals Editor and the Executive Director (hereinafter collectively “Key Leaders”) and other elected or appointed leaders, and staff. Decisions on behalf of the College must be based solely on the interest of the College and its membership. Decisions must not be influenced by desire for personal profit, loyalty to other organizations, or other extraneous considerations.

2. Key Leaders shall annually sign a statement acknowledging their fiduciary responsibility to the College and pledge to avoid conflicts of interest or the appearance of conflicts of interest. The issue of conflicts of interest with regard to the remainder of the staff shall be the responsibility of the Executive Director. The issue of conflicts of interest with regard to Section and Task Force Members who participate in the development of policy and resources on behalf of the Colleges shall be the responsibility of the Section and Task Force Chairs with the ultimate determination made by the College President as to Section and Task Force Members to be designated as Key Leaders for the purpose of this policy and the related disclosures, acknowledgements, pledges and statements.

3. Key Leaders shall annually complete a form designated by the ACEP Board of Directors that includes the disclosure of pertinent financial and career-related information and shall update that information as necessary to continuously keep it current and active.

4. Key Leaders shall annually sign a statement acknowledging that they may have access to confidential information and pledge to protect the confidentiality of that information.

5. Officers, Board Members, the Executive Director, and the General Counsel shall annually pledge to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the
membership as a whole, or as an officer or member of the Board of Directors or senior staff member.

6. Officers, Board Members, the Executive Director, the General Counsel or their designees will periodically review the conflict of interest disclosure statements submitted to the College to be aware of potential conflicts that may arise with others.

7. When an Officer, Board Member, the Executive Director, or General Counsel believes that an individual has a conflict of interest that has not been properly recognized or resolved, the Officer, Board Member, Executive Director, or General Counsel will raise that issue and seek proper resolution.

8. Any member may raise the issue of conflict of interest by bringing it to the attention of the Board of Directors through the President or the Executive Director. The final resolution of any conflict of interest shall rest with the Board of Directors.

B. Disclosure Form

1. Key Leaders shall annually complete a form that discloses the following:

   a. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and entities – eg, board of directors, committees, spokesperson role. Include a brief description of the nature and purposes of the organization or entity.

   b. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily responsibilities of the employment.

   c. Direct financial interest (other than less than 1% interest in a publicly traded company) or positions of responsibility in any entity:

      i. From which ACEP obtains substantial amounts of goods or services;

      ii. That provides services that substantially compete with ACEP; and

      iii. That provides goods or services in support of the practice of emergency medicine (e.g. physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company).
d. Industry-sponsored research support within the preceding twenty-four (24) months.

e. Speaking fees from non-academic entities during the preceding twenty-four (24) months.

f. The receipt of any unusual gifts or favors from an outside entity or person, or the expectation that a future gift or favor will be received in return for a specific action, position, or viewpoint taken in regards to ACEP or its products.

g. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to ACEP or that may create the appearance of a conflict of interest.

2. Except as provided in Section 4 below, completed disclosure forms shall be submitted to the President and the Executive Director no later than sixty (60) days prior to commencement of the annual meeting of ACEP’s Council. For Officers and Board Members newly elected during a meeting of ACEP’s Council, the forms shall be submitted no later than thirty (30) days following their election if they were not previously submitted. Any Key Leader who has not submitted a completed disclosure form by the applicable deadline will be ineligible to participate in those specific College activities for which they have been appointed or elected until their completed disclosure forms have been received and reviewed as set forth in this policy.

3. Information disclosed by Officers, Board Members, and the Executive Director pursuant to this policy will be placed in the General Reference Notebook available at each Board meeting for review by Officers and Board Members. Committee, Section, and Task Force Chairs will have access to the disclosure forms of the members of the entity they chair. In addition, any ACEP member may request a copy of a Key Leader’s disclosure form upon written request to the ACEP President.

4. Completed disclosure forms required from Section and Task Force Members will be submitted to the relevant Section or Task Force Chair and the Executive Director within thirty (30) days of appointment or assignment.

5. ACEP may disclose to its members and the public the disclosure forms of its Officers, Board Members, Annals Editor, and the Executive Director.

C. Additional Rules of Conduct

1. Prior to participating in any deliberation or vote on an issue in which they may have a conflict, Key Leaders shall disclose the existence of any actual or possible interest or concern of:
a. The individual;

b. A member of that individual’s immediate family; or

c. Any party, group, or organization to which the individual has allegiance that can cause ACEP to be legally or otherwise vulnerable to criticism, embarrassment or litigation.

2. After disclosure of the interest or concern that could result in a conflict of interest as defined in this policy and all material facts, the individual shall leave the Board, Committee, Section, or Task Force meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board, Committee, Section, or Task Force members shall decide by majority vote if a conflict of interest exists. If a conflict of interest is determined to exist, the individual having the conflict shall retire from the room in which the Board, Committee, Section, or Task Force is meeting and shall not participate in the deliberation or decision regarding the matter under consideration. However, that individual shall provide the Board, Committee, Section, or Task Force with any and all relevant information requested.

3. The minutes of the Board, Committee, Section, or Task Force meeting shall contain:

a. The name of the individual who disclosed or otherwise was found to have an interest or concern in connection with an actual or possible conflict of interest, the nature of the interest, any action taken to determine whether a conflict of interest was present, and the Board’s, Committee’s, Section’s, or Task Force’s decision as to whether a conflict of interest existed;

b. The extent of such individual’s participation in the relevant Board, Committee, Section, or Task Force meeting on matters related to the possible conflict of interest; and

c. The names of the individuals who were present for discussion and votes relating to the action, policy, or arrangement in question, the content of the discussion including alternatives to the proposed action, policy, or arrangement, and a record of any votes taken in connection therewith.
2020 Virtual Council Meeting
https://web.lumiagm.com/255598814
October 24-25, 2020
Pre-Meeting Events Occur Friday Evening, October 23, 2020

TIMED AGENDA
(with flexibility because of the virtual environment)

All times listed are Central Time Zone.

Saturday, October 24, 2020

1. Call to Order
   A. Meeting Dedication
   B. Pledge of Allegiance
   C. National Anthem

   Dr. Katz

2. Introduction and Explanation of Virtual Format
   Dr. Katz

3. Welcome from TX Chapter President
   Dr. Hancock

4. Tellers, Credentials & Election Committee
   A. Credentials Report

   Dr. Thompson

5. Changes to the Agenda
   Dr. Katz

6. EMF Challenge (click to donate www.emfoundation.org/council)
   Dr. Wilcox

7. NEMPAC Challenge
   (click to donate https://www.emergencyphysicianspac.org/donate-userinfo.aspx)

8. Temporary 2020 Virtual Council Meeting Standing Rules
   Dr. Katz/Mr. Slaughter

9. Review and Acceptance of Minutes
   A. Council Meeting – October 25-26, 2019

   Dr. Katz

10. Approval of Steering Committee Actions
    A. Steering Committee Meeting – January 22, 2020
    B. Steering Committee Meeting – April 26, 2020
    C. Steering Committee Meeting – June 9, 2020
    D. Steering Committee Conference Call – August 25, 2020

   Dr. Katz

11. Call for and Presentation of Emergency Resolutions
    Dr. Katz

12. Steering Committee’s Report on Late Resolutions
    A. Reference Committee Assignments of Allowed Late Resolutions
    B. Disallowed Late Resolutions

    Dr. Katz

13. Nominating Committee Report
    A. Board of Directors
       1. Slate of Candidates
       2. Call for Floor Nominations
    B. President-Elect
       1. Slate of Candidates
       2. Call for Floor Nominations

    Dr. Katz

10:30 am
Saturday, October 24, 2020 (Continued)

14. Candidate Opening Statements
   A. Board of Directors Candidates (2 minutes each)  Dr. Gray-Eurom
   B. President-Elect Candidates (5 minutes each)

15. Reference Committee Assignments  Dr. Katz

16. Reference Committee Hearings
   A – Governance & Membership  Dr. Green  10:55 am

**BREAK**  
11:55 am – 12:10 pm

   B – Advocacy & Public Policy  Dr. Booth-Norse  12:10 pm
   C – Emergency Medicine Practice  Dr. Fairbrother  1:10 pm

**BREAK**  
2:10 pm – 2:25 pm

17. Candidate Forum for the President-Elect Candidates  Dr. Katz/Dr. Gray-Eurom  2:25 pm

   **Note: Candidate Forum for Board of Directors Candidates – videos will be available on demand.**

18. Speaker’s Report  Dr. Katz  2:55 pm

19. In Memoriam  Dr. Katz
   A. Reading of Memorial Resolutions  Dr. Gray-Eurom
      *Adopt by observing a moment of silence.*

20. Secretary-Treasurer’s Report  Dr. Kang

21. EMF & NEMPAC Challenge Updates  Dr. Katz

22. President’s Address  Dr. Jaquis

23. Announcements  Dr. Katz

**RECESS**  
3:45 pm

**Virtual Candidate Receptions ● 5:00 – 6:00 pm**

*Zoom call information for each candidate’s reception will be provided on the Council engagED site.*

**President-Elect Candidates**

Christopher S. Kang, MD, FACEP
Gillian R. Schmitz, MD, FACEP

**Board of Directors Candidates**

Michael J. Baker, MD, FACEP
Alison J. Haddock, MD, FACEP
Aisha T. Terry (Liferidge), MD, MPH, FACEP
James L. Shoemaker, Jr., MD, FACEP
Arvind Venkat, MD, FACEP
**Sunday, October 25, 2020**

1. **Call to Order**
   - Dr. Katz
   - 10:00 am

2. **Tellers, Credentials, & Elections Committee Report**
   - Dr. Thompson

3. **Demographic Data Questions**
   - Dr. Katz

4. **Executive Directors Report**
   - Ms. Sedory

5. **Reference Committee Reports**
   - Dr. Green
   - 10:50 am

   **BREAK**
   - 11:50 am – 12:05 pm

   - B. Reference Committee B
     - Dr. Booth-Norse
     - 12:05 pm

   - C. Reference Committee C
     - Dr. Fairbrother
     - 1:05 pm

6. **Reading of Commendation Resolutions**
   - Dr. Katz/Dr. Gray-Eurom
   - 2:05 pm

   *Adopt by acclamation.*

7. **President-Elect’s Address**
   - Dr. Rosenberg

8. **Installation of President**
   - Dr. Jaquis/Dr. Rosenberg

9. **Tellers, Credentials, & Elections Committee Report**
   - Dr. Thompson

10. **Elections**
    - A. Board of Directors
    - Dr. Katz/Dr. Gray-Eurom
    - 3:00 pm
    - B. President-Elect

11. **Announcements**
    - Dr. Katz
    - 3:30 pm

**ADJOURN**

- **3:35 pm**

**Videos and reports available on demand**
- Candidate Forum for Board of Directors Candidates
- ABEM Report
- AOBEM Report
- EMRA Report
- EMF Report (click to donate [www.emfoundation.org/council](http://www.emfoundation.org/council))

**Next Annual Council Meeting ● October 23-24, 2021 ● Boston, MA**
2020 Council Meeting Materials

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  • Gillian R. Schmitz, MD, FACEP
17 Board of Directors Candidates
  • Michael J. Baker, MD FACEP
  • Alison J. Haddock, MD, FACEP
  • James L. Shoemaker, Jr., MD, FACEP
  • Aisha T. (Liferidge) Terry, MD, FACEP
  • Arvind Venkat, MD, FACEP
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<td>Kelly Gray-Eurom, MD, MMM,</td>
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<td>Angela P. Cornelius, MD, FACEP</td>
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<td>Justin W. Fairless, DO, FACEP</td>
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<td>Daniel Freess, MD, FACEP</td>
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<td>Muhammad N. Husainy, DO, FACEP</td>
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<td>Rami Khoury, MD, FACEP</td>
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<td>Jeffrey F. Linzer, MD, FACEP</td>
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<td>Kurtis A. Mayz, MD, JD, MBA, FACEP</td>
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<td>Gregg A. Miller, MD, FACEP</td>
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<td>Christina Millhouse, MD, FACEP</td>
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<td>Randy Pilgrim, MD, FACEP</td>
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<th>Matthew Rudy, MD, FACEP</th>
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<td>Evans, GA</td>
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<tr>
<th>Arvind Venkat, MD, FACEP</th>
<th>Karina Sanchez, MD (EMRA REP to Steering Committee)</th>
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<td>Wexford, PA</td>
<td>Johnstown, PA</td>
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Attending 2020 Virtual Council Meeting
October 24 - 25, 2020

You will be able to view a live stream of the meeting, ask questions, and submit your votes in real time.

Go to https://web.lumiagm.com/255598814 in your web browser (not a Google search). You will need the latest versions of Chrome or Edge. DO NOT USE INTERNET EXPLORER OR SAFARI. You must use a desktop or laptop to attend the meeting. (Mobile devices, including iPhones, iPads or other tablets, and Androids are not supported.)

Councillors with voting rights, past presidents, past speakers, past chairs of the Board, and current members of the Board of Directors (who have speaking rights) will receive a log in credential to log into the meeting. Select the “I have a Member ID” button and enter your Member ID and the password: acep2020 (lower case). Everyone else will join the meeting as an observer. All participants have the right to speak during the Reference Committee hearings on the first day of the Council meeting. Only councillors, past presidents, past speakers, past chairs of the Board, and current members of the Board of Directors have the right to speak on the second day of the Council meeting during discussion of the Reference Committee reports.

The virtual site will be open October 21 – 23, 9:00 am – 5:00 pm Central time, to test your log in. Please visit the above meeting URL to make sure you can log in to the virtual platform prior to the meeting start on October 24. Please contact councilmeeting@acep.org if you experience any issues.
Any councillor or others with speaking rights who have logged in to the meeting is eligible to ask questions.

If you would like to ask a question, select the double chat bubble icon from the top.

Questions can be submitted at any time during the Q&A session up until the Speaker closes the session.

When successfully authenticated, the info screen will be displayed on the left.

You can join the speaking queue by clicking on the double chat bubble icon in the center.

You can view documents by clicking on the documents icon on the right.

The Zoom panel will be on the left side of the screen to view and hear the meeting proceedings. After logging in, you will need to click “Join Computer Audio” to hear the meeting.

Once the voting has opened, the item you are voting on will be automatically displayed. Only credentialled councillors will be allowed to vote.

To vote, simply select your response from the options shown on screen. A confirmation message will appear to show your vote has been received.

To change your vote, simply select another choice while the vote is open. If you wish to cancel your vote, press Cancel.

If selecting more than one choice, you will be required to press the SEND button.

Type your message within the chat box at the bottom of the messaging screen.

Once you are happy with your message click the arrow button to submit.

Questions sent via the online platform will be moderated before being sent to the Speaker.
Everyone who has logged in to the meeting is eligible to speak during the Reference Committee Hearings on October 24. During discussion of the Reference Committee reports on October 25, only councillors, past presidents, past speaker, past chairs of the Board, and current members of the Board of Directors may speak In Favor or Opposed to motions. Only credentialed councillors may request to remove an item from the Consent Agenda.

If you would like to speak, select the chat bubble icon. To be added to the speaker queue, you must type in what you would like to speak about.

You may only request to speak at times during the meeting when the Speaker requests that individuals to submit a request to “speak from the floor”.

Type your request within the text box at the bottom of the messaging screen. Your message must be formatted in this manner:

IN FAVOR
OPPOSED
REFER
REMOVE FROM CONSENT
I HAVE A QUESTION

Requests sent via the online platform will be moderated before being sent to the Speaker.

If you are selected to speak, at the appropriate time you will be called upon by the Speaker.

You will then need to go to the Zoom panel on the right and Raise Your Hand. Click on the “Raise Hand” button from the bottom menu.

Once you raise your hand, the production staff can then more easily find you. They will prompt you to unmute your microphone.

First, allow your web browser permission to access your microphone by clicking “Allow” from the pop up window you receive.

Then, click the blue “Unmute myself” button from the right Zoom panel and begin speaking.

After you speak, the production team will mute your microphone in the Zoom panel and you may continue to listen to the proceedings.
LUMI Technology Cheat Sheet

This cheat sheet is provided to assist with navigating the Virtual 2020 Council Meeting. Information such as understanding how to use and log into the LUMI platform, how to join the speaking queue, and what to do if you are having technical problems are included. We advise reading this cheat sheet prior to attendance at the Virtual Council Meeting and prior to the orientation session. Keep it available during the Council Meeting for easy reference.

How to Log In to the Virtual Meeting Platform

1. Go to: https://web.lumiagm.com/255598814
2. Each councillor, past president, past speaker, past chair of the Board, and current Board members will receive an email on October 19 with the following log in information:
   a. Username = ACEP Member ID
   b. Password = acep2020 (all lower case)

   **Note: all others participating in the meeting will log in as observers.**

After Logging In

- After logging into the virtual platform, you must connect your Computer Audio to the Zoom Webinar that is inside the Lumi Platform. To do this:
  - Click on the blue “Join Audio by Computer” button that pops up on the right Zoom panel of the virtual platform
Navigating the Virtual Meeting Platform
You will use the LUMI platform to attend the virtual meeting. The LUMI platform has two panels to participate in the meeting.

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<td><strong>Use for:</strong></td>
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<td>• Voting on elections and motions</td>
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<td>• Entering the speaking queue. (A key to the speaking queue terms you must use will be found on the information page of the LUMI platform.)</td>
<td>• Raising your hand to speak after being called on by the Council Speaker</td>
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<td>• Enabling audio and video to participate in the discussion, after being called on by the Council Speaker</td>
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If you are attending the virtual meeting by yourself from home:
You will log into the LUMI platform from your laptop or desktop computer. (Mobile devices, including iPhones, iPads, and Android phones, are not supported.)

When connecting to Zoom:
• All microphones will be muted. You will only be able to unmute if asked to do so.
• **DO NOT** turn on your video (webcam) unless asked to do so. This can be very distracting to other delegates.

If you are attending the virtual meeting with others in a viewing party:
Each individual person will log into the LUMI platform on their own computer and only one person will use their computer speakers for the rest of the group. Everyone else should mute their computer. If a person in the group is called on to speak, the computer speakers of the group should be muted and the person called upon should unmute their computer speakers.

Speaking during the virtual meeting
Once the Speaker opens the Speaking Queue, you may submit your request to speak. All participants have the right to speak during the Reference Committee hearings on the first day of the Council meeting. Only councillors, past presidents, past speakers, past chairs of the Board, and current members of the Board of Directors have the right to speak on the second day of the Council meeting during discussion of the Reference Committee reports.

**Step 1: Click the messaging icon in the top blue menu bar.**
Step 2: Type in your request to speak in the text box at the bottom of the screen.
Use the legend on the screen of what items you can type in. Press the arrow button to submit your request.
You have now joined the speaking queue.

Step 3: Raise your hand in the Zoom Panel.
You must raise your hand so production staff can enable your microphone.
Once the production staff have enabled your microphone, **first** you will be prompted to click “ALLOW” on the pop up from your web browser to give your browser access to your microphone, (you only need to do this the first time you speak).

If you do not receive a pop up from your web browser to allow your audio and microphone, you can click on the padlock icon in the browser bar right before the web address to bring up your microphone and sound settings for your browser. Make sure both say ALLOW.
Next, you will unmute your microphone in Zoom by clicking the blue “unmute myself” button.

Once your turn to speak is over, the production team will mute your microphone.

**Voting during the virtual meeting**

When voting is open, the vote option will appear automatically on the left hand side of the LUMI platform for those eligible voting delegates. To vote, simply click on your selection from the options shown on the screen. A confirmation message will appear to show your vote has been received. To change your vote, simply make another selection while the voting is still open or press the CANCEL button to remove your vote and vote again.

If you must make more than one selection (such as in the Board of Directors election), click on all of your selections, then press the SEND button from the bottom right to send your entire ballot. A confirmation message will appear to show your vote has been received.
Accessing Documents in the virtual platform
To access documents in the virtual platform, click on the Documents module from the top blue menu bar. It is the far right icon. Then click on the document that you would like to view to open that document.

Best Practice Tips
The following are tips to prepare for the best virtual Council meeting:
- If possible, connect to the Internet via an Ethernet cable. If using WiFi, ensure that you are close to your wireless router and that your connection is stable.
- Headsets are helpful for hearing audio more clearly.
- Please keep your audio muted in Zoom until called upon to speak
- Please keep your video turned off in Zoom
- Want a preview? Watch the mini tutorial 2020 Virtual Council Meeting.

Getting Connected
The following are tips for getting connected to the Virtual Council meeting:
- Check your internet connectivity
- Check your laptop or headset for speaker and microphone
- Log into the LUMI platform 15 minutes before each session.
- Familiarize yourself with Zoom:
  - Join Audio: bottom left-hand corner (You must connect your computer audio to hear the meeting proceedings.)
  - Mute Button: bottom left-hand corner
  - Raise your hand button: bottom center of the screen

Test Your Tech Time
- There will be opportunity before the virtual Council meeting to practice logging into the virtual platform and practice connecting your computer audio so that you will be able to hear the meeting. We encourage all delegates to test their log in once during the practice time.
- Ensure that the computer you use to access the virtual platform during the practice time is the same computer you use to access the Virtual House of Delegates.
  - October 21 – 23: You may log in anytime between 9:00 am – 5:00 pm Central time on any of these days to test your computer. Please follow the on screen prompts to test your audio connection as well.
FAQs

• **My member number and unique password do not seem to be working to log into the LUMI platform?**
  Be sure you entered your member number and unique password correctly *(the password is case sensitive)*

  Anyone with problems logging in may contact council meeting@acep.org or call 214-223-4270 or 817-305-3565 for assistance with obtaining your username and password.

• **I entered the wrong password 5 times and now I am locked out for 5 minutes. What do I do?**
  Anyone with problems logging in may contact council meeting@acep.org or call 214-223-4270 or 817-305-3565 for assistance with obtaining the correct unique password. You will be required to wait 5 minutes before attempting to login again.

• **Where can I get help if I lose internet connectivity?**
  Anyone with technical issues may contact council meeting@acep.org or call 214-223-4270 or 817-305-3565 for assistance. Please note that unless there is a widespread outage in one area, proceedings will continue.

• **Does the platform allow for voting members to group chat with each other and other voting members during the virtual meeting?**
  No. The Zoom chat feature will be deactivated. Voting members are responsible for determining a preferred method of communications outside of the provided LUMI platform and Zoom platform. Some options include use of free group chat platforms like Slack, group text, or email chains, conference lines, or apps like GroupMe.

• **How do I vote?**
  When a motion / resolution or is put before the Council, or during the elections, the voting will automatically pop up within your LUMI platform. Simply click on your selection to cast your vote.

• **Which devices and browsers are supported?**
  Only laptop computers or desktop computers running Windows and the latest version of Google Chrome or Microsoft Edge browsers are supported. No mobile devices or tablets are supported.
# 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<thead>
<tr>
<th>Chapter/Section</th>
<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td><strong>ALABAMA CHAPTER</strong></td>
<td>Councillor</td>
<td>Neil L Christen, MD, FACEP</td>
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<td></td>
<td>Councillor</td>
<td>Bobby R Lewis, MD, FACEP</td>
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<td>Councillor</td>
<td>Michael Raphael Salomon, MD, FACEP</td>
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<td>Councillor</td>
<td>Annalise Sorrentino, MD, FACEP</td>
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<td>Alternate</td>
<td>Melissa Wysong Costello, MD, FACEP</td>
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<td>Muhammad N Husainy, DO, FACEP</td>
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<td><strong>ALASKA CHAPTER</strong></td>
<td>Councillor</td>
<td>Nicholas Papacostas, MD, FACEP</td>
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<td>Councillor</td>
<td>David James Scordino, MD, FACEP</td>
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<td>Anne Zink, MD, FACEP</td>
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<td><strong>ARIZONA CHAPTER</strong></td>
<td>Councillor</td>
<td>Patricia A Bayless, MD, FACEP</td>
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<td>Councillor</td>
<td>Bradley A Dreifuss, MD, FACEP</td>
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<td>Dale P Woolridge, MD, PhD, FACEP</td>
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<td>Olga Gokova, MD, FACEP</td>
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<td>Rebecca B Parker, MD, FACEP</td>
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<td><strong>ARKANSAS CHAPTER</strong></td>
<td>Councillor</td>
<td>J Shane Hardin, MD, PhD, FACEP</td>
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<td>Robert Thomas VanHook, MD, FACEP</td>
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<td>Charles Scott, MD, FACEP</td>
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<tr>
<td><strong>ASSOCIATION OF ACADEMIC CHAIRS OF EMERGENCY MEDICINE</strong></td>
<td>Councillor</td>
<td>Theodore A Christopher, MD, FACEP</td>
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<td><strong>CALIFORNIA CHAPTER</strong></td>
<td>Councillor</td>
<td>Zahir I Basrai, MD</td>
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<td>Councillor</td>
<td>Andrea M Brault, MD, FACEP, President/CEO</td>
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<td>Reb JH Close, MD, FACEP</td>
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<td>Councillor</td>
<td>Taylor S Nichols, MD</td>
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## 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<tr>
<th>Role</th>
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<tr>
<td>Councillor</td>
<td>Valerie C Norton, MD, FACEP</td>
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<td>Bradley Alan Zlotnick, MD, FACEP</td>
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### COLORADO CHAPTER

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<tr>
<td>Councillor</td>
<td>Ramnik S Dhaliwal, MD, JD</td>
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<td>Nathaniel T Hibbs, DO, FACEP</td>
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<td>Eric B Olsen, MD, FACEP</td>
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### CONNECTICUT CHAPTER

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<td>Thomas A Brunell, MD, FACEP</td>
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<td>Elizabeth Schiller, MD, FACEP</td>
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<td>Hynes M Birmingham, MD, FACEP</td>
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<td>Michael L Carius, MD, FACEP</td>
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<td>Peter J Jacoby, MD, FACEP</td>
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<td>Karen J Jubanyik-Barber, MD</td>
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## 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<tr>
<th>Alternate</th>
<th>Listy Anam Thomas, MD, FACEP</th>
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<td>Michael F Zanker, MD, FACEP</td>
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**COUNCIL OF EMERGENCY MEDICINE RESIDENCY DIRECTORS (CORD)**

**COUNCILLOR**

| Alternate | Maria E Moreira, MD, FACEP |

**DELAWARE CHAPTER**

**COUNCILLOR**

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| Alternate | John T Powell, MD, MHCDS, FACEP |
| Alternate | Kathryn Groner, MD, FACEP   |
| Alternate | Paul A Smyser, MD           |
| Alternate | Erin E Watson, MD, FACEP    |

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| Councillor | James M Gaylor, MD             |
| Councillor | James D Maloy, MD              |
| Councillor | Rita A Manfredi-Shutler, MD, FACEP |

**EMERGENCY MEDICINE RESIDENTS' ASSOCIATION**

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| Councillor | Angela Cai, MD, MBA     |
| Councillor | Hannah R Hughes, MD, MBA|
| Councillor | Omar Z Maniya, MD, MBA  |
| Councillor | Tracy Marko, MD, PhD, MS|
| Councillor | Karina Sanchez, MD      |
| Councillor | George RJ Sontag, MD    |
| Councillor | Sophia Spadafore, MD    |
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| Alternate | Breanne M Jaqua, DO, MPH |
| Alternate | Deena Khamees, MD       |
| Alternate | Priyanka Lauber, DO     |
| Alternate | Maggie Moran, MD        |
| Alternate | Nishad A Rahman, MD     |
| Alternate | Nicholas R Salerno, MD  |
| Alternate | Gregory H Tanquary      |

**FLORIDA CHAPTER**

**COUNCILLOR**

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| Councillor | Ashley Booth-Norse, MD, FACEP |
| Councillor | Damian E Caraballo, MD, FACEP |
| Councillor | Jordan GR Celeste, MD, FACEP |
| Councillor | Andrzej T Dmowski, MD     |
| Councillor | Eliot Goldner, MD, FACEP  |
| Councillor | Shayne M Gue, MD          |
| Councillor | Omar Hammad, MD, FACEP    |
| Councillor | Steven B Kailes, MD, FACEP|
| Councillor | Mike Lozano, Jr, MD, MSHI, FACEP |
| Councillor | Kristin McCabe-Kline, MD, FACEP |
| Councillor | Ryan T McKenna, DO, FACEP |
| Councillor | Ryan D Nesselroade, MD    |
| Councillor | David J Orban, MD, FACEP  |
**2020 COUNCILLORS & ALTERNATE COUNCILLORS**

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Sanjay Pattani, MD, FACEP
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Tracy G Sanson, MD, FACEP
Alternate  
David Charles Seaberg, MD, CPE, FACEP
Alternate  
John Caleist Soud, DO

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Brett H Cannon, MD, FACEP
Councillor  
James Joseph Dugal, MD(E), FACEP(E)
Councillor  
Matthew Taylor Keadey, MD, FACEP
Councillor  
Jeffrey F Linzer, Sr, MD, FACEP
Councillor  
Matthew Lyon, MD, FACEP
Councillor  
DW "Chip" Pettigrew, III, MD, FACEP
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James L Smith, Jr, MD, FACEP
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Johnny L Sy, DO, FACEP
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Mark A Griffiths, MD
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Carmen D. Sulton, MD, FACEP
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Michelle P Wan, MD, FACEP
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John L Wood, MD, FACEP

**GOVT SERVICES CHAPTER**

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Andrea Austin, MD, FACEP
Councillor  
Tyler Davis, MD
Councillor  
Gerald Delk, MD, FACEP
Councillor  
Alan Jeffrey Hirshberg, MD, MPH, FACEP
Councillor  
Julio Rafael Lairet, DO, FACEP
Councillor  
Linda L Lawrence, MD, CPE, FACEP
Councillor  
Maximilian S Lee, MD, FACEP
Councillor  
David S McClellan, MD, FACEP
Councillor  
Torree M McGowan, MD, FACEP
Councillor  
Nadia M Pearson, DO, FACEP
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Alternate  
Roderick Fontenelle, MD, FACEP
Alternate  
Laura Tilley, MD, FACEP
Alternate  
Danielle Wickman
### 2020 COUNCILLORS & ALTERNATE COUNCILLORS

#### HAWAI’I CHAPTER

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<td>Mark Baker, MD, FACEP</td>
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#### IDAHO CHAPTER

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<td>Alternate</td>
<td>Travis Aaron Newby, DO, FACEP</td>
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#### ILLINOIS CHAPTER

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<th>Councillor</th>
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<td>Amit D Arwindekar, MD, FACEP</td>
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<td>Christine Babcock, MD, FACEP</td>
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<td>E Bradshaw Bunney, MD, FACEP</td>
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<td>Shu Boun Chan, MD, FACEP</td>
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<td>Cai Glushak, MD, FACEP</td>
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<td>Scott A Heinrich, MD, FACEP</td>
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<td>George Z Hevesy, MD, FACEP</td>
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<td>Jason A Kegg, MD, FACEP</td>
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<td>Janet Lin, MD, FACEP</td>
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<td>Christopher M McDowell, MD, FACEP</td>
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<td>Henry Pitzele, MD, FACEP</td>
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<td>Yanina Purim-Shem-Tov, MD, FACEP</td>
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<td>Ernest Enjen Wang, MD, FACEP</td>
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<td>Deborah E Weber, MD, FACEP</td>
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<td>Adnan Hussain, MD, FACEP</td>
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<td>Napoleon B Knight, MD, FACEP</td>
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<td>Alternate</td>
<td>Kurtis A Mayz, JD, MD, MBA, FACEP</td>
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<td>Laura D Napier, MD, FACEP</td>
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<td>Alternate</td>
<td>Regina Royan Stamm, MD</td>
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<td>Alternate</td>
<td>Willard W Sharp, MD, FACEP</td>
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#### INDIANA CHAPTER

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<td>Michael D Bishop, MD, FACEP(E)</td>
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<td>Bart S Brown, MD, FACEP</td>
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<td>Timothy A Burrell, MD, MBA, FACEP</td>
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<td>Daniel W Elliott, MD</td>
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<td>Tyler G Johnson, DO, FACEP</td>
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<td>James L Shoemaker, Jr, MD, FACEP</td>
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<td>Lauren Stanley, MD, FACEP</td>
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<td>Sara Ann Brown, MD, FACEP</td>
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<td>Gina Teresa Huhnke, MD, FACEP</td>
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<td>Christian Ross, MD, FACEP</td>
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<td>Lindsay Zimmerman, MD, FACEP</td>
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#### IOWA CHAPTER

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<td>Kelly M Douglas, MD</td>
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<td>Stacey Marie Marlow, MD, JD, FACEP</td>
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<td>Rachael Sokol, DO, FACEP</td>
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<td>Alternate</td>
<td>Kathryn K Dierks, DO, FACEP</td>
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<td>Hans Roberts House, MD, FACEP</td>
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<td>Jacqueline E Kitchen, MD</td>
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<td>Nicholas Holden Kluesner, MD, FACEP</td>
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- **Councillor** Mark Notash, MD, FACEP
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2020 COUNCILLORS & ALTERNATE COUNCILLORS

NEW MEXICO CHAPTER
Councillor  Melissa Beth Fleegler, MD, FACEP
Councillor  Margaret Greenwood-Ericksen, MD
Councillor  Tatsuya Norii, MD, FACEP
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Alternate  Michael C Leo, MD, FACEP

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- Alternate: Richard Lucarelli, MD
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| Alternate | Daniel M Tauber, MD |
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| Alternate | Kevin Matthew Wilcox, DO |
| Alternate | Chaethana Yalamanchili, MD |

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| Alternate | David Brent Mabey, MD |
| Alternate | Sean D Slack, DO |

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| Councillor | Alexandra Nicole Thran, MD, FACEP |

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| Councillor | Joseph Mason, MD, FACEP |
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| Councillor | Todd Parker, MD, FACEP |
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| Alternate | Aubrey B Miner, MD |
| Alternate | Jessica Nguyen, MD |

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| Councillor | Raul J Garcia-Rodríguez, DO, FACEP |
| Councillor | Carlton E Heine, MD, PhD, FACEP |
| Councillor | Gregg A Miller, MD, FACEP |
| Councillor | Karolyn K Moody, DO, MPH, FACEP |
| Councillor | Lola Mudgistrovata, MD |
| Councillor | Nathaniel R Schlicher, MD, JD, MBA, FACEP |
| Councillor | Susan Amy Stern, MD |
### 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<tr>
<th>Section</th>
<th>Councillor</th>
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<tr>
<td><strong>COUNCILLORS</strong></td>
<td>Liam Yore, MD, FACEP</td>
<td>Herbert Duber, MD, MPH, FACEP</td>
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<tr>
<td><strong>WEST VIRGINIA CHAPTER</strong></td>
<td>Councillor</td>
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<td>Liam Yore, MD, FACEP</td>
<td>Herbert Duber, MD, MPH, FACEP</td>
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<td>Justin Matthew Fuehrer, DO</td>
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<td>Michael J Zylstra, MD</td>
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<td><strong>WISCONSIN CHAPTER</strong></td>
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<td>Adam Thomas Crawford, DO, FACEP</td>
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<td>Christopher S Goode, MD, FACEP</td>
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<td>Frederick C Blum, MD, FACEP</td>
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<td>Erica B Shaver, MD, FACEP</td>
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<td><strong>WYOMING CHAPTER</strong></td>
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<td></td>
<td>Bradley Burmeister, MD</td>
<td>Jamie Schneider, MD</td>
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<td><strong>AIR MEDICAL TRANSPORT SECTION</strong></td>
<td>Councillor</td>
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<td>Jeffrey J Pothof, MD, FACEP</td>
<td>Michael Dean Repplinger, MD, PhD, FACEP</td>
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<td>Alternate</td>
<td>Jamie Schneider, MD</td>
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<td>Brian Sharp, MD, FACEP</td>
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<td><strong>AMERICAN ASSOCIATION OF WOMEN EMERGENCY</strong></td>
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<td>PHYSICIANS SECTION</td>
<td>Elizabeth Dubey, MD, FACEP</td>
<td>Samuel J Slimmer, MD</td>
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<td>Sarah Hoper, MD, JD, FACEP</td>
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<td>Peta-Gay S Nolan, MD</td>
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<td><strong>CAREERS IN EMERGENCY MEDICINE SECTION</strong></td>
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<td>Sanford H Herman, MD, FACEP</td>
<td>Constance J Doyle, MD, FACEP</td>
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<td><strong>CRITICAL CARE MEDICINE SECTION</strong></td>
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<td>Nicholas M Mohr, MD, FACEP</td>
<td>Susan R Wilcox, MD, FACEP</td>
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<td><strong>CRUISE SHIP MEDICINE SECTION</strong></td>
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<td>Sydney W Schneidman, MD, FACEP</td>
<td>Ruben Dario Parejo</td>
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<td><strong>DEMOCRATIC GROUP PRACTICE SECTION</strong></td>
<td>Councillor</td>
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<td>David F Tulsiak, MD, FACEP</td>
<td>Craig Savoy Brummer, MD, FACEP</td>
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<td><strong>DISASTER MEDICINE SECTION</strong></td>
<td>Councillor</td>
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<td>Justin W Fairless, DO, NRP, FACEP</td>
<td>Samantha Noll, MD</td>
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## 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<td>DIVERSITY &amp; INCLUSION SECTION</td>
<td>Ugo A Ezenkwele, MD, FACEP</td>
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<td>DUAL TRAINING SECTION</td>
<td>Carissa J Tyo, MD, FACEP</td>
<td>Vinay Mikkilineni, MD</td>
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<td>EMERGENCY MEDICAL INFORMATICS SECTION</td>
<td>John D Manning, MD, FACEP</td>
<td>Benjamin Heritier Slovis, MD, FACEP</td>
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<td>EMERGENCY MEDICAL SERVICES-PREHOSPITAL CARE SECTION</td>
<td>Michael O'Brien, MD, FACEP</td>
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<td>EMERGENCY MEDICINE LOCUM TENENS SECTION</td>
<td>Pamela Andrea Ross, MD, FACEP</td>
<td>Charles A Caton, MD, FACEP</td>
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<td>John R Dayton, MD, FACEP</td>
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<td>Carolyn M Waldo, MD, FACEP</td>
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<td>EMERGENCY MEDICINE PRACTICE MANAGEMENT AND HEALTH POLICY SECTION</td>
<td>Richard Lee Austin, Jr, MD</td>
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<td>EMERGENCY MEDICINE WORKFORCE SECTION</td>
<td>Leslie Mukau, MD, FACEP</td>
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<td>EMERGENCY TELEMEDICINE SECTION</td>
<td>David C Ernst, MD, FACEP</td>
<td>Emily M Hayden, MD</td>
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<td>EMERGENCY ULTRASOUND SECTION</td>
<td>Lisa M Bundy, MD, FACEP</td>
<td>Kenton L Anderson, MD, FACEP</td>
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<td>EVENT MEDICINE SECTION</td>
<td>Claire E Melin, MD</td>
<td>Melissa D Kohn, MD, FACEP</td>
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<td>Paul E Pepe, MD, FAEMS, FACEP</td>
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<td>FORENSIC MEDICINE SECTION</td>
<td>Ralph James Riviello, MD, FACEP</td>
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<td>FREESTANDING EMERGENCY CENTERS</td>
<td>Edward A Shaheen, MD, FACEP</td>
<td>Carl R Menckhoff, MD, FACEP</td>
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<td>Lonnie R Schwirtlich, MD, FACEP</td>
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<td>GERIATRIC EMERGENCY MEDICINE SECTION</td>
<td>Maura Kennedy, MD</td>
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<td>Shan W Liu, MD, FACEP</td>
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<td>INTERNATIONAL EMERGENCY MEDICINE SECTION</td>
<td>Jeffrey A Nielson, MD, FACEP</td>
<td>Camilo E Gutierrez, MD, FACEP</td>
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## 2020 COUNCILLORS & ALTERNATE COUNCILLORS

**MEDICAL DIRECTORS SECTION**

**Councillor**
- C Ryan Keay, MD, FACEP

**Alternate**
- Thomas F Spiegel, MD, MBA, MS, FACEP

**MEDICAL HUMANITIES SECTION**

**Councillor**
- Zayir Malik, MD

**Alternate**
- Robert C Solomon, MD, FACEP

**OBSERVATION SERVICES SECTION**

**Councillor**
- Kristy Ziontz, DO, FACEP

**Alternate**
- Alexei Wagner, MD

**PAIN MANAGEMENT SECTION**

**Councillor**
- Eric Michael Ketcham, MD, FACEP

**Alternate**
- Alexis M LaPietra, DO, FACEP

**PALLIATIVE MEDICINE SECTION**

**Councillor**
- Eric D Isaacs, MD, FACEP

**Alternate**
- David Wang, MD

**PEDIATRIC EMERGENCY MEDICINE SECTION**

**Councillor**
- Eric R Schmitt, MD, MPH, FACEP

**Alternate**
- Jason T Lowe, DO

**QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION**

**Councillor**
- Robert Sands Redwood, MD, MPH, FACEP

**Alternate**
- Alexis C Lawrence, MD, FACEP

**Alternate**
- Shashank Ravi, MD MBA

**RESEARCH, SCHOLARLY ACTIVITY, AND INNOVATION SECTION**

**Councillor**
- James Ross Miner, MD, FACEP

**Alternate**
- Richard Gentry Wilkerson, MD, FACEP

**RURAL EMERGENCY MEDICINE SECTION**

**Councillor**
- Darrell L Carter, MD, FACEP

**Alternate**
- William Ken Milne, MD

**SOCIAL EMERGENCY MEDICINE SECTION**

**Councillor**
- Aislinn D Black, DO, FACEP

**Alternate**
- Breena R Taira, MD, MPH, FACEP

**SPORTS MEDICINE SECTION**

**Councillor**
- William Denq, MD

**Alternate**
- Calvin E Hwang, MD, FACEP

**TACTICAL EMERGENCY MEDICINE SECTION**

**Councillor**
- Howard K Mell, MD, MPH, CPE, FACEP

**Alternate**
- Amado Alejandro Baez, MD, FACEP

**Alternate**
- Ameen Mohammad Jamali, MD, FACEP

**TOXICOLOGY SECTION**

**Councillor**
- Jennifer Hannum, MD, FACEP

**Alternate**
- Jason B Hack, MD, FACEP

**Alternate**
- Eric J Lavonas, MD, FACEP
## 2020 COUNCILLORS & ALTERNATE COUNCILLORS

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<tr>
<td>Trauma &amp; Injury Prevention</td>
<td>Gregory Luke Larkin, MD, FACEP</td>
<td>Mark Robert Sochor, MD, FACEP</td>
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<td>Undersea &amp; Hyperbaric Medicine</td>
<td>Stephen Hendriksen, MD, FACEP</td>
<td>Robert W Sanders, MD, FACEP</td>
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<td>Wellness</td>
<td>Susan T Haney, MD, FACEP</td>
<td>Angelica N McPartlin, MD</td>
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<td>Kristen Nordenholz, MD, FACEP</td>
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<td>Matthew L Wong, MD, FACEP</td>
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<td>Wilderness Medicine</td>
<td>Brendan Harry Milliner, MD</td>
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<td>Young Physicians</td>
<td>Benjamin Karfunkle, MD</td>
<td>Nnenna Cynthia Ejesieme, DO</td>
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TEMPORARY 2020 VIRTUAL COUNCIL
MEETING STANDING RULES

Due to emergency declarations, Stay at Home Orders, and the impossibility of holding an in-person 2020 Council meeting, the following Rules governing the virtual 2020 Council meeting are recommended for adoption, upon advice of ACEP’s General Counsel and Parliamentarian:

Rule 1. The Council meeting shall be conducted using the LUMI platform.

Rule 2. Participation during the Council meeting shall be limited to councillors, alternate councillors, members of the Board of Directors, past presidents, past speakers, past chairs of the Board, ACEP members, and authorized ACEP staff or guests.

Rule 3. Reference Committee hearings shall be held virtually in succession and limited to one hour each. Reference Committees shall include within their consideration asynchronous comments made prior to the virtual hearing on the ACEP platform.

Rule 4. Following any Reference Committee hearing, the Reference Committee may propose amendments to resolutions and Bylaws proposals and shall determine resolutions to be placed on a consent agenda. Any councillor may remove an item from the consent agenda using the LUMI platform.

Rule 5. During Council debate on any matter, anyone wishing to speak shall use the recognition feature of the LUMI platform and shall be recognized in order.

Rule 6. Upon recognition by the Council speaker, anyone wishing to speak shall identify themselves by stating their name, affiliation, and whether they are speaking “for” or “against” the motion.

Rule 7. No individual shall speak more than once on the same item, nor longer than one (1) minute.

Rule 8. No seconds to motions shall be necessary, and there shall be no amendments to resolutions or Bylaws proposals from the floor.

Rule 9. Total debate time allotted for each Bylaws amendment or resolution shall be ten (10) minutes. If there are speakers in the queue when the debate time expires, a vote shall be taken on whether to extend debate for an additional five (5) minutes.

Rule 10. Each candidate for president-elect shall be given an opportunity to speak for five (5) minutes. Each candidate for the Board of Directors shall be given the opportunity to speak for two (2) minutes. Candidate speeches may be live or prerecorded.

Rule 11. Except as expressly provided in these Temporary Rules, all other Council Standing Rules shall remain in effect.
Council Standing Rules

Revised October 2018
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. A councillor or an alternate councillor may not serve simultaneously as an alternate councillor for more than one component body.

If the number of alternate councillors is insufficient to fill all councillor positions for a component body, then a member of that component body may be seated as a councillor pro-tem by either the concurrence of an officer of the component 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, and component bodies are responsible for abiding by the campaign rules.

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP’s Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

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 component body 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 councillor. 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, & Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials, & Elections Committee, at a minimum, will report the number of credentialled 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, past speakers, and past chairs of the Board 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, past chair, 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 by the presiding officer. 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 presiding officer, 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, & 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, & 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.

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.

Electronic Devices
All electronic devices must be kept in “quiet” mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of electronic devices for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Leadership Development Advisory Committee
The Leadership Development Advisory Committee (LDAC) is a Council Committee charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAC will offer to interested members guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee.

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 committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization 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, past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened.

Members not nominated by the Nominating Committee may declare themselves “floor candidates” at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a “declared floor candidate,” has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee and must comply with all rules and requirements of the 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 Limiting Debate and Voting Immediately.

Any councillor may call for a “point of personal privilege,” “point of order,” or “parliamentary inquiry” 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,” etc. to interject debate is out of order.
Past Presidents, Past Speakers, and Past Chairs of the Board Seating
Past presidents, past speakers, and past chairs of the Board of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

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 not adopted, 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 component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body.

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

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

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

Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as “Late Resolutions.”
• **Bylaws Resolutions**
  Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

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

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

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

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

**Smoking Policy**

Smoking is not permitted in any College venue.

**Unanimous Consent Agenda**

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

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

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

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

**Voting Immediately**

A motion to “vote immediately” may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting. Councillors are out of order who move to “vote immediately” during or immediately following their presentation of testimony on that motion. The motion to “vote immediately” applies only to the immediately pending matter, therefore, motions to “vote immediately on all pending matters” is out of order. The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to “vote immediately” will be considered in order. See also *Debate and Limiting Debate*.

**Voting on Resolutions and Motions**

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

Revised October 2018
BYLAWS
Revised October 2018

ARTICLE I — NAME

This corporation, an association of physicians active in emergency medicine organized under the laws of the State of Texas, shall be known as the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (hereinafter sometimes referred to as “ACEP” or the “College”). The words “physician” or “physicians” as used herein include both medical and osteopathic medical school graduates.

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

The American College of Emergency Physicians exists to support quality emergency medical care and to promote the interests of emergency physicians.

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

1. To establish guidelines for quality emergency medical care.
2. To encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.
3. To encourage and facilitate training and education in emergency medicine for all medical students.
4. To promote education in emergency care for all physicians.
5. To promote education about emergency medicine for our patients and for the general public.
6. To promote the development and coordination of quality emergency medical services and systems.
7. To encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management.
8. To evaluate the social and economic aspects of emergency medical care.
9. To promote universally available and cost effective emergency medical care.
10. To promote policy that preserves the integrity and independence of the practice of emergency medicine.
11. To encourage and support basic and clinical research in emergency medicine.
12. To encourage emergency physician representation within medical organizations and academic institutions.

ARTICLE III — COLLEGE MEETINGS

All meetings of the Board of Directors of the College (the “Board of Directors” or the “Board”), the Council, and College committees shall be open to all members of the College. A closed session may be called by the Board of Directors, the Council, or any College committee for just cause, but all voting must be in open session.

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

Membership in the College is contingent upon the applicant or member showing a significant interest in emergency medicine and being of good moral and professional character. Members agree to abide by the “Code of Ethics for Emergency Physicians.” No person shall be denied membership because of sex, race, age, political or religious beliefs, sexual orientation, or real or perceived gender identity.
Section 2 — Classes of Membership

All members shall be elected or appointed by the Board of Directors to one of the following classes of membership: (1) regular member; (2) candidate member; (3) honorary member; or (4) international member. The qualifications required of the respective classes, their rights and obligations, and the methods of their election or appointment shall be set forth in these Bylaws or as otherwise determined by the Board of Directors in the extraordinary case of an individual who does not satisfy all of the criteria of any particular class. Benefits for each class of membership shall be determined by the Board of Directors.

Section 2.1 — Regular Members

Regular members of the College are physicians who devote a significant portion of their medical endeavors to emergency medicine. All regular members must meet one of the following criteria: 1) satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); 2) satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country; 3) satisfactory completion of a subspecialty training program in pediatric emergency medicine accredited by the ACGME; 4) primary board certification by an emergency medicine certifying body recognized by ACEP; or 5) eligibility for active membership in the College (as defined by the College Bylaws then in force) at any time prior to close of business December 31, 1999.

Regular members shall be assigned by the Board of Directors to one of the following statuses: (1) active, (2) inactive, or (3) retired. Members who qualify will additionally be assigned to life status. All applicants for regular membership shall, hold a current, active, full, valid, unrestricted, and unqualified license to practice medicine in the state, province, territory, or foreign country in which they practice, or be serving in a governmental medical assignment. All regular members must either continue to maintain a valid license to practice medicine or have voluntarily relinquished the license upon leaving medical practice. A license to practice medicine shall not be considered voluntarily relinquished if it was surrendered, made inactive, or allowed to expire under threat of probation or suspension or other condition or limitation upon said license to practice medicine by a licensing body in any jurisdiction.

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

Regular members who have retired from medical practice for any reason shall be assigned to retired status.

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

Regular members, with the exception of those in inactive status, may hold office, may serve on the Council, and may vote in committees on which they serve. Regular members in inactive status shall not be eligible to hold office, to serve on the Council, or serve on committees.

Section 2.2 — Honorary Members

Persons of distinction who are not members of the College, but have rendered outstanding service to the College or to the specialty of emergency medicine may be elected to honorary membership by the Board of Directors. Individual members and Council component bodies may propose candidates for honorary membership in the College to the Board of Directors. Honorary members cannot be eligible for other categories of College membership. Honorary members are considered members for life and shall not be required to pay any dues. Honorary members may not hold office and may not serve on the Council. Honorary members may vote in committees on which they serve.

Section 2.3 — Candidate Members

Candidate members must meet one of the following criteria: 1) medical student or intern interested in emergency medicine; 2) physician participating in an emergency medicine residency training program; 3) physician participating in a fellowship training program immediately following an emergency medicine residency; 4) physician
participating in a pediatric emergency medicine fellowship training program; or 5) physician in the uniformed services while serving as general medical officer. General medical officers shall be eligible for candidate membership for a maximum of four years. All candidate members will be assigned by the Board of Directors to either active or inactive status.

The rights of candidate members at the chapter level are as specified in their chapter’s bylaws. At the national level, candidate members shall not be entitled to hold office, but physician members may serve on the Council. Candidate members appointed to national committees shall be entitled to vote in committees on which they serve.

Candidate members whose training is interrupted for any reason may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application. Candidate members in inactive status shall not be eligible to hold office, serve on the Council, or serve on committees.

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

Acceptance of membership in the College shall constitute an agreement by the member to comply with the ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member's right to be or to remain a member, subject to the due process as described in the College Manual.

All right, title, and interest, both legal and equitable, of a member in and to the property of this organization shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of the member's name from the roll of members; c) the member’s death or resignation.

Section 4 — Disciplinary Action

Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.

Section 5 — Dues, Fees, and Assessments

Application fees and annual dues shall be determined annually by the Board of Directors. Assessments of members may not be levied except upon recommendation of the Board of Directors and by a majority vote of the Council. Notice of any proposed assessment shall be sent to each member of the College by mail or official publication at least 30 days before the meeting of the Council at which the proposed assessment will be considered. The Board of Directors shall establish uniform policies regarding dues, fees, and assessments.

Any member whose membership has been canceled for failure to pay dues or assessments shall lose all privileges of membership. The Board of Directors may establish procedures and policies with regard to the
nonpayment of dues and assessments.

Section 6 — Official Publications

Each member shall receive Annals of Emergency Medicine and ACEP Now as official publications of the College as a benefit of membership.

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

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.

Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate, and determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee.

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

This corporation may grant charters to chapters of the College according to procedures described in the College Manual.
Section 2 — Chapter Bylaws

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and current approved chapter bylaws guidance documents. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

No chapter is permitted to act on behalf of, or to appear to third parties to be acting on behalf of, the College. In accepting or retaining a charter as a chapter of the College, the chapter and its members acknowledge the fact that the chapter is not an agent of the College notwithstanding that the College has the authority to establish rules governing actions of the chapter which may give the appearance of a principal-agent relationship.

Section 3 — Qualifications

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

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

A member of a chapter who changes residential or professional location may remain a member of that chapter if there is no chapter at the new location.

Section 4 — Component Branches

A chapter may, under provisions in its bylaws approved by the Board of Directors, charter branches in counties or districts within its area. Upon the approval of the Board of Directors of the College, such component branches may include adjacent counties or districts.

Section 5 — Charter Suspension – Revocation

The charter of any chapter may be suspended or revoked by the Board of Directors when the actions of the chapter are deemed to be in conflict with the Bylaws, or if the chapter fails to comply with all the requirements of these Bylaws or with any lawful requirement of the College.

On revocation of the charter of any chapter by the Board of Directors, the chapter shall take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter shall no longer make any use of the College name or logo.

Section 6 — Ultimate Authority by College

Where these Bylaws and the respective chapter bylaws are in conflict, the provisions of these Bylaws shall be supreme. When, due to amendment, these Bylaws and the chapter bylaws are in conflict, the chapter shall have two years from written notice of such conflict to resolve it through amendment of chapter bylaws.
ARTICLE VII — SECTIONS

The College may have one or more groups of members known as sections to provide for members who have special areas of interest within the field of emergency medicine.

Upon the petition of 100 or more members of the College, the Board of Directors may charter such a section of the College. Minimum dues and procedures to be followed by a section shall be determined by the Board of Directors.

ARTICLE VIII — COUNCIL

The Council is an assembly of members representing ACEP’s chartered chapters, sections, the Emergency Medicine Residents’ Association (EMRA), the American College of Osteopathic Emergency Physicians (ACOEP), the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), and the Society for Academic Emergency Medicine (SAEM). These component bodies, also known as sponsoring bodies, shall elect or appoint councillors to terms not to exceed three years. Any limitations on consecutive terms are the prerogative of the sponsoring body.

Section 1 — Composition of the Council

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

An organization currently serving as, or seeking representation as, a component body of the Council must meet, and continue to meet, the criteria stated in the College Manual. These criteria do not apply to chapters or sections of the College.

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

ACOEP shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of ACOEP.

AACEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of AACEM.

CORD shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of CORD.

SAEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of SAEM.

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section if the number of section dues-paying and complimentary candidate members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year.

A councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Each component body shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body’s councillor at Council meetings at which such councillor is not available to participate. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.
Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.

Section 2 — Powers of the Council

The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions and other actions or appropriations enacted by the Council. Notwithstanding any other provision of these Bylaws, the Council shall have the right to amend the College Bylaws and College Manual, amend or restate or repeal the College Articles of Incorporation, and to elect the Council officers, the president-elect, and the members of the Board of Directors.

The Council shall have, in addition, the following powers:

1. To prepare and control its own agenda.
2. To act on any matter brought before it by a councillor or the Board of Directors.
3. To originate and act on resolutions.
4. To form, develop, and utilize committees.
5. To develop, adopt, and amend its rules of procedure (the Council Standing Rules) and other procedures for the conduct of Council business, which do not require action by the Board of Directors.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the Bylaws, amendment of the College Manual, amendment or restatement or repeal of the Articles of Incorporation, and election of the Council officers, the president-elect, and the members of the Board of Directors, are vested exclusively in members currently serving as councillors and are specifically denied to all other members. These rights are not applicable at the chapter level unless specifically permitted in a chapter’s bylaws.

Section 3 — Meetings

An annual meeting of the Council shall be held within or outside of the State of Texas at such time and place as determined by the Board of Directors. Notice for the annual meeting is not required. Whenever the term “annual meeting” is used in these Bylaws, it shall mean the annual meeting of the Council.

Special meetings of the Council may be held within or outside of the State of Texas and may be called by an affirmative vote of two-thirds of the entire Board of Directors, by the speaker with concurrence of a two-thirds vote of the entire Steering Committee, or by a petition of councillors comprised of signatures numbering one-third of the number of councillors present at the previous annual meeting, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee, provided that the time and place of such meeting shall be announced not less than 40 nor more than 50 days prior to the meeting.

Voting by proxy shall be allowed only at special meetings of the Council. The proxy of any councillor can be revoked by that councillor at any time. The results of any vote that includes proxy ballots will have the same force as any other vote of the Council.

Councillors eligible to vote at a special meeting of the Council are those who were credentialed by the Tellers, Credentials, & Elections Committee at the previous annual meeting of the Council.

All members of the College shall be notified of all Council meetings by mail or official publication.

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.
Section 5 — Voting Rights

Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed by the president, secretary, or chairperson of the sponsoring body. No councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body’s certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.

ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions.”

Whenever the term “present” is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee.

Section 6 — Resolutions

Resolutions pertinent to the objectives of the College or in relation to any report by an officer or committee of the College shall be submitted in writing at least 90 days in advance of the Council meeting at which they are to be considered. Resolutions submitted within 90 days of the Council meeting shall be considered only as provided in the Council Standing Rules. Each resolution must be signed by at least two members of the College.

In the case of a resolution submitted by a component body of the Council or by a committee of the College, such resolution must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Upon approval by the Council, and except for changes to the Council Standing Rules, resolutions shall be forwarded immediately to the Board of Directors for its consideration.

Section 7 — Nominating Committee

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members and the president shall appoint the president-elect plus two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor.

Section 8 — Board of Directors Action on Resolutions

The Board of Directors shall act on all resolutions adopted by the Council, unless otherwise specified in these Bylaws, no later than the second Board meeting following the annual meeting and shall address all other matters referred to the Board within such time and manner as the Council may determine.

The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.
ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

The management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws.

Section 2 — Composition and Election

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

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

The term of office of directors shall be three years and shall begin at the conclusion of the Board meeting following the annual meeting at which their elections occur and shall end at the conclusion of the Board meeting following the third succeeding annual meeting. No director may serve more than two consecutive three-year terms unless specified elsewhere in these Bylaws.

Section 3 — Meetings

The Board of Directors shall meet at least three times annually. One of these meetings shall take place not later than 30 days following the annual meeting of the College. The other meetings shall take place at such other times and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A majority of the Board shall constitute a quorum.

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the members of the Board of Directors at a meeting of the Board of Directors.

Special meetings of the Board of Directors may be called by the president with not less than 10 nor more than 50 days notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

Section 4 — Removal

Any member of the Board of Directors may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the member of the Board of Directors was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.
Section 5 — Vacancy

Any vacancy filled shall be for the remainder of the unexpired term.

A vacancy created by removal shall be filled by a majority vote of the councillors present and voting at the Council meeting at which the removal occurs. Nominations for such vacancy shall be accepted from the floor of the Council.

Vacancies created other than by removal may be filled by a majority vote of the remaining Board if more than 90 days remain before the annual Council meeting. If there are more than three concurrent vacancies, the Council shall elect directors to fill all vacancies via special election. If fewer than 90 days remain before the annual Council meeting, then the vacancies will not be filled until the annual Council meeting.

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 — Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice president, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2 — Election of Officers

The chair, vice-president, and secretary-treasurer shall be elected by a majority vote at the Board meeting immediately following the annual meeting. The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the Councillors present and voting at the annual meeting.

Section 3 — Removal

Any officer of the Council, the president, and the president-elect may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the Council officer was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.

Removal of an individual from the position of chair, vice president, or secretary-treasurer without removal as a member of the Board of Directors shall be carried out by the Board of Directors. Removal as chair shall also remove that individual from the Board of Directors if the chair is serving only by virtue of that office. Removal shall require a three-quarters vote of the full Board excluding the officer under consideration. Replacement shall be by the same process as for regular elections of these Board officers.

Section 4 — Vacancy

Vacancies in the offices of the Board of Directors and the Council occurring for reasons other than removal shall be filled in accordance with sections 4.1 through 4.4 of this Article X. Vacancies occurring by removal shall be filled in accordance with sections 4.5 and 4.6 of this Article X. Succession or election to fill any vacated office shall not count toward the term limit for that office.

Section 4.1 — President

In the event of a vacancy in the office of the president, the president-elect shall immediately succeed to the office of the president for the remainder of the unexpired term, after which their regular term as president shall be served.
Section 4.2 — President-Elect

In the event of a vacancy in the office of the president-elect, the Board of Directors, speaker, and vice speaker may fill the vacancy by majority vote for the remainder of the unexpired term from among the members of the Board. If the vacancy in the office of president-elect is filled in such a manner, at the next annual Council meeting, the Council shall, by majority vote of the credentialed councillors, either ratify the elected replacement, or failing such ratification, the Council shall elect a new replacement from among the members of the Board. The Council shall, in the normal course of Council elections, elect a new president-elect to succeed the just-ratified or just-elected president-elect only when the latter is succeeding to the office of president at the same annual meeting.

Section 4.3 — Chair, Vice President, & Secretary-Treasurer

In the event of a vacancy in the office of chair, vice president, or secretary-treasurer, election to the vacant office shall occur as the first item of business, after approval of the minutes, at the next meeting of the Board of Directors.

Section 4.4 — Council Officers

In the event of a vacancy in the office of vice speaker, the Steering Committee shall nominate and elect an individual who meets the eligibility requirements of these Bylaws to serve as vice speaker. This election shall occur as the first item of business, following approval of the minutes, at the next meeting of the Steering Committee, by majority vote of the entire Steering Committee. If the vacancy occurs during the first year of a two-year term, the vice speaker will serve until the next meeting of the Council when the Council shall elect a vice speaker to serve the remainder of the unexpired term.

In the event of a vacancy in the office of speaker, the vice speaker shall succeed to the office of speaker for the remainder of the unexpired term, and an interim vice speaker shall then be elected as described above.

In the event that the offices of both speaker and vice speaker become vacant, the Steering Committee shall elect a speaker to serve until the election of a new speaker and vice speaker at the next meeting of the Council.

Section 4.5 — Vacancy by Removal of a Board Officer

In the event of removal of an officer of the Board of Directors, excluding the president, replacement shall be conducted by the same process as for regular elections of those officers. If the president is removed, the vacancy shall be filled by the president-elect for the remainder of the unexpired term, after which their regular term as president shall be served.

Section 4.6 — Vacancy by Removal of a Council Officer

In the event of removal of a Council officer, nominations for replacement shall be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at which the removal occurs. In the event that the speaker is removed and the vice speaker is elected to the office of speaker, the office of vice speaker shall then be filled by majority vote at that same meeting, from nominees from the floor of the Council.

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president’s term of office shall begin 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.

Section 6 — Chair

The chair shall be a member of and shall chair the Board of Directors. Any director shall be eligible for election to the position of chair and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The chair’s term of office shall begin at the conclusion of the meeting at which the election as
chair occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No director may serve more than one term as chair.

Section 7 — Vice President

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

Section 8 — President-Elect

Any member of the Board of Directors excluding the president, president-elect, and immediate past president 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 councillors 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.

Section 9 — Secretary-Treasurer

The secretary-treasurer shall be a member of the Board of Directors. The secretary-treasurer shall cause to be kept adequate and proper accounts of the properties, funds, and records of the College and shall perform such other duties as prescribed by the Board.

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

The secretary-treasurer shall deposit or cause to be deposited all monies and other valuables in the name and to the credit of the College with such depositories as may be designated by the Board of Directors. The secretary-treasurer shall disburse the funds of the College as may be ordered by the Board of Directors; shall render to the Board of Directors, whenever it may request it, an account of all transactions as treasurer, and of the financial condition of the College; and shall have such powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws. Any of the duties of the secretary-treasurer may, by action of the Board of Directors, be assigned to the executive director.

Section 10 — Immediate Past President

The immediate past president shall remain a member of the Board of Directors for a period of one year following the term as president, or until such time as the regular term as a Board member shall expire, whichever is longer. The term of the immediate past president shall commence at the conclusion of the second annual meeting of the Council following the meeting at which the election of president-elect occurred and shall end at the conclusion of the third annual meeting following the election. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council.

Section 11 — Speaker

The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the Council, except that the vice speaker may preside at the discretion of the speaker. The speaker shall prepare, or cause
to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and shall inform the councillors of the activities of the College. The speaker’s term of office shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to the Board of Directors of the College. No speaker may serve consecutive terms.

Section 12 — Vice Speaker

The term of office of the vice speaker of the Council shall be two years. The vice speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The vice speaker shall assume the duties and responsibilities of the speaker if the speaker so requests or if the speaker is unable to perform such duties. The term of the office of the vice speaker shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. During the term of office, the vice speaker is ineligible to accept nomination to the Board of Directors of the College. No vice speaker may serve consecutive terms.

Section 13 — Executive Director

An executive director shall be appointed for a term and at a stipend to be fixed by the Board of Directors. The executive director shall, under the direction of the Board of Directors, perform such duties as may be assigned by the Board of Directors. The executive director shall keep or cause to be kept an accurate record of the minutes and transactions of the Council and of the Board of Directors and shall serve as secretary to these bodies. The executive director shall supervise all other employees and agents of the College and have such other powers and duties as may be prescribed by the Board of Directors or these Bylaws. The executive director shall not be entitled to vote.

Section 14 — Assistant Secretary-Treasurer

Annually, the ACEP Board of Directors shall appoint an individual to serve as assistant secretary-treasurer. The assistant secretary-treasurer shall serve as an officer of the corporation without authority to act on behalf of the corporation, except (i) to execute and file required corporate and financial administrative and franchise type reports to state, local, and federal authorities, or (ii) pursuant to any authority granted in writing by the secretary-treasurer. All other duties of the secretary-treasurer are specifically omitted from this authority and are reserved for the duly elected secretary-treasurer. The assistant secretary-treasurer shall not be a member of the Board of Directors.

ARTICLE XI — COMMITTEES

Section 1 — General Committees

The president shall annually appoint committees and task forces to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board.

The president shall appoint annually committees on Compensation, Bylaws, and Finance.

Section 2 — Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board, subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.
Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall be required to meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.

The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

Section 4 — Bylaws Interpretation Committee

In addition to the College Bylaws Committee, there shall also be a Bylaws Interpretation Committee, appointed annually and consisting of five ACEP members. The president shall appoint two of the members and the Council speaker shall appoint three members. The chair of this committee shall be chosen by a vote of its members. When petitioned to do so, the Bylaws Interpretation Committee shall be charged with the definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of these Bylaws. Interpretation of other articles of these Bylaws shall be by the Board of Directors.

Any member shall have the right to petition the Bylaws Interpretation Committee for an opinion on any issue within its purview. If the petition alleges an occurrence of improper action, inaction, or omission, such petition must be received by the executive director no more than 60 days after the occurrence. In the event of a question regarding whether the subject of the petition is addressed by a portion of the Bylaws which falls within the committee’s jurisdiction, or a question of whether the time limit has been met, such question shall be resolved jointly by the president and the speaker. The committee shall then respond with an interpretation within 30 days of receipt of the petition. An urgent interpretation can be requested by the president, the Board of Directors, the speaker, or the Council in which case the interpretation of the committee shall be provided within 14 days. The Board shall provide the necessary funds, if requested by the committee, to assist the committee in the gathering of appropriate data and opinions for development of any interpretation. The Bylaws Interpretation Committee shall render its response to the petitioner as a written interpretation of that portion of the Bylaws in question. That response shall be forwarded to the petitioner, the officers of the Council, and the Board of Directors.

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

The Bylaws Committee shall be appointed by the president. The Bylaws Committee is charged with the ongoing review of the College Bylaws for areas that may be in need of revision and also charged with the review of chapter bylaws. The Bylaws Committee may be assigned additional objectives by the president or Board of Directors.
Section 7 — Compensation Committee

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board’s proposed compensation, the Compensation Committee’s recommendation will then take effect.

ARTICLE XII — ETHICS

The “Code of Ethics for Emergency Physicians” shall be the ethical foundation of the College. Charges of violations of ethical principles or policies contained in the “Code of Ethics for Emergency Physicians” may be brought in accordance with procedures described in the College Manual.

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

Any member of the College may submit proposed amendments to these Bylaws. Each amendment proposal must be signed by at least two members of the College. In the case of an amendment proposed by a component body of the Council or by a committee of the College, each amendment proposal must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Such submissions must be presented to the Council secretary of the College at least 90 days prior to the Council meeting at which the proposed amendments are to be considered. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the submitters, may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

If a proposed Bylaws amendment is a Contested Amendment, as hereinafter defined, then such Contested Amendment shall be considered already to have fulfilled the submission obligation.

Section 2 — Notice

For any proposed Bylaws amendment, including a Contested Amendment as hereinafter defined, the executive director of the College shall give notice to the members of the College, by mail or official publication, at least 30 days prior to the Council meeting at which any such proposed Bylaws amendment is to be considered for adoption.

Section 3 — Amendment Under Initial Consideration

A proposed Bylaws amendment which, at any meeting of the Council, has received an affirmative vote of at least two-thirds of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee, shall be deemed an Amendment Under Initial Consideration. The Board of Directors must vote upon an Amendment Under Initial Consideration no later than the conclusion of the Board’s second meeting following said Council meeting. If the Amendment Under Initial Consideration receives the affirmative vote of at least two-thirds of the members of the Board of Directors, then it shall be adopted and these Bylaws shall be so amended immediately.

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment.
The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council’s component bodies and councillors shall be notified within 30 days of the Board action. The Steering Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than 40 and no more than 50 days prior to the meeting.

The Contested Amendment, identical in every way to its parent Amendment Under Initial Consideration, and the positions and vote of each member of the Board of Directors regarding such Contested Amendment, shall be presented to the Council at the Council's first meeting following said vote of the Board of Directors.

If the unmodified Contested Amendment receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the chair of the Tellers, Credentials, & Elections Committee, then such proposed Bylaws amendment shall be adopted, and these Bylaws shall be so amended immediately.

If a Contested Amendment is modified in any way, and then receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the Tellers, Credentials, & Elections Committee, such Contested Amendment shall then be deemed an Amendment Under Initial Consideration and be subject to the process for adoption defined herein.

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

The minutes of the proceedings of the Board of Directors and of the Council, the membership books, and books of account shall be open to inspection upon the written demand of any member at any reasonable time, for any purpose reasonably related to the member's interest as a member, and shall be produced at any time when requested by the demand of 10 percent of the members at any meeting of the Council. Such inspection may be made by the member, agent, or attorney, and shall include the right to make extracts thereof. Demand of inspection, other than at a meeting of the members, shall be in writing to the president or the secretary-treasurer of the College.

Section 2 — Annual Report

The Board of Directors shall make available to the members as soon as practical after the close of the fiscal year, audited financial statements, certified by an independent certified public accountant.

Section 3 — Parliamentary Authority

The parliamentary authority for meetings of the College shall be The Standard Code of Parliamentary Procedure (Sturgis), except when in conflict with the Bylaws of the College or the Council Standing Rules.

Section 4 — College Manual

The College shall have a College Manual to address such matters as may be deemed suitable by the Board of Directors and the Council.

Amendments to the College Manual may be made by majority vote of both the Council and the Board of Directors.

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

To the full extent permitted by the Texas Business Organizations Code, as amended from time to time, the College shall indemnify all Directors, Officers, and all Employees of the College against judgments, penalties (including excise and similar taxes), fines, settlements and reasonable expenses (including court costs and attorneys’ fees) actually incurred by any such person who was, is or is threatened to be made a named defendant or respondent in
a proceeding because the person is or was a Director, Officer, or Employee of the College and the College shall advance to such person(s) such reasonable expenses as are incurred by such person in connection therewith.

Section 2 — Definitions

For purposes of this Article XV:

1. “Director” means any person who is or was a director of the College and any person who, while a director of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.

2. “Officer” means any person who is or was an officer of the College and any person who, while an officer of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.

3. “Employee” means an individual:
   a. Selected and engaged by ACEP;
   b. To Whom wages are paid by ACEP;
   c. Whom ACEP has the power to dismiss; and
   d. Whose work conduct ACEP has the power or right to control.

4. “Proceeding” means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, arbitrative, or investigative, any appeal in such action, suit, or proceeding, and any inquiry or investigation that could lead to such an action, suit, or proceeding.

Section 3 — Non-Exclusive; Continuation

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

Section 4 — Insurance or Other Arrangement

The College shall have the power to purchase and maintain insurance or another arrangement on behalf of any person who is or was a Director, Officer, or Employee of the College, or who is or was not a Director, Officer, or Employee of the College but is or was serving at the request of the College as a Director, Officer, or Employee or any other capacity in another corporation, or a partnership, joint venture, trust or other enterprise, against any liability asserted against such person and incurred by such person in such capacity, arising out of such person’s status as such, whether or not such person is indemnified against such liability by the provisions of this Article XV.

Section 5 — Exclusion of Certain Acts from Indemnification

Notwithstanding any other provision of this Article XV, no Director, Officer, or Employee of the College shall be indemnified for any dishonest or fraudulent acts, willful violation of applicable law, or actions taken by such person when acting outside of the scope of such person's office, position, or authority with or granted by the College or the Board of Directors.
## College Manual

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I. Applications for Membership

All applications for membership will be in writing on an application form approved by the Board of Directors. Each member will receive a certificate of membership in such form as may be determined by the Board of Directors. The title to such a certificate shall remain, at all times, with the College.

II. Procedures for Addressing Charges of Ethical Violations and Other Misconduct

Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in accordance with College policy.

A. Complaint Received

A complaint may be initiated by an ACEP member, chapter, committee, or section. No others have standing to present a complaint.

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of ACEP Bylaws, current ACEP “Principles of Ethics for Emergency Physicians,” other current ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within twelve (12) years prior to the submission of the complaint;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, the Ethics Committee, the Bylaws Committee, the Board of Directors, and to the respondent should the complaint be forwarded to the respondent;
6. Must be submitted to the ACEP Executive Director.

B. Executive Director

1. Sends a written acknowledgement to the complainant confirming the complainant’s intent to file a complaint and identifying the elements that must be addressed in an ethics complaint.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct (“Procedures”).”
3. Notifies the ACEP President and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the chair of the Ethics and/or Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics for Emergency Physicians or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
b. Determines, in consultation with the Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics for Emergency Physicians, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or
c. Determines, in consultation with the Bylaws Committee chair, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Board of Directors will review the President’s action at the next regularly scheduled Board meeting. The President’s action can be overturned by a majority vote of the Board, or
e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

5. Within ten (10) business days after the determinations specified in Section B.4.b. or Section B.4.c. of these Procedures, forwards the complaint to the respondent by certified U.S. mail with a copy of these Procedures and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the Board decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent’s rights in the hearing, and a list of the names of the members of the ACEP Ethics Committee or the ACEP Bylaws Committee, as appropriate and the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.

6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics Committee, the Bylaws Committee, or the subcommittee appointed to review the complaint as appropriate.

C. Bylaws Committee [within sixty (60) days of the forwarding of the complaint/response specified in Section B.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of current ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action; minority reports may also be presented.
7. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:
   a. Dismiss the complaint; or
   b. Take disciplinary action, the specifics of which shall be included in the committee’s report.
8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

D. Ethics Committee [within sixty (60) days of the forwarding of the complaint/response specified in Section B.4.b. above]
1. Reviews the written record of any complaint that alleges a violation of current ACEP “Principles of Ethics for Emergency Physicians” or other current ACEP ethics policies.
2. Discusses the complaint and response by telephone conference call;
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP “Principles of Ethics for Emergency Physicians” or other current ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of current ACEP “Principles of Ethics for Emergency Physicians” or other current ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.
7. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors:
   a. Dismiss the complaint; or
   b. Take disciplinary action, the specifics of which shall be included in the committee’s report.
8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

E. Board of Directors
1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and the complaint and response.
2. May request further information in writing from the complainant and/or respondent.
3. Decides to:
   a. Dismiss the complaint; or
   b. Render a decision to impose disciplinary action based on the written record.
4. If the Board determines to impose disciplinary action pursuant to Section E.3.b., the respondent will be provided with notification of the Board’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Board decision based solely on the written record.
5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.
6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee
1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.

2. This Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.

3. The Ad Hoc Committee:
   a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and the complaint and response.
   b. May request further information in writing from the complainant and/or respondent.
   c. Decides to:
      i. Dismiss the complaint; or
      ii. Render a decision to impose disciplinary action based on written record.
   d. If the Ad Hoc Committee determines to impose disciplinary pursuant to Section F.3.c.i., the respondent will be provided with notification of the Ad Hoc Committee’s determination and the option of:
      i. A hearing conducted by the Ad Hoc Committee; or
      ii. The imposition of the Ad Hoc Committee decision based solely on the written record.
   e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.

G. Right of Respondent to Request a Hearing
   If the Board chooses the option described in Section E.3.b., or an Ad Hoc Committee chooses the option described in Section F.3.c.i., the Executive Director will send to the respondent a written notice by certified U.S. mail of the right to request a hearing or to have the Board or the Ad Hoc Committee impose its decision based solely on the written complaint. This notice will list the respondent’s hearing rights as set forth in Section H. below. The respondent’s request for a hearing must be submitted in writing to the Executive Director within thirty (30) business days of receipt of the notice of right to a hearing. In the event of no response, the ACEP President may determine the manner of proceeding.

H. Hearing Procedures
1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by certified U.S. mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F., intends to call in the hearing.
2. The Executive Director will send a notification of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by certified U.S. mail.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.

4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.

5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.

6. The hearing may be conducted by the entire Board, by a subcommittee of three to five members of the Board of Directors, at the discretion of and as appointed by the chair of the Board of Directors or, if required pursuant to Section F., by an Ad Hoc Committee described in Section F. If the hearing is conducted by a subcommittee or by an Ad Hoc Committee that includes one or more Board members as described in Section F., the presiding officer of the hearing will be a Board member designated by the chair of the Board. The chair of the Board of Directors will act as the presiding officer throughout the hearing conducted by the full Board unless the chair is unable to serve or is disqualified from serving, in which case the ACEP President will designate a member of the Board of Directors to chair the hearing. If all Board members have recused themselves, the Ad Hoc Committee members shall choose an individual from among themselves to chair the hearing. If a subcommittee of the Board or an Ad Hoc Committee conducts the hearing, such hearing must take place with all of the parties and all the members of the subcommittee or ad hoc committee present in person. If the full Board conducts the hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take place by telephone conference call.

7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.

8. The Board, its appointed subcommittee, or an Ad Hoc Committee will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.

9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee’s recommendation or the Ad Hoc Committee’s decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.

10. The decision of the Board or Ad Hoc Committee will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board's or Ad Hoc Committee’s decision will be sent by certified U.S. mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board’s or Ad Hoc Committee’s decision and a statement of the basis for that decision.

I. Disciplinary Action: Censure, Suspension, or Expulsion

1. Censure
   a. Private Censure: a private letter of censure informs a member that his or her conduct is not in conformity with the College’s ethical standards; it may detail the manner in which the Board expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. The content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed.
b. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section A.2. above.

2. Suspension from ACEP membership shall be for a period of twelve months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. At the end of the twelve-month period of suspension, the suspended member shall be offered reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues).

3. Expulsion from ACEP membership shall be for a period of five years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors.

J. Disclosure
1. Nature of Disciplinary Action
   a. Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.
   b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.
   c. Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which may result in a report of such action to the National Practitioner Data Bank.
   d. Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP members: Any ACEP member may transmit to the Executive Director a request for information regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section J.1.
   b. Public Disclosure: The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication.

K. Ground Rules
1. All proceedings are confidential until a final decision on the complaint is rendered by the Board of Directors or an Ad Hoc Committee pursuant to Section F., at which time the decision will be available upon request by ACEP members, to the extent specified in Section J. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Committee, the Bylaws Committee, the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee’s, Board’s,
subcommittee’s, or Ad Hoc Committee’s overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee.

4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.

5. If a participant in this process (such as a member of the Ethics Committee, the Bylaws Committee, or Board of Directors) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.

6. Once the Board has made a decision or implemented a decision of an Ad Hoc Committee pursuant to Section F. on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.

7. The Board's decision or the decision of an Ad Hoc Committee pursuant to Section F. to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.

8. If a respondent fails to respond to a complaint, to notice of the right to request a hearing, or to a request for information, the Board or an Ad Hoc Committee pursuant to Section F. may make a decision on the complaint solely on the basis of the information it has received.

9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

10. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

III. Chartering Chapters

Upon petition of any five members of the College or one third of the members within the petitioning jurisdiction, whichever number is greater, the Board may issue a charter for a chapter of the College. No more than one chapter will be chartered in any one state, territory, or commonwealth. The Board of Directors may issue a charter for a government services chapter without geographic restrictions upon petition of five or more active members of the College serving in government medical assignments.

Chapters will be in such form as will be approved by the Board of Directors. Each chapter in a state, territory, or commonwealth in which incorporation is possible will incorporate within one year of receiving its charter.

Each chapter will have power to acquire, lease, own, and convey property; to invest in financial instruments sanctioned by its Board of Directors; to fund and carry on research; to issue publications and distribute information by various electronic means; to establish, conduct, and maintain schools, courses, museums, libraries, and other institutions for study in and teaching of emergency patient care and emergency services; to retain professional legislative analysts; to retain legal counsel; and to use any reasonable means for attainment of objectives to fulfill the mission of the College.

IV. Charter Suspension-Revocation

Any member of the College may file written charges against any chapter with the executive director of the College. Such charges must be signed, and must specify the acts of conduct for which the complaint is made. The executive director of the College must present the charges to the Board of Directors at its next meeting. The Board of Directors will then act upon the charges and will either dismiss them or proceed as hereinafter set forth.
If the Board fails to dismiss the charges it will within 10 days thereafter cause a copy of the charges to be served upon the accused chapter by sending it by registered United States mail to the secretary or other officer of the chapter. The Board will notify the accuser at the same time and in the same manner.

A hearing will be convened not less than 15 days nor more than 90 days after service of charges. The Board will, after having given the accused and the accuser reasonable opportunity to be heard in person or by counsel and to present all evidence and proofs, conclude the hearing and within 30 days render a decision. The affirmative vote of a majority of the members of the Board present and voting will constitute the decision of the Board, which may either dismiss the charges or take such actions as it deems appropriate. In either event the Board will make known its decision in a written resolution signed by the secretary and president. In the former event the Board will furnish the accused and the accuser with a copy of the resolution. In the latter event its resolution will be read at the next regular meeting of the Board or at a special meeting duly called for that purpose, provided that a copy of the decision will be delivered to the accused in the same manner provided for the service of charges at least 15 days before such meeting. The accused and the accusers will be given reasonable opportunity to be heard at the meeting of the Board of Directors where the decision is read. A two-thirds majority vote of the entire Board of Directors will be required to suspend or to revoke the charter.

On revocation of the charter of any chapter by the Board of Directors, the chapter will take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter will no longer make any use of the College name or logo.

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

Nominations: A slate of one or more nominees for each vacant position will be developed by the Nominating Committee.

Eligibility: Eligibility for a vacancy election nomination shall be in accordance with Article IX, Section 2 of the Bylaws.

Order of Elections: If there are multiple vacancies with varying lengths of unexpired terms, the longest term will be elected first, then followed in succession to the shortest term.

Term of Office: When elected by the Council, the replacement director’s term will begin at the conclusion of the Board meeting following the annual meeting at which their election occurs or immediately upon election if elected at any other Council meeting. If elected by the Board, the term shall begin at the conclusion of the Board meeting at which their election occurs. In all instances the term shall be for the remainder of the unexpired term to which they have been elected.

Election by the Board of Directors (when applicable in accordance with the Bylaws):

When selecting nominees for election by the Board of Directors, the Nominating Committee will give special consideration to unelected nominees from the most recent Board and Council Officer elections. The election may occur at any Board meeting more than 90 days before the annual meeting and shall be by a majority vote of the remaining directors (i.e. total number of directors). The Board shall consider each vacant position separately. Board members may choose to abstain from voting for any particular nominee. If a nominee fails to achieve a majority vote after being considered for all vacant positions, the nominee shall be removed from consideration and additional nominees from the Nominating Committee considered until all vacant positions have been filled. No floor nominations are allowed.

Election by the Council (when applicable in accordance with the Bylaws):
The election will comply with the usual Council election process as closely as possible except as noted. A special meeting of the Council may be held in accordance with the Bylaws to elect replacement directors. If the election is at the annual Council meeting, the Council will hold the vacancy election following the regular elections and elect the replacement director from the remaining slate of nominees (including Speaker and Vice-Speaker nominees when applicable).

VI. **Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council**

Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet, at the time the Council representation is sought, and continue to meet, the following criteria:

A. Non-profit.
B. Impacts the practice of emergency medicine, the goals of ACEP, and represents a unique contribution to emergency medicine that is not already represented in the Council.
C. Not in conflict with the Bylaws and policies of ACEP.
D. Physicians comprise the majority of the voting membership of the organization.
E. A majority of the organization’s physician members are ACEP members.
F. Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.
G. National in scope, membership not restricted geographically, and members from a majority of the states. If international, the organization must have a U.S. branch or chapter in compliance with these guidelines.
H. Seek representation as a component body through the submission of a Bylaws amendment.

The College will audit these component bodies every two years to ensure continued compliance with these guidelines.

VII. **Amendments**

The method of amending the College Manual shall be specified in the College Bylaws.
Minutes

The 48th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:03 am, Friday, October 25, 2019, by Speaker John G. McManus, Jr., MD, MBA, FACEP.

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

Dr. McManus provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance and singing the National Anthem.

Dr. McManus introduced ACEP’s Parliamentarian Jim Slaughter, JD, CPP, and ACEP’s Executive Director Dean Wilkerson, JD, MBA, CAE. He then welcomed new councillors, new alternate councillors, first time attendees, and guests.

Donald E. Stader, MD, FACEP, president of the Colorado Chapter, welcomed councillors and other meeting attendees.

Melissa W. Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 331 councillors of the 433 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

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 2019 Council meeting:

ALABAMA CHAPTER
Melissa Wysong Costello, MD, FACEP
Muhammad N Husainy, DO, FACEP
Eric McDonald, MD
Annalise Sorrentino, MD, FACEP

ALASKA CHAPTER
David James Scordino, MD, FACEP
Anne Zink, MD, FACEP

ARIZONA CHAPTER
Patricia A Bayless, MD, FACEP
Bradley A Dreifuss, MD, FACEP
Nicole R Hodgson, MD
Paul Andrew Kozak, MD, FACEP
J Scott Lowry, MD, FACEP
Wendy Ann Lucid, MD, FACEP
Todd Brian Taylor, MD, FACEP
Dale P Woolridge, MD, PhD, FACEP

ARKANSAS CHAPTER

Brian L Hohertz, MD, FACEP
Erin N Willard, MD

AACEM

Gabor David Kelen, MD, FACEP

CALIFORNIA CHAPTER

Harrison Alter, MD, FACEP
Zahir I Basrai, MD
Rodney W Borger, MD, FACEP
Andrea M Brault, MD, FACEP
Reb JH Close, MD, FACEP
John Dirk Coburn, MD, FACEP
Carrieann E Drenten, MD, FACEP
Irv E Edwards, MD, FACEP
Jorge A Fernandez, MD
William E Franklin, DO, FACEP
Marc Allan Futernick, MD, FACEP
Michael Gertz, MD, FACEP
Douglas Everett Gibson, MD, FACEP
Vikant Gulati, MD, FACEP
William K Mallon, MD, FACEP
Aimee K Moulin, MD, FACEP
Leslie Mukau, MD, FACEP
Bing S Pao, MD, FACEP
Hunter M Pattison, MD
Chi Lee Perlroth, MD, FACEP
Vivian Reyes, MD, FACEP
Peter Erik Sokolove, MD, FACEP
Susanne J Spano, MD, FACEP
Melanie T Stanzer, DO, FACEP
Lawrence M Stock, MD, FACEP
Thomas Jerome Sugarman, MD, FACEP
Gary William Tamkin, MD, FACEP
David Terca, MD
Patrick Um, MD, FACEP
Andrea M Wagner, MD, FACEP
Lori D Winston, MD, FACEP
Anna L Yap, MD
Bradley Alan Zlotnick, MD, FACEP

COLORADO CHAPTER

Ramnik S Dhaliwal, MD, JD
Nathaniel T Hibbs, DO, FACEP
Douglas M Hill, DO, FACEP
Christopher David Johnston, MD, FACEP
Carla Elizabeth Murphy, DO, FACEP
Eric B Olsen, MD, FACEP
Donald E Stader, MD, FACEP

CONNECTICUT CHAPTER

Thomas A Brunell, MD, FACEP
Daniel Freess, MD, FACEP
B Bryan Jordan, DO
Elizabeth Schiller, MD, FACEP
Gregory L Shangold, MD, FACEP
David E Wilcox, MD, FACEP

CORD

Maria E Moreira, MD, FACEP
DELAWARE CHAPTER
Emily M Granitto, MD, FACEP
John T Powell, MD, MHCDS, FACEP

DISTRICT OF COLUMBIA CHAPTER
Jessica Galarraga, MD, MPH
Rita A Manfredi-Shutler, MD, FACEP
Leah E Steckler, MD

EMRA
Erik Blutinger, MD, MSc
Hannah R Hughes, MD
Zachary Joseph Jarou, MD
Omar Z Maniya, MD, MBA
Scott H Pasichow, MD, MPH
Nicholas R Salerno, MD
Karina Sanchez, MD
Nathan P Vafaie, MD, MBA

FLORIDA CHAPTER
Andrew I Bern, MD, FACEP
Ashley Booth-Norse, MD, FACEP
Jordan GR Celeste, MD, FACEP
Andrzej T Dmowski, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Shayne M Gue, MD
Steven B Kaines, MD, FACEP
Mike Lozano, Jr, MD, MSHI, FACEP
Rene S Mack, MD, FACEP
Kristin McCabe-Kline, MD, FACEP
Ryan T McKenna, DO, FACEP
Ryan D Nesselroade, MD
David J Orban, MD, FACEP
Sanjay Pattani, MD, FACEP
Russell D Radke, MD
Danyelle Redden, MD, MPH, FACEP
Todd L Slesinger, MD, FACEP
John Caleist Soud, DO
L Kendall Webb, MD, FACEP
Aaron Anthony Wohl, MD, FACEP
Christian C Zuver, MD, FACEP

GEORGIA CHAPTER
Brett H Cannon, MD, FACEP
James Joseph Dugal, MD, FACEP(E)
Matthew Taylor Keadey, MD, FACEP
Jeffrey F Linzer, Sr, MD, FACEP
DW “Chip” Pettigrew, III, MD, FACEP
Matthew Rudy, MD, FACEP
Stephen A Shiver, MD, FACEP
James L Smith, Jr, MD, FACEP
Matthew J Watson, MD, FACEP

GOVT SERVICES CHAPTER
Andrea Austin, MD, FACEP
Kyle E Couperus, MD
Tyler Davis, MD
Gerald Delk, MD, FACEP
Roderick Fontenette, MD, FACEP
Melissa L Givens, MD, FACEP
Lindsay Grubish, DO, FACEP
Alan Jeffrey Hirshberg, MD, MPH, FACEP
Julio Rafael Lairet, DO, FACEP
Regan F Lyon, MD, FACEP
HAWAII CHAPTER
Torree M McGowan, MD, FACEP
Nadia M Pearson, DO, FACEP
Laura Tilley, MD, FACEP

Mark Baker, MD, FACEP
Daniel Cheng, MD

IDAHO CHAPTER
Ken John Gramyk, MD, FACEP
Andrew G Southard, MD, FACEP

ILLINOIS CHAPTER
Amit D Arwindekar, MD, FACEP
Christine Babcock, MD, FACEP
Cai Glushak, MD, FACEP
Scott A Heinrich, MD, FACEP
George Z Hevesy, MD, FACEP
Jason A Kegg, MD, FACEP
Napoleon B Knight, MD, FACEP
Janet Lin, MD, FACEP
Christopher M McDowell, MD, FACEP
Henry Pitzele, MD, FACEP
Yanina Purim-Shem-Tov, MD, FACEP
Willard W Sharp, MD, FACEP
Ernest Enjen Wang, MD, FACEP
Deborah E Weber, MD, FACEP

INDIANA CHAPTER
Michael D Bishop, MD, FACEP(E)
Bart S Brown, MD, FACEP
Sara Ann Brown, MD, FACEP
Timothy A Burrell, MD, MBA, FACEP
James L Shoemaker, Jr, MD, FACEP
Lauren Stanley, MD, FACEP
Lindsay M Weaver, MD, FACEP

IOWA CHAPTER
Kelly M Douglas, MD
Sarah Hoper, MD, JD, FACEP
Rachael Sokol, DO, FACEP

KANSAS CHAPTER
Dennis Michael Allin, MD, FACEP
John F McMaster, MD, FACEP
Jeffrey G Norvell, MD, MBA, FACEP

KENTUCKY CHAPTER
David Wesley Brewer, MD, FACEP
Melissa Platt, MD, FACEP
Hugh W Shoff, MD, FACEP
Ryan Stanton, MD, FACEP

LOUISIANA CHAPTER
James B Aiken, MD, FACEP
Angela Pettit Cornelius, MD, FACEP
Julius (Jay) A Kaplan, MD, FACEP
Phillip Luke LeBas, MD, FACEP
Randy L Pilgrim, MD, FACEP

MAINE CHAPTER
Thomas C Dancoes, DO, FACEP
Garreth C Debiegun, MD, FACEP
Charles F Pattavina, MD, FACEP

MARYLAND CHAPTER
Michael C Bond, MD, FACEP
Arjun S Chanmugam, MD, FACEP
Richard J Ferraro, MD, FACEP
Kyle Fischer, MD, FACEP
Kathleen D Keffe, MD, FACEP
Michelle Pyka, MD, FACEP
Theresa E Tassey, MD

MASSACHUSETTS CHAPTER
Brien Alfred Barnewolt, MD, FACEP
Stephen K Epstein, MD, MPP, FACEP
Laura Janneck, MD, FACEP
Kathleen Kerrigan, MD, FACEP
Matthew B Mostofi, DO, FACEP
Mark D Pearlmutter, MD, FACEP
Jesse Rideout, MD, FACEP
Brian Sutton, MD, FACEP
Joseph C Tennyson, MD, FACEP
Scott G Weiner, MD, FACEP

MICHIGAN CHAPTER
Michael J Baker, MD, FACEP
Sara S Chakel, MD, FACEP
Nicholas Dyc, MD, FACEP
Gregory Gafni-Pappas, DO, FACEP
Rami R Khoury, MD, FACEP
Warren F Lanphear, MD, FACEP
Jacob Manteuffel, MD, FACEP
Therese G Mead, DO, FACEP
Emily M Mills, MD, FACEP
James C Mitchiner, MD, MPH, FACEP
Kevin Monfette, MD, FACEP
Diana Nordlund, DO, JD, FACEP
David T Overton, MD, FACEP
Paul R Pomeroy, Jr, MD, FACEP
Larisa May Traill, MD, FACEP
Bradley J Uren, MD, FACEP
Gregory Link Walker, MD, FACEP
Bradford L Walters, MD, FACEP
Mildred J Willy, MD, FACEP
James Michael Ziadeh, MD, FACEP

MINNESOTA CHAPTER
Heather Ann Heaton, MD, FACEP
William G Heegaard, MD, FACEP
Kurt M Isenberger, MD, FACEP
Timothy James Johnson, MD, FACEP
David Nestler, MD, MS, FACEP
Lane Patten, MD, FACEP
Thomas E Wyatt, MD, FACEP
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Fred E Kency, Jr, MD
Philip L Levin, MD, FACEP

MISSOURI CHAPTER
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Jonathan Heidt, MD, MHA, FACEP
Louis D Jamtgaard, MD, FACEP
Thomas B Pinson, MD, FACEP
Robert Francis Poirier, Jr, MD, MBA, FACEP
Evan Schwarz, MD, FACEP
MONTANA CHAPTER
Harry Eugene Sibold, MD, FACEP

NEBRASKA CHAPTER
Renee Engler, MD, FACEP
Benjamin L Fago, MD, FACEP

NEVADA CHAPTER
John Dietrich Anderson, MD, FACEP
Graham Stephen Ingalsbe, MD
Gregory Alan Juhl, MD, FACEP

NEW HAMPSHIRE CHAPTER
Reed Brozen, MD, FACEP
Sarah Garlan Johansen, MD, FACEP

NEW JERSEY CHAPTER
Victor M Almeida, DO, FACEP
Thomas A Brabson, DO, FACEP
William Basil Felegi, DO, FACEP
Rachelle Ann Greenman, MD, FACEP
Steven M Hochman, MD, FACEP
Marianna Karounos, DO, MS, FACEP
Marjory E Langer, MD, FACEP
Jessica M Maye, DO, FACEP
Amy Ondeyka, MD, FACEP
Michael Ruzek, DO, FACEP

NEW MEXICO CHAPTER
Eric Michael Ketcham, MD, FACEP
Tatsuya Norii, MD, FACEP

NEW YORK CHAPTER
Brahim Ardolic, MD, FACEP
Joseph Basile, MD, FACEP
Nicole Berwald, MD, FACEP
Robert M Bramante, MD, FACEP
Mark Curato, DO, FACEP, FACEP
Jeremy T Cushman, MD, FACEP
Mathew Foley, MD, FACEP
Sanjey Gupta, MD, FACEP
Abbas Husain, MD, FACEP
Marc P Kanter, MD, FACEP
Stuart Gary Kessler, MD, FACEP
Penelope Chun Lema, MD, FACEP
Robert McCormack, MD, FACEP
Mary E McLean, MD
Laura D Melville, MD
Joshua B Moskovitz, MD, MBA, MPH, FACEP
Nestor B Nestor, MD, FACEP
Louise A Prince, MD, FACEP
Jennifer Pugh, MD, FACEP
Jeffrey S Rabrich, DO, FACEP
Nishad A Rahman, MD
Christopher C Raio, MD, FACEP
Sachin Santhakumar, MD
Livia M Santiago-Rosado, MD, FACEP
Virgil W Smaltz, MD, MPA, FACEP
Jessica M Thomas, MD
Asa “Peter” Viccellio, MD, FACEP
Luis Carlos Zapata, MD, FACEP
Joseph A Zito, MD, FACEP

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Gregory J Cannon, MD, FACEP
Jennifer Casaletto, MD, FACEP  
Charles W Henrichs, III, MD, FACEP  
Thomas Lee Mason, MD, FACEP  
Eric E Maur, MD, FACEP  
Abhishek Mehrotra, MD, MBA, FACEP  
Bret Nicks, MD, MHA, FACEP  
Sankalp Puri, MD, FACEP  
Stephen A Small, MD, FACEP  
David Matthew Sullivan, MD, FACEP  

NORTH DAKOTA CHAPTER  
K J Temple, MD, FACEP  

OHIO CHAPTER  
Eileen F Baker, MD, PhD, FACEP  
Dan Charles Breeze, DO, FACEP  
Tyler Hill, DO, FACEP  
Erika Charlotte Kube, MD, FACEP  
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Catherine Anna Marco, MD, FACEP  
Michael McCrea, MD, FACEP  
Richard N Nelson, MD, FACEP  
John R Queen, MD, FACEP  
Bradley D Raetzke, MD, FACEP  
Zachary Dennis Rasmussen, MD  
Matthew J Sanders, DO, FACEP  
Imran Shaikh, MD  
Ryan Squier, MD, FACEP  
Travis Ulmer, MD, FACEP  
Nicole Ann Veitinger, DO, FACEP  

OKLAHOMA CHAPTER  
Jeffrey Michael Goodloe, MD, FACEP  
Cecilia Guthrie, MD, FACEP  
Jeffrey Johnson, MD, FACEP  
James Raymond Kennedye, MD, FACEP  

OREGON CHAPTER  
Meaghan Francis Dehning, MD  
Joshua Lupton, MD  
Michael F McCaskill, MD, FACEP  
John C Moorhead, MD, FACEP  
Michelle R Shaw, MD, FACEP  

PENNSYLVANIA CHAPTER  
Smeet R Bhimani, DO  
Ankur A Doshi, MD, FACEP  
Eleanor Dunham, MD, FACEP  
Marcus Eubanks, MD, FACEP  
Todd Fijewski, MD, FACEP  
Ronald V Hall, MD, FACEP  
Richard Hamilton, MD, FACEP  
F Richard Heath, MD, FACEP  
Annahieta Kalantari, DO, FACEP  
Gary Khammahavong, MD  
Chadd K Kraus, DO, DrPH, MPH, FACEP  
Priyanka Lauber, DO  
Dhimitri Nikolla, DO  
Vishnu M Patel, MD  
Shawn M Quinn, DO, FACEP  
Jennifer L Savino, DO, FACEP  
Michael A Turturro, MD, FACEP  
Arvind Venkat, MD, FACEP
PUERTO RICO CHAPTER
Miguel F. Agrait Gonzalez, MD, FACEP
Angelisse M Almodovar Bernier, MD

RHODE ISLAND CHAPTER
Nadine T Himelfarb, MD, FACEP
Achyut B Kamat, MD, FACEP
Jessica Smith, MD, FACEP

SAEM
Kathleen J Clem, MD, FACEP

SOUTH CAROLINA CHAPTER
Matthew D Bitner, MD, FACEP
Stephen A D Grant, MD, FACEP
Allison Leigh Harvey, MD, FACEP
Tiffany Jackson, MD
Kelly Johnson, MD
Christina Millhouse, MD, FACEP

SOUTH DAKOTA CHAPTER
Donald Neilson, MD

TENNESSEE CHAPTER
Sanford H Herman, MD, FACEP
Sudave D Mendiratta, MD, FACEP
Thomas R Mitchell, MD, FACEP
John H Proctor, MD, MBA, FACEP
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TEXAS CHAPTER
Carrie de Moor, MD, FACEP
Justin W Fairless, DO, FACEP
Diana L Fite, MD, FACEP
Juan Francisco Fitz, MD, FACEP
Andrea L Green, MD, FACEP
Robert D Greenberg, MD, FACEP
Robert Hancock, Jr, DO, FACEP
Alexander J Kirk, MD, FACEP
Heidi C Knowles, MD, FACEP
Edward Kuo, MD
Jason A Lesnick, MD
Laura N Medford-Davis, MD, FACEP
Craig Meek, MD, FACEP
Daniel Eugene Peckenpaugh, MD, FACEP
R Lynn Rea, MD, FACEP
Angela Siler Fisher, FACEP
Marcus Lynn Sims, II, DO, FACEP
Nicholas P Steinour, MD, FACEP
Gerald A Troutman, MD, FACEP
Hemant H Vankawala, MD, FACEP
James M Williams, DO, FACEP
Sandra Williams, DO, MPH, FACEP

UTAH CHAPTER
Jim V Antinori, MD, FACEP
Stephen Carl Hartsell, MD, FACEP
Kathleen Marie Lawliss, MD, FACEP
David Brent Mabey, MD

VERMONT CHAPTER
Alexandra Nicole Thran, MD, FACEP

VIRGINIA CHAPTER
Trisha Danielle Anest, MD, MPH, FACEP
Kenneth Hickey, MD, FACEP
David Matthew Kruse, MD, FACEP
Bruce M Lo, MD, MBA, RDMS, FACEP
WASHINGTON CHAPTER
Cameron Ross Buck, MD, FACEP
Herbert Duber, MD, MPH, FACEP
Callan Fockele, MD
C Ryan Keay, MD, FACEP
Gregg A Miller, MD, FACEP
Karolyn K Moody, DO, MPH, FACEP
Jennifer L'Hommedieu Stankus, MD, FACEP
Liam Yore, MD, FACEP

WEST VIRGINIA CHAPTER
Adam Thomas Crawford, DO, FACEP
David Benjamin Deuell, DO, FACEP
Christopher S Goode, MD, FACEP

WISCONSIN CHAPTER
Bradley Burmeister, MD
William D Falco, MD, MS, FACEP
Jeffrey J Pothof, MD, FACEP
Robert Sands Redwood, MD, MPH, FACEP
Michael Dean Repplinger, MD, PhD, FACEP
Brian Sharp, MD, FACEP

WYOMING CHAPTER
Carol Lea Wright Becker, MD, FACEP

Sections of Membership
AIR MEDICAL TRANSPORT
Henderson D McGinnis, MD, FACEP

AMER ASSOC OF WOMEN EMER PHYSICIANS
E Lea Walters, MD, FACEP

CAREERS IN EMERGENCY MEDICINE
Constance J Doyle, MD, FACEP

CRITICAL CARE MEDICINE
Ayan Sen, MD, FACEP

CRUISE SHIP MEDICINE
Ruben Dario Parejo, MD

DEMOCRATIC GROUP PRACTICE
David F Tulsiak, MD, FACEP

DISASTER MEDICINE
David Wayne Callaway, MD, FACEP

DIVERSITY & INCLUSION
Ugo A. Ezenkwele, MD, FACEP

DUAL TRAINING
De Benjamin Winter, III, MD

EMERGENCY MEDICAL INFORMATICS
John D. Manning, MD

EMS-PREHOSPITAL CARE
Maia Dorsett, MD

EMERGENCY MED LOCUM TENENS
Angela F. Mattke, MD, FACEP

EMER MED PRAC MGMT & HEALTH POLICY
Richard Lee Austin, Jr., MD

EMERGENCY MEDICINE RESEARCH
James Ross Miner, MD, FACEP
EMERGENCY MEDICINE WORKFORCE
Otto J. Marquez, MD, FACEP

EMERGENCY ULTRASOUND
Lisa M. Bundy, MD, FACEP

EVENT MEDICINE
Sara F. Sutherland, MD, FACEP

FREESTANDING EMERGENCY CENTERS
Edward A. Shaheen, MD, FACEP

GERIATRIC EMERGENCY MEDICINE
Maura Kennedy, MD

INTERNATIONAL EMERGENCY MEDICINE
Jeffrey A. Nielson, MD, FACEP

MEDICAL DIRECTORS
Johnny L. Sy, DO, FACEP

MEDICAL HUMANITIES
Robert C. Solomon, MD, FACEP

OBSERVATION SERVICES
Kristi Ziontz, DO, FACEP

PAIN MANAGEMENT
Alexis M LaPietra, DO, FACEP

PALLIATIVE MEDICINE
Marynell Jelinek, MD, FACEP

PEDIATRIC EMERGENCY MEDICINE
Eric R Schmitt, MD, MPH, FACEP

QUALITY IMPROVEMENT & PATIENT SAFETY
Susan M. Nedza, MD, FACEP

RURAL EMERGENCY MEDICINE
Stephen J. Jameson, MD, FACEP

SOCIAL EMERGENCY MEDICINE
Aislinn D. Black, DO, FACEP

SPORTS MEDICINE
William Denq, MD

TACTICAL EMERGENCY MEDICINE
Howard K. Mell, MD, MPH, CPE, FACEP

TELEHEALTH
Alexander Chiu, MD, FACEP

TOXICOLOGY
Jennifer Hannum, MD, FACEP

TRAUMA & INJURY PREVENTION
Gregory Luke Larkin, MD, MPH, FACEP

UNDERSEA & HYPERBARIC MEDICINE
Robert W Sanders, MD, FACEP

WELLNESS
Susan T. Haney, MD, FACEP

WILDERNESS MEDICINE
Brendan H. Milliner, MD

YOUNG PHYSICIANS
Benjamin Karfunkle, 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)
Fredrick Blum, MD, FACEP (WV)
Brooks F. Bock, MD, FACEP (CO)
Michael L. Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Gregory L. Henry, MD, FACEP (MI)
Nicholas J. Jouriles, MD, FACEP (OH)
Brian F. Keaton, MD, FACEP (OH)
Linda L. Lawrence, MD, FACEP (GS)
Rebecca B. Parker, MD, FACEP (IL)
Michael T. Rapp, MD, FACEP (VA)
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, past speakers, and past chairs of the Board 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, past chair, 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, & 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, & 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.

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.

Electronic Devices

All electronic devices must be kept in “quiet” mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of electronic devices for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Leadership Development Advisory Committee

The Leadership Development Advisory Committee (LDAC) is a Council Committee charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAC will offer to interested members guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee.

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 committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization 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, past speaker, or past chair of the Board, 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, Past Speakers, and Past Chairs of the Board Seating
Past presidents, past speakers, and past chairs of the Board of the College are invited to sit with their respective chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

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

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

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

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

A Reference Committee may recommend that a resolution:
A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.
B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.
C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee’s motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.

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

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

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

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

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.
Background information, including financial analysis, will be prepared by staff on all resolutions submitted on or before 90 days prior to the annual meeting.

• **Regular Non-Bylaws Resolutions**
  Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as “regular resolutions” and will be referred to an appropriate Reference Committee for consideration at the annual meeting. Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as “Late Resolutions.”

• **Bylaws Resolutions**
  Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws. Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

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

• **Emergency Resolutions**
  Emergency resolutions are resolutions that do not qualify as “regular” or “late” resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. See also Appeals of Decisions from the Chair.
  Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

**Smoking Policy**
Smoking is not permitted in any College venue.

**Unanimous Consent Agenda**
A “Unanimous Consent Agenda” is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:
1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

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

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

**Voting Immediately**

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

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

**Voting on Resolutions and Motions**

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

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The councillors reviewed and accepted the minutes of the October 29-30, 2018, Council meeting and approved the actions of the Steering Committee taken at their January 29, 2019, and May 5, 2019, meetings.

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

Dr. McManus reported that seven late resolutions were received and reviewed by the Steering Committee. Three memorial resolutions were accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. Two late resolutions were accepted for submission to the Council. “Role of Private Equity in Emergency Medicine” was numbered 58 and assigned to Reference Committee A. “Opposition to the Auction of Hahnemann Graduate Medical Education Slots” was numbered 59 and assigned to Reference Committee B. Two late resolutions were not accepted for submission to the Council. Dr. McManus stated the reasons the late resolutions were rejected.

It was moved THAT THE COUNCIL OVERRULE THE STEERING COMMITTEE’S DECISION TO REJECT THE LATE RESOLUTION “VACCINATIONS.” The motion was adopted.

The resolution was numbered 60 and assigned to Reference Committee B.

The Board of Directors requested to withdraw Resolution 10. There were no objections and the resolution was withdrawn. The Emergency Medicine Resident’s Association requested to withdraw Resolution 16. There were no objections and the resolution was withdrawn.

Dr. McManus presented the Nominating Committee report. Dr. Katz was the only nominee for Speaker of the Council. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. Katz was declared as the 2019-21 speaker of the Council.

Three members were nominated for Council Vice Speaker: Kelly Gray-Eurom, MD, MMM, FACEP; Andrea L. Green, MD, FACEP; and Howard K. Mell, MD, CPE, FACEP. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed.

Eight members were nominated for four positions on the Board of Directors: Michael J. Baker, MD, FACEP;
Jeffrey M. Goodloe, MD, FACEP; Rachelle A. Greenman, MD, FACEP; Gabor D. Kelen, MD, FACEP, Pamela A. Ross, MD, FACEP; Gillian R. Schmitz, MD, FACEP; Ryan A. Stanton, MD, FACEP; and Thomas J. Sugarman, MD, FACEP. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed.

Two members were nominated for President-Elect: Jon Mark Hirshon, MD, PhD, MPH, FACEP, and Mark S. Rosenberg, DO, MBA, FACEP. Dr. McManus called for floor nominations. There were no floor nominees. The nominations were then closed.

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

The Council recessed at 9:30 am for the Reference Committee hearings. The resolutions considered by the 2019 Council appear below as submitted.

2019 Council Resolutions

**RESOLUTION 1**
RESOLVED, That the American College of Emergency Physicians commends Paul D. Kivela, MD, MBA, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

**RESOLUTION 2**
RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends Kevin M. Klauer, DO, EJD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.

**RESOLUTION 3**
RESOLVED, That the American College of Emergency Physicians commends John G. McManus, Jr., MD, MBA, FACEP, for his service as Council Speaker and Council Vice Speaker, and for his enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

**RESOLUTION 4**
RESOLVED, That the American College of Emergency Physicians commends Debra G. Perina, MD, FACEP, for her dedication as an emergency physician, educator, and leader in the specialty of emergency medicine.

**RESOLUTION 5**
RESOLVED, That the American College of Emergency Physicians commends Rhonda R. Whitson, RHIA, for her service as Clinical Practice Manager.

**RESOLUTION 6**
RESOLVED, That the American College of Emergency Physicians recognizes Jonathan Eric Epstein, MD, FACEP, commemorates his dedication to emergency medicine and the College, and celebrates his many accomplishments during his too brief life and career.

**RESOLUTION 7**
RESOLVED, That the American College of Emergency Physicians extends to the family of Rakesh Engineer, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his residents and the countless patients who have benefited from his care.

**RESOLUTION 8**
RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Kevin S. Mickelson, MD, FACEP, and extends condolences and gratitude to his wife, Colette, family, and friends for his service to the specialty of emergency medicine and to patient care.
RESOLUTION 9
RESOLVED, That the College Manual be amended to read:

VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council:
Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet at the time the Council representation is sought, and continue to meet, the following criteria:
A. Non-profit.
B. Impacts the practice of emergency medicine, the goals of ACEP, and represents a unique contribution to emergency medicine that is not already represented in the Council.
C. Not in conflict with the Bylaws and policies of ACEP.
D. Physicians comprise the majority of the voting membership of the organization.
E. A majority of the organization’s physician members are ACEP members.
F. Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.
G. National in scope, membership not restricted geographically, and members from a majority of the states. If international, the organization must have a U.S. branch or chapter in compliance with these guidelines.
H. Seek representation as a component body through the submission of a Bylaws amendment.

The College will audit these component bodies every two years to ensure continued compliance with these guidelines.

RESOLUTION 10  (This resolution was withdrawn.)
RESOLVED, That the College Manual be amended by substitution of the Procedures for Addressing Charges of Ethical Violations and Other Misconduct to read:

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in accordance with College policy.

A. Definitions
1. ACEP shall mean the American College of Emergency Physicians
2. Code of Ethics shall mean the Code of Ethics for Emergency Physicians
3. Principles of Ethics shall mean Principles of Ethics for Emergency Physicians
4. Procedures shall mean Procedures for Addressing Charges of Ethical Violations and Other Misconduct
5. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee
6. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee
7. Board Hearing Panel consists of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee or Bylaws Committee, as appropriate

AB. Complaint Received
A complaint may be initiated by an ACEP member, chapter, committee, or section. No others have standing to present a complaint.
1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of ACEP Bylaws, current ACEP Principles of Ethics, for Emergency Physicians; other current ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within twelve (12) seven (7) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is
responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;

5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, the Ethics Committee, the Bylaws Committee, the Board of Directors any additional ACEP review body listed in these Procedures, and to the respondent should the complaint be forwarded to the respondent; and

6. Must be submitted to the ACEP Executive Director.

B. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.

b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming the complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing and identifying the guidelines and timetable elements that must be followed addressed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the Procedures.

2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the Procedures. “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” (“Procedures”)

3. a. Determines, in consultation with the ACEP President and the chair of the Ethics Committee and/or the Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics or for Emergency Physicians or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or

b. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics for Emergency Physicians, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Complaint Review Panel Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or

c. Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee chair, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or

d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Ethics Complaint Review Panel or the Bylaws Committee Board of Directors will review the President’s action at the next regularly scheduled Board meeting. The President’s action can be overturned by a majority vote of the appropriate review bodies.

4. Within ten (10) business days after the determinations specified in Section B.C.4.b. or Section B.C.4.c. of these Procedures, forwards the complaint to the respondent by USPS Certified Mail certified U.S. mail with a copy of these Procedures and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the Board appropriate review panel decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication.
Such notice must also include a summary of the respondent’s rights in the hearing, and a list of the names of the members of the ACEP Ethics Committee or the ACEP Bylaws Committee, as appropriate review and hearing panels; and the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.

6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics Complaint Review Panel or Committee, the Bylaws Committee, or the subcommittee appointed to review the complaint, as appropriate.

C. Bylaws Committee D. Ethics Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section BC.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of the ACEP Principles of Ethics or other current ACEP ethics policies and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP Principles of Ethics or other current ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of current ACEP Principles of Ethics or other current ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.
6. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors:
5. Decides to:
   a. Dismiss the complaint; or
   b. Take disciplinary action, the specifics of which shall be included in the committee’s report. Ethics Complaint Review Panel renders a decision to impose disciplinary action based on the written record.
8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

E. Bylaws Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section C.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of current ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   Proceed to develop its recommendation based solely on the written record.

6. Develops a report regarding the complaint and recommendation for action. A minority reports may also be presented.

7. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:
   a. Dismiss the complaint; or
   b. Take disciplinary action, the specifics of which shall be included in the committee’s report. Bylaws Committee renders a decision to impose disciplinary action based solely on the written record.

8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee’s decision based solely on the written record.

7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

E. Board of Directors
1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.
2. May request further information in writing from the complainant and/or respondent.
3. Decides to:
   Render a decision to impose disciplinary action based on the written record.
4. If the Bylaws Committee Board determines to impose disciplinary action pursuant to Section E.53.b.,” the respondent will be provided with notification of the Bylaws Committee’s Board’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee’s Board decision based solely on the written record.
5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.
6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee
1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.
2. This Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse
themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.

3. The Ad Hoc Committee:
   a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.
   b. May request further information in writing from the complainant and/or respondent.
   c. Decides to:
      i. Dismiss the complaint; or
      ii. Render a decision to impose disciplinary action based on the written record.
   d. If the Ad Hoc Committee determines to impose disciplinary action pursuant to Section F.3.c.ii., the respondent will be provided with notification of the Ad Hoc Committee’s determination and the option of:
      i. A hearing conducted by the Ad Hoc Committee; or
      ii. The imposition of the Ad Hoc Committee decision based solely on the written record.
   e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below.
   f. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated.
   g. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.

G.F. Right of Respondent to Request a Hearing

If the Ethics Complaint Review Panel or Bylaws Committee Board chooses to impose disciplinary action, the option described in Section E.3.b., or an Ad Hoc Committee chooses the option described in Section F.3.c.iii., the Executive Director will send to the respondent a written notice by certified U.S. mail USPS Certified Mail of the right to request a hearing, or to have the Board or the Ad Hoc Committee impose its decision based solely on the written complaint. This notice will list the respondent’s hearing rights as set forth in Section G.H. below. The respondent’s request for a hearing must be submitted in writing to the Executive Director within thirty (30) business days of receipt of the notice of right to a hearing. In the event of no response, the ACEP President may determine the manner of proceeding applicable review body will implement its final decision.

H.G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by certified U.S. mail USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel, its appointed subcommittee pursuant to Section II.6. below, or an Ad Hoc Committee pursuant to Section F., intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by certified U.S. mail.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person. Hearings may not take place by telephone conference call.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board Hearing Panel, its appointed subcommittee, or an Ad Hoc Committee will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.
9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee’s recommendation or the Ad Hoc Committee’s decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.

10.9. The decision of the Board or Ad Hoc Committee The decision of the Board Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board’s or Ad Hoc Committee’s Board Hearing Panel’s decision will be sent by certified U.S. mail USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board’s or Ad Hoc Committee’s Board Hearing Panel’s decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the appropriate committee or panel in its review of the complaint. The Board shall review the Procedures used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these Procedures were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Actions

a. Censure, Suspension, or Expulsion

i. Censure

i.1. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College’s ethical standards; it may detail the manner in which the Board ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. The content Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the a private letter of censure shall not be disclosed, provided, but the fact that such a letter has been issued shall be disclosed.

ii. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section A.2. B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or bylaw was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action.

ii.1. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. ACEP President. At the end of the twelve (12) month period of suspension, the suspended member shall be offered may request reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or bylaw was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to suspension to the Boards of
Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

3-Expulsion from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. The expulsion shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors.

J. Disclosure

1. Nature of Disciplinary Action

a. Private censure: the content of a private letter of censure shall not be announced in an appropriate ACEP publication. The published announcement disclosed, but the fact that such a letter has been issued shall also state which ACEP policy or Bylaws provision was violated by the member. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.

b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.

c. Suspension: the dates of suspension, including whether or not the member and shall inform ACEP members that they were reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which may request further information about the disciplinary result in a report of such action. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure

a. Disclosure to ACEP members Members: Any ACEP member may transmit to the Executive Director a request for information to the Executive Director regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section J.1.

b. Public Disclosure Disclosure to Non-Members: If a non-member The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided.

K. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the Board of Directors or an Ad Hoc Committee pursuant to Section F: appropriate review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section J.1. Files of these proceedings, including written submissions and hearing record will be kept confidential.

2. Timetable guidelines are counted by calendar days unless otherwise specified.

3. The Ethics Committee Complaint Review Panel, the Bylaws Committee, or the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee Hearing Panel, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee’s, Board’s, subcommittee’s, or Ad Hoc Committee’s overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee review body’s overall time to complete its task.

4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.

5. If a participant in this process (such as a member of the Ethics Committee Complaint Review Panel, the Bylaws Committee, or the Board of Directors Hearing Panel) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic
competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent, **at which time the ACEP President will appoint a replacement**. Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.

6. Once the **Board Ethics Complaint Review Panel or the Bylaws Committee** has made a decision or implemented a decision of an Ad Hoc Committee pursuant to Section F, on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.

7. The **Board’s Ethics Complaint Review Panel or the Bylaws Committee’s decision or the decision of an Ad Hoc Committee pursuant to Section F** to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.

8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the **Board or an Ad Hoc Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel pursuant to Section F.** may make a decision on the complaint solely on the basis of the information it has received.

9. **If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.**

10. **If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.**

**RESOLUTION 12**

RESOLVED, That ACEP provide the Council with an annual report on the demographics of its councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP’s committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

**RESOLUTION 13**

RESOLVED, That ACEP, in its official publications, discussions, announcements, communications, and documents, etc., will work to eliminate the use of the word “provider” when referring to physician and non-physician healthcare practitioners, instead referring to them more accurately by the educational degree(s) and titles that they obtained.

**RESOLUTION 14**

RESOLVED, That ACEP develop and publicize a policy statement that encourages implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and be it further RESOLVED, That ACEP continue to create and advertise free, CME-eligible, online training related to implicit bias.

**RESOLUTION 15**

RESOLVED, ACEP support the practice of increased NEMPAC transparency through making available online to ACEP members the voting/sponsorship record of key ACEP legislation for NEMPAC sponsored candidates.

**RESOLUTION 16**  *(This resolution was withdrawn.)*

RESOLVED, That ACEP oppose further study or use of the Association of American Medical Colleges Standardized Video Interview for emergency medicine applicants.

**RESOLUTION 17**

RESOLVED, That ACEP develop a policy statement in favor of physician salary and benefit package transparency.

**RESOLUTION 18**

RESOLVED, That ACEP create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board certified emergency medicine physicians.
RESOLUTION 19
RESOLVED, That ACEP support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper, and be it further
RESOLVED, That ACEP support the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) and will partner with AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

RESOLUTION 20
RESOLVED, That ACEP promote awareness of current ACEP policy statement that supports decreasing the barriers, perceived or real, to physicians to feel safe seeking treatment for mental health, substance use, and other issues; and be it further
RESOLVED, That ACEP work with the American Medical Association and state medical societies to advocate for a change at state medical boards for protections for licensure for physicians to seek help and treatment for mental health, substance use, and other disorders.

RESOLUTION 21
RESOLVED, That ACEP provide and pay for one videoconference meeting host* for each chapter and section that requests this service.

RESOLUTION 22
RESOLVED, That ACEP encourage Leadership & Advocacy Conference participants to bring and wear their white coat when making Hill visits to help make a visual impact when meeting with legislators, staffers, and the public who may be also visiting the Hill; and be it further
RESOLVED, ACEP work with a third party vendor to issue branded ACEP white coats to all active national ACEP Board of Directors members to help create a powerful visual that accompanies our advocacy message while also ensuring clarity that our national representative is speaking on behalf of our organization and the specialty while not creating confusion of favoring any group, practice style, etc.

RESOLUTION 23
RESOLVED, That ACEP advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine
RESOLUTION 24
RESOLVED, That ACEP does not view the current CMS sepsis quality metrics as the standard of care for the treatment of patients with sepsis; and be it further
RESOLVED, That ACEP reach out to the Centers for Medicare and Medicaid Services to revise the current sepsis quality metrics.

RESOLUTION 25
RESOLVED, That ACEP work with CMS to create a formal caveat allowing clinicians to withhold 30cc/kg crystalloid bolus(es) in select patients with presumed sepsis and a higher risk of fluid overload or harm; and be it further
RESOLVED, That ACEP affirm with CMS that the bedside emergency physician’s judgement of potential harm be allowed withhold 30cc/kg crystalloid boluses in patients with presumed sepsis without penalty.

RESOLUTION 26
RESOLVED, That ACEP support and advocate that all EMTALA related services have liability coverage commensurate with that which exists under the Federal Tort Claims Act for National Health Service members.

RESOLUTION 27
RESOLVED, That if a physician is not onsite at all times in a facility that otherwise meets the definition of an Emergency Department or Freestanding Emergency Department as defined by ACEP, and that facility advertises itself as providing unscheduled care, such facility should not use the word “emergency” or “ER” in its name in any way; and be it further
RESOLVED, That ACEP will consider it a top priority and will draft legislation for state and federal legislators and such legislation will mandate that the terms “emergency” and “ER” are indicative of physician-led care and should be regulated to ensure public safety and public transparency.
RESOLUTION 28
RESOLVED, That in the interest of public health and safety, ACEP promote to policymakers that the benefits of EMTALA should be expanded to urgent care and primary care clinics so that they may contribute to ensuring that the unscheduled care needs of the public are met, better coordinate care with emergency departments, and lower overall costs to the health systems by evaluating and treating those patients that can safely be cared for in their clinics; and be it further
RESOLVED, That ACEP promote the expansion of EMTALA to include that if a patient is required to be sent to the emergency department, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

RESOLUTION 29
RESOLVED, That ACEP support the extension of Medicaid coverage to 12 months postpartum; and be it further
RESOLVED, That ACEP work with relevant stakeholders to support the extension of Medicaid coverage to 12 months postpartum.

RESOLUTION 30
RESOLVED, That ACEP set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style “Go Teams” and a database into which gathered information would be entered for research purposes; and be it further
RESOLVED, That ACEP support the development processes of both a National Transportation Safety Board-style “Go Teams” and a database of gathered information for research purposes.

RESOLUTION 31
RESOLVED, That ACEP advocate to the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration for emergency department specific requirements and curriculum so as to reach the greatest number of patients safely and without onerous barriers; and be it further
RESOLVED, That ACEP advocate for our physicians in emergency department settings who are uniquely trained by our environment to recognize and respond to the complications of opioid addiction and furthermore that ACEP continue to advocate for patients seeking treatment for opioid addiction and/or dependence through the elimination of X-waiver requirements for emergency physicians for treatment that is initiated from an emergency department setting.

RESOLUTION 32
RESOLVED, That ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician’s representative specialty.

RESOLUTION 33
RESOLVED, That ACEP work directly with CMS and other willing stakeholders to assist in the adoption and promulgation of tort “best practices” for submission to Congress with a request for action; and be it further
RESOLVED, That ACEP adopt principles of national medical tort reform that simultaneously preserves CMS budget viability and essential legal rights of patients.

RESOLUTION 34
RESOLVED, That ACEP oppose legislation to add naloxone administration to the Prescription Drug Monitoring Program and work with chapters in developing strategies and supporting materials to stop such legislation.

RESOLUTION 35
RESOLVED, That ACEP develop and enact strategies (including legislative solutions) to prevent insurance companies from arbitrarily downcoding charts; and be it further
RESOLVED, That ACEP work to develop and enact policy at the federal level that prevents insurance companies from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

RESOLUTION 36
RESOLVED, That ACEP work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.
RESOLUTION 37
RESOLVED, That ACEP support the adoption of a single-payer health insurance program that finances care for all Americans while fostering competition, preserving patient choice, and recognizing the essential value of emergency medicine; and be it further
RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing universal health care to all Americans.

RESOLUTION 38
RESOLVED, That ACEP work with legislators to enact legislation that makes it illegal for an insurance company to engage in automatic denials; and be it further
RESOLVED, That in order to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and be it further
RESOLVED, That patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by insurance companies and that ACEP work towards getting an affirmation in writing from insurance companies that they will adopt this as policy.

RESOLUTION 39
RESOLVED: That ACEP oppose mandatory work requirements that force Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

RESOLUTION 40
RESOLVED, That ACEP work with identified stakeholder groups and professional organizations, including the American Academy of Family Physicians and the National Rural Health Association, to create effective strategies and to promote emergency medicine practice delivery models that encourage collaboration, increase quality, and reduce costs in rural health care settings; and be it further
RESOLVED, That ACEP identify and promote a variety of existing training opportunities, such as procedural skills, simulation labs, and continuing medical education, to be available to maintain physician and non-physician clinicians’ skills and to improve rural emergency medicine care; and be it further
RESOLVED, That ACEP work collaboratively with organizations to develop a rural emergency medicine white paper that identifies best practices, site criteria, supervision requirements, and studies funding mechanisms to promote the development and uniform availability of rural emergency medicine electives within emergency medicine residency training programs; and be it further
RESOLVED, That ACEP encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine and rural healthcare.

RESOLUTION 41
RESOLVED, That ACEP establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

RESOLUTION 42
RESOLVED, That ACEP convene an Emergency Medicine Artificial Intelligence (EMAI) Summit and/or a task force; and be it further
RESOLVED, That the purpose of convening an Emergency Medicine Artificial Intelligence (EMAI) Summit is to produce an information paper to include recommendations based on the best available knowledge or opinion on the issues and concerns surrounding artificial intelligence and make recommendations for how the College will continue to be informed and advised on matters related to EMAI; and be it further
RESOLVED, That the Board of Directors consider updating the College’s Strategic Plan to include artificial intelligence; and be it further
RESOLVED, That during the Leadership & Advocacy Conference 2020 and/or ACEP20, a presentation on artificial intelligence in emergency medicine, panel discussion, town hall, or similar session on emergency medicine artificial intelligence be offered.

RESOLUTION 43
RESOLVED, That ACEP create a policy statement regarding the safety and effectiveness of the use of droperidol for various indications in the ED; and be it further
RESOLVED, That ACEP develop a clinical policy to guide its members on the safe and effective use of droperidol for various indications in the ED based on existing medical evidence.
RESOLUTION 44
RESOLVED, That ACEP review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;” and be it further RESOLVED, That ACEP develop tools and strategies to identify and educate communities, local, state, and the federal government regarding the importance of emergency physician staffing of emergency department; and be it further RESOLVED, That ACEP oppose the independent practice of emergency medicine by non-physician providers; and be it further RESOLVED, That ACEP develop and enact strategies, including legislative solutions, to ensure that the practice of emergency medicine includes mandatory on-site supervision by an emergency physician.

RESOLUTION 45
RESOLVED, That ACEP make a public statement in support of medical neutrality.

RESOLUTION 46
RESOLVED, That ACEP support increasing the capacity of current conventional mental health facilities to provide care for children with special needs; and be it further RESOLVED, That ACEP support policies that allow a pediatric patient to be admitted to a conventional mental health facility and receive treatment while remaining “on the list” for a bed at a neuropsychiatric facility.

RESOLUTION 47
RESOLVED, That ACEP study, track, and trend statistical data regarding accidental self-harm promoted by social media posts in collaboration with the Centers for Disease Control; and be it further RESOLVED, That ACEP develop guidelines for the recognition of self-harm content and develop programs to advance awareness amongst adolescents; and be it further RESOLVED, That ACEP promote legislation that protects patients from self-harm materials and prohibits the posting of self-harm challenge content and videos on social media sites and the internet.

RESOLUTION 48
RESOLVED, That ACEP attempt to collaborate with the American College of Obstetricians and Gynecologists to promote maternal and infant health; and be it further RESOLVED, That ACEP work with the American College of Obstetricians and Gynecologists and other stakeholders to provide educational materials, such as toolkits, to emergency physicians regarding how to provide care that is up-to-date and consistent with best clinical practices for these vulnerable populations.

RESOLUTION 49
RESOLVED, That ACEP adopt the following statement and disseminate its content to its members and other parties: “It is the position of the American College of Emergency Physicians that emergency physicians who provide services to patients during a time of contract transitions should be fully compensated for their professional efforts without delay, barrier, or requirement to continue employment with a specific party. This compensation should include monetary compensation as well as uninterrupted provision of malpractice coverage. Parties involved in contract transitions, including contract management groups and the hospitals and health systems involved, have a responsibility to meet these obligations immediately and not use such a transition as leverage in the contract process.”

RESOLUTION 50
RESOLVED, That ACEP promote the consistent inclusion of social workers and/or care managers in the team of clinicians caring for patients in the ED; and be it further RESOLVED, That ACEP educate hospitals on the need to include social workers and/or care managers on ED care teams; and be it further RESOLVED, That ACEP compile information on best practices related to ED care models that include social workers and care managers and create resources to assist members in implementing multidisciplinary care models.

RESOLUTION 51
RESOLVED, That ACEP promote telehealth research awareness to its members, maintain a database of telehealth programs and interested researchers, and make introductions between interested parties; and be it further RESOLVED, That ACEP allocate lobbying resources at the federal level for promoting the increase of federal funding toward telehealth research in emergency medicine; and be it further
RESOLVED, That ACEP work with outside organizations, such as the American Academy of Emergency Medicine, the Society for Academic Emergency Medicine, American Telemedicine Association, Healthcare Information and Management Systems Society, and others to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

**RESOLUTION 52**

RESOLVED, That unless a policy statement specifically indicates that it only applies to in-person emergency services, ACEP extend all ACEP policies that include or refer to emergency physicians to specifically apply to all emergency physicians regardless of whether their services are provided remotely or in-person.

**RESOLUTION 53**

RESOLVED, That ACEP support the elimination of non-medical exclusions for vaccines; and be it further

RESOLVED, That ACEP make a public statement of support for the safety and efficacy of vaccines in preventing disease.

**RESOLUTION 54**

RESOLVED, That ACEP develop resources for physicians to help with the early identification, diagnosis, and recommendations for limiting spread of illness previously rare due to vaccination; and be it further

RESOLVED, That ACEP make a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who medically can be vaccinated.

**RESOLUTION 55**  *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Patricia Lee, MD, FACEP, as a brilliant, compassionate leader in emergency medicine; and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to her daughters, Elizabeth Lee and Emily Lee Reno, their spouses, and her grandchildren, gratitude for her tremendous service to Emergency Medicine and her patients.

**RESOLUTION 56**  *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the short but fulfilled life of Tamara O’Neal, MD, as a young and upcoming leader in emergency medicine; and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to her parents, Tom and Glenda O’Neal, and her entire family gratitude for her tremendous service to emergency medicine and her patients.

**RESOLUTION 57**  *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians extends to Elliot S. Nipomnick, MD, FACEP’s wife Kim; daughter Summer, son Ian, brother Geoffrey, his friends, and colleagues our deepest condolences with richly deserved gratitude for his generous gifts to us, our specialty, his patients, and ours.

**RESOLUTION 58**  *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP study and report annually the market penetration of non-physician ownership, namely private equity, insurance company ownership, hospital ownership, and corporate non-physician ownership and management of emergency groups; and be it further

RESOLVED, That ACEP study and report the effects on individual physicians of the actions of private equity groups, insurance company ownership, hospital ownership, corporate non-physician ownership and management of emergency physician groups; and be it further

RESOLVED, That ACEP develop resources to protect access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcy, etc. or other adverse events of their employer/management company.

**RESOLUTION 59**  *(This late resolution was accepted by the Council.)*

RESOLVED That ACEP support CMS in opposing the proposed sale of Hahnemann’s GME slots.

**RESOLUTION 60**  *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP issue a statement immediately, strongly supporting vaccination of any persons detained by U.S. Immigration and Customs Enforcement (ICE) or ICE contracted detention facilities.
Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 9-22, and 58 were referred to Reference Committee A. Larisa M. Traill, MD, FACEP, chaired Reference Committee A and other members were: Mariana Karounos, DO, MS, FACEP; Kurtis Mayz, MD, MD, MBA, FACEP; Robert C. Solomon, MD, FACEP; James D. Thompson, MD, FACEP; L. Carlos Zapata, MD, FACEP; Leslie Moore, JD; and Maude Surprenant Hancock.

Resolutions 23-39, and 59-60 were assigned to Reference Committee B. Catherine A. Marco, MD, FACEP, chaired Reference Committee B and other members were: Bradley Burmeister, MD; Zachary J. Jarou, MD, Thom R. Mitchell, MD, FACEP; Randy L. Pilgrim, MD, FACEP; Lindsay M. Weaver, MD, FACEP; Ryan McBride, MPP; and Harry Monroe.

Resolutions 40-54 were referred to Reference Committee C. Michael A. Turturro, MD, FACEP, chaired Reference Committee C and other members were: Sara A. Brown, Md, FACEP; Angela P. Cornelius, MD, FACEP; Steven M. Hochman, MD, FACEP; Matthew J. Sanders, DO, FACEP; John C. Soud, DO; Margaret Montgomery, RN, MSN; and Travis Schulz, MLS, AHIP.

At 12:45 pm a Town Hall Meeting was convened. The topic was “Growth of the ACEP Council.” Michael McCrea, MD, FACEP, served as the moderator and the discussants were Paul Pomeroy, MD, FACEP, and Arlo Weltge, MD, MPH, FACEP.

The Candidate Forum for the president-elect candidates began at 2:00 pm with the president-elect candidates in the main Council meeting room. The Candidate Forum for the Vice Speaker and Board of Directors candidates began at 2:45 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:45 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. McManus addressed the Council and then introduced the Steering Committee and the Board of Directors.

Dr. McManus reviewed the procedure for the adoption of the 2019 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then read the resolvsed of the memorial resolutions for Jonathan E. Epstein, MD, FACEP; Rakesh Engineer, MD, FACEP; Patricia Lee, MD, FACEP; Kevin S. Mickelson, MD, FACEP; Elliot S. Nipomnick, MD, FACEP; and Tamara O’Neal, MD. The Council honored the memory of those who passed away since the last Council meeting 2019 and adopted the memorial resolutions by observing a moment of silence.

Dr. McManus announced that the commendation resolutions would be presented during the Council luncheon on Saturday, October 26, 2019.

Jill Baren, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Christopher Zabbo, DO, FACOEP, FACEP, secretary of the American Osteopathic Board of Emergency Medicine, addressed the Council.

Mark S. Rosenberg, DO, MBA, FACEP, presented the secretary-treasurer’s report.

Omar Maniya, MD, addressed the Council regarding the activities of the Emergency Medicine Residents’ Association.

Jordan GR Celeste, 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.

Vidor E. Friedman, MD, FACEP, president, addressed the Council. He reflected on the past year as ACEP
president and highlighted the successes of the College.

The Council recessed at 6:21 pm for the candidate reception and reconvened at 8:02 am on Saturday, October 26, 2019.

Dr. Costello reported that 426 councillors of the 433 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, executive director and Council secretary, addressed the Council.

The Council viewed a video orientation on submitting resolution amendments electronically through the Council meeting website.

REFERENCE COMMITTEE B

Dr. Marco 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: Substitute Resolution 23, Amended Resolution 26, Resolution 29, Resolution 30, Amended Resolution 32, Amended Resolution 35, Amended Resolution 36, Amended Resolution 38, Amended Resolution 39, Amended Resolution 59, Substitute Resolution 60

Not for adoption: Resolution 25, Resolution 27, Resolution 28, Resolution 31, Resolution 33, Resolution 37

For referral: Substitute Resolution 24

Substitute Resolution 24, Amended Resolution 26, Resolution 37, and Amended Resolution 59 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

SUBSTITUTE RESOLUTION 23 ALLOW EMERGENCY PHYSICIANS TO PRESCRIBE BUPRENORPHINE EXPANDING EMERGENCY PHYSICIAN UTILIZATION AND ABILITY TO PRESCRIBE BUPRENORPHINE

RESOLVED, THAT ACEP WORK DIRECTLY WITH THE DEA AND SAMHSA TO MINIMIZE BARRIERS FOR EMERGENCY DEPARTMENT PHYSICIANS TO ENACT MEANINGFUL THERAPY FOR PATIENTS IN A TIME OF OPIOID CRISIS IN THE UNIQUE ENVIRONMENT IN WHICH WE WORK; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE TO THE DEA AND SAMHSA FOR EMERGENCY DEPARTMENT SPECIFIC REQUIREMENTS AND CURRICULUM SO AS TO REACH THE GREATEST NUMBER OF PATIENTS SAFELY AND WITHOUT ONEROUS BARRIERS; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO ADVOCATE FOR THE REMOVAL OF THE DEA X-WAIVER REQUIREMENT FOR EMERGENCY PHYSICIANS WHO PRESCRIBE A BRIDGING COURSE OF BUPRENORPHINE FOR OPIOID USE DISORDER FROM AN EMERGENCY DEPARTMENT SETTING.

AMENDED RESOLUTION 32

RESOLVED, THAT ACEP OPPOSE ANY AND ALL STATE OR FEDERAL LEGISLATION AND/OR REGULATION THAT CREATES CRIMINAL OR CIVIL PENALTIES FOR THE PRACTICE OF MEDICINE DEEMED TO BE WITHIN THE PHYSICIAN’S SCOPE OF PRACTICE FOR A PHYSICIAN’S REPRESENTATIVE SPECIALTY.

AMENDED RESOLUTION 35

RESOLVED, THAT ACEP DEVELOP AND ENACT STRATEGIES (INCLUDING STATE AND FEDERAL LEGISLATIVE SOLUTIONS) TO PREVENT INSURANCE COMPANIES PAYORS FROM ARBITRARILY DOWNCODING CHARTS; AND BE IT FURTHER
RESOLVED, THAT ACEP WORK TO DEVELOP AND ENACT POLICY AT THE STATE AND FEDERAL LEVEL THAT PREVENTS INSURANCE COMPANIES PAYORS FROM DOWNCODING BASED ON A FINAL DIAGNOSIS AND PROVIDES MEANINGFUL DISINCENTIVES FOR DOING SO.

**AMENDED RESOLUTION 36 RESEARCH FUNDING AND LEGISLATION TO CURB GUN ADDRESS BOTH FIREARM VIOLENCE AND INTIMATE PARTNER VIOLENCE**

RESOLVED, THAT ACEP WORK WITH STAKEHOLDERS TO RAISE AWARENESS AND ADVOCATE FOR RESEARCH FUNDING AND LEGISLATION TO CURB GUN ADDRESS BOTH FIREARM VIOLENCE AND INTIMATE PARTNER VIOLENCE

**AMENDED RESOLUTION 38**

RESOLVED, THAT ACEP WORK WITH LEGISLATORS TO ENACT LEGISLATION THAT MAKES IT ILLEGAL FOR AN INSURANCE COMPANY A PAYOR TO ENGAGE IN AUTOMATIC DENIALS; AND BE IT FURTHER

RESOLVED, THAT IN ORDER TO DENY A CLAIM, A PHYSICIAN (I.E., MD OR DO) WHO IS BOARD CERTIFIED AND REMAINS CLINICALLY ACTIVE IN A FIELD RELATED TO THE CLAIM, CAREFULLY REVIEW THE DENIAL, AND ATTEST TO THE CAUSE OF THE DENIAL WITH THEIR SIGNATURE ATTACHED TO THE DOCUMENTATION THAT SHALL BE PROVIDED TO THE PATIENT; AND BE IT FURTHER

RESOLVED, THAT PATIENTS HAVE THE LEGAL RIGHT UNDER EMTALA TO SEEK EMERGENCY CARE AND THAT THEIR CLAIMS SHALL NOT BE DENIED BY INSURANCE COMPANIES PAYORS AND THAT ACEP WORK TOWARDS GETTING AN AFFIRMATION IN WRITING FROM INSURANCE COMPANIES PAYORS THAT THEY WILL ADOPT THIS AS POLICY.

**AMENDED RESOLUTION 39**

RESOLVED, THAT ACEP OPPOSE MANDATORY WORK REQUIREMENTS THAT FORCE FOR MEDICAID BENEFICIARIES TO PROVE THEY ARE EMPLOYED, OR SEEKING EMPLOYMENT, TO GET OR KEEP HEALTH INSURANCE.

**SUBSTITUTE RESOLUTION 60**

RESOLVED, THAT ACEP ISSUE A STATEMENT IMMEDIATELY, STRONGLY SUPPORTING VACCINATION OF ANY PERSONS DETAINED BY U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) OR ICE CONTRACTED DETENTION FACILITIES.

The committee recommended that Substitute Resolution 24 be referred to the Board of Directors.

It was moved THAT SUBSTITUTE RESOLUTION 24 BE REFERRED TO THE BOARD OF DIRECTORS:

RESOLVED, THAT ACEP CONTINUE TO WORK WITH CMS TO SUPPORT EVIDENCE-BASED QUALITY MEASURES FOR THE TREATMENT OF SEPSIS AND SEPTIC SHOCK; DOES NOT VIEW THE CURRENT CMS SEPSIS QUALITY METRICS AS THE STANDARD OF CARE FOR THE TREATMENT OF PATIENTS WITH SEPSIS; AND BE IT FURTHER

RESOLVED, THAT ACEP REACH OUT TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO REVISE THE CURRENT SEPSIS QUALITY METRICS. The motion was adopted.

The committee recommended that Amended Resolution 26 be adopted.

It was moved THAT AMENDED RESOLUTION 26 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT AND ADVOCATE THAT ALL EMTALA-MANDATED RELATED SERVICES HAVE LIABILITY COVERAGE COMMENSURATE WITH THAT WHICH EXISTS UNDER THE FEDERAL TORT CLAIMS ACT FOR NATIONAL HEALTH SERVICE MEMBERS.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:
RESOLVED, THAT ACEP SUPPORT AND ADVOCATE FOR LIABILITY PROTECTION TO COVER EMTALA-MANDATED SERVICES. 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 OPPOSE LEGISLATION TO ADD NALOXONE ADMINISTRATION TO THE PRESCRIPTION DRUG MONITORING PROGRAM AND WORK WITH CHAPTERS IN DEVELOPING STRATEGIES AND SUPPORTING MATERIALS TO STOP SUCH LEGISLATION.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP SUPPORT STATE CHAPTERS TO OPPOSE LEGISLATION TO ADD NALOXONE ADMINISTRATION TO THEIR PRESCRIPTION DRUG MONITORING PROGRAM AND WORK WITH CHAPTERS IN DEVELOPING STRATEGIES AND SUPPORTING MATERIALS TO STOP SUCH LEGISLATION. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 37 not be adopted.

It was moved THAT RESOLUTION 37 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 59 be adopted with the revised title “Opposition to the Auction Sale and Commoditization of Hahnemann Graduate Medical Education Slots.”

It was moved THAT AMENDED RESOLUTION 59 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT CMS IN OPPOSING THE PROPOSED SALE OF HAHNEMANN’S GME SLOTS; AND BE IT FURTHER RESOLVED, THAT ACEP OPPOSE ANY SALE OR OTHER COMMODITIZATION OF GME SLOTS.

It was moved THAT THE WORD “IMMEDIATELY” BE INSERTED BEFORE THE WORD “SUPPORT” AND THAT THE WORD “HAHNEMANN’S” BE RETAINED. The motion was adopted.

The amended main motion was then voted on and adopted.

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 9, Amended Resolution 12, Amended Resolution 13, Resolution 19, Amended Resolution 21

Amended Resolution 13 was extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 12

RESOLVED, THAT ACEP PROVIDE THE COUNCIL WITH AN ANNUAL REPORT ON THE DEMOGRAPHICS OF ITS COUNCILLORS AND ALTERNATE COUNCILLORS ON A CHAPTER-BY-CHAPTER BASIS, AS WELL AS THE DEMOGRAPHICS OF ACEP’S COMMITTEE AND SECTION
LEADERS, BOARD OF DIRECTORS, AND GENERAL MEMBERSHIP STRATIFIED BY AGE, GENDER, RACE/ETHNICITY, EDUCATION, BOARD CERTIFICATION, LIFE CAREER STAGE, AND EMPLOYMENT ENVIRONMENT.

**AMENDED RESOLUTION 13**

RESOLVED, THAT ACEP WILL **WORK TO** ELIMINATE THE USE OF THE WORD “PROVIDER” IN ITS **FUTURE** OFFICIAL PUBLICATIONS, DISCUSSIONS, ANNOUNCEMENTS, COMMUNICATIONS, AND DOCUMENTS, ETC., **WILL WORK TO** ELIMINATE THE USE OF THE WORD “PROVIDER,” **EXCEPT AS REQUIRED FOR LEGAL AND/OR POLICYMAKING PURPOSES,** WHEN REFERRING TO PHYSICIAN AND NON-PHYSICIAN HEALTHCARE PRACTITIONERS, INSTEAD REFERRING TO THEM MORE ACCURATELY BY THE EDUCATIONAL DEGREE(S) AND TITLES THAT THEY OBTAINED.

**AMENDED RESOLUTION 21**

RESOLVED, THAT ACEP PROVIDE AND PAY FOR ONE VIDEOCONFERENCE MEETING HOST FOR EACH CHAPTER AND SECTION THAT REQUESTS THIS SERVICE.

The committee recommended that Resolution 11 be referred to the Board of Directors.

It was moved THAT RESOLUTION 11 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED:

RESOLVED, THAT ACEP WILL **WORK TO** ELIMINATE THE USE OF THE WORD “PROVIDER” IN ITS **FUTURE** OFFICIAL PUBLICATIONS, DISCUSSIONS, ANNOUNCEMENTS, COMMUNICATIONS, AND DOCUMENTS, ETC., **WILL WORK TO** ELIMINATE THE USE OF THE WORD “PROVIDER,” **EXCEPT AS REQUIRED FOR LEGAL AND/OR POLICYMAKING PURPOSES,** WHEN REFERRING TO PHYSICIAN AND NON-PHYSICIAN HEALTHCARE PRACTITIONERS, INSTEAD REFERRING TO THEM MORE ACCURATELY BY THE EDUCATIONAL DEGREE(S) AND TITLES THAT THEY OBTAINED.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP IN ITS OFFICIAL PUBLICATIONS, DISCUSSIONS, ANNOUNCEMENTS, COMMUNICATIONS, AND DOCUMENTS, ETC., **WILL WORK TO** ELIMINATE THE USE OF THE WORD “PROVIDER” AND OTHER GENERIC TERMS (E.G., “CLINICIAN”) WHEN REFERRING TO PHYSICIAN AND NON-PHYSICIAN HEALTHCARE PRACTITIONERS, INSTEAD REFERRING TO THEM MORE ACCURATELY BY THE EDUCATIONAL DEGREE(S) AND TITLES THAT THEY OBTAINED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 14 be adopted.

It was moved THAT AMENDED RESOLUTION 14 BE ADOPTED:

RESOLVED, THAT ACEP DEVELOP AND PUBLICIZE A POLICY STATEMENT THAT ENCOURAGES IMPLICIT BIAS TRAINING FOR **ALL PHYSICIANS; MEDICAL RESIDENTS AND PHYSICIAN LEADERS IN EDUCATION, ORGANIZED MEDICINE, ADMINISTRATIVE, AND MANAGERIAL ROLES; AND BE IT FURTHER** RESOLVED, THAT ACEP CONTINUE TO CREATE **SPONSOR, AND ADVERTISE FREE, CME-ELIGIBLE, ONLINE TRAINING RELATED TO IMPLICIT BIAS FREE OF CHARGE TO ACEP MEMBERS.**

It was moved THAT THE FIRST RESOLVED BE AMENDED TO READ:
RESOLVED, THAT ACEP DEVELOP AND PUBLICIZE A POLICY STATEMENT THAT ENCOURAGES IMPLICIT BIAS TRAINING FOR ALL PROVIDERS AND MEDICAL STUDENTS. The motion was not adopted.

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

RESOLVED, THAT ACEP DEVELOP AND PUBLICIZE A POLICY STATEMENT THAT ENCOURAGES IMPLICIT BIAS TRAINING FOR ALL HEALTH CARE WORKERS AND TRAINEES. The motion was not adopted.

The 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. The motion was not adopted.

The committee recommended that Amended Resolution 17 be adopted.

It was moved THAT AMENDED RESOLUTION 17 BE ADOPTED:

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT IN FAVOR OF PHYSICIAN SALARY AND BENEFIT PACKAGE EQUITY AND TRANSPARENCY. The motion was adopted.

The committee recommended that Amended Resolution 18 be adopted.

It was moved THAT AMENDED RESOLUTION 18 BE ADOPTED:

RESOLVED, THAT ACEP CREATE A PUBLIC AWARENESS CAMPAIGN TO HIGHLIGHT THE UNIQUE SKILL SET, KNOWLEDGE BASE, AND VALUE OF EMERGENCY MEDICINE RESIDENCY-TRAINED AND BOARD CERTIFIED EMERGENCY PHYSICIANS. RESOLVED, THAT ACEP PARTNER WITH THE AMERICAN MEDICAL ASSOCIATION AND WITH OTHER NATIONAL MEDICAL SPECIALTY SOCIETIES ON A CAMPAIGN TO PROMOTE THE UNIQUE SKILL SET, KNOWLEDGE BASE, AND VALUE OF RESIDENCY TRAINED AND BOARD CERTIFIED PHYSICIANS.

It was moved THAT THE WORD “MEDICINE” BE DELETED FROM THE TITLE OF THE RESOLUTION. The motion was adopted.

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

RESOLVED, THAT ACEP CREATE A PUBLIC AWARENESS CAMPAIGN TO HIGHLIGHT THE UNIQUE SKILL SET, KNOWLEDGE BASE, AND VALUE OF EMERGENCY MEDICINE RESIDENCY-TRAINED AND BOARD CERTIFIED EMERGENCY PHYSICIANS. The motion was not adopted.

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

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

RESOLVED, THAT ACEP CREATE A PUBLIC AWARENESS CAMPAIGN TO HIGHLIGHT THE UNIQUE SKILL SET, KNOWLEDGE BASE, AND VALUE OF BOARD CERTIFIED EMERGENCY MEDICINE PHYSICIANS. The motion was not adopted.
UNIQUE SKILL SET, KNOWLEDGE BASE, AND VALUE OF THOSE THAT MEET THE ACEP DEFINITION OF EMERGENCY PHYSICIAN. The motion was adopted.

It was moved THAT THE SECOND RESOLVED BE AMENDED TO ADD THE WORDS “AMERICAN BOARD OF EMERGENCY MEDICINE, AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, AND THE EMERGENCY MEDICINE RESIDENTS’ ASSOCIATION” AFTER THE WORD “ASSOCIATION” AND ADD THE WORD “APPROPRIATE” BEFORE THE WORD “NATIONAL.” The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 20 be adopted.

It was moved THAT AMENDED RESOLUTION 20 BE ADOPTED:

RESOLVED, THAT ACEP PROMOTE AWARENESS OF CURRENT ACEP POLICY STATEMENT THAT SUPPORTS DECREASING THE BARRIERS, PERCEIVED OR REAL, TO PHYSICIANS TO FEEL SAFE SEEKING TREATMENT FOR MENTAL HEALTH, SUBSTANCE USE, AND OTHER ISSUES; AND BE IT FURTHER
RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION AND STATE MEDICAL SOCIETIES TO ADVOCATE FOR A CHANGE AT STATE MEDICAL BOARDS FOR PROTECTIONS FOR LICENSURE FOR PHYSICIANS TO SEEK HELP AND TREATMENT FOR MENTAL HEALTH, SUBSTANCE USE, AND OTHER DISORDERS; AND BE IT FURTHER
RESOLVED, THAT ACEP PARTNER WITH APPROPRIATE STAKEHOLDERS TO INVESTIGATE THE EFFECTIVENESS AND QUALITY OF EVIDENCE OF PHYSICIAN HEALTH PROGRAMS (PHPS) ACROSS THE STATES AND PRODUCE A WHITE PAPER THAT REPORTS ON THE FINDINGS.

It was moved THAT THE SECOND RESOLVED BE AMENDED TO ADD THE WORDS “FEDERATION OF STATE MEDICAL BOARDS” AFTER THE WORD “ASSOCIATION.” The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 22 not be adopted.

It was moved THAT RESOLUTION 22 BE ADOPTED.

It was requested that each resolved be voted on separately.

It was moved THAT THE FIRST RESOLVED BE ADOPTED. The motion was not adopted.

It was moved THAT THE SECOND RESOLVED BE ADOPTED.

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

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:45 pm on Saturday, October 26, 2019.

Dr. Costello reported that 433 councillors of the 433 eligible for seating had been credentialed.

Lynne Richardson, MD, FACEP, presented the survey results of the Council regarding firearms. Dr. Traill then resumed presentation of recommendations from Reference Committee A.

The committee recommended that Amended Resolution 58 be adopted.

It was moved THAT AMENDED RESOLUTION 58 BE ADOPTED:
RESOLVED, THAT ACEP STUDY AND REPORT ANNUALLY THE MARKET PENETRATION OF NON-PHYSICIAN OWNERSHIP, NAMELY PRIVATE EQUITY, INSURANCE COMPANY OWNERSHIP, HOSPITAL OWNERSHIP, AND CORPORATE NON-PHYSICIAN OWNERSHIP AND MANAGEMENT OF EMERGENCY GROUPS; AND BE IT FURTHER

RESOLVED, THAT ACEP STUDY AND REPORT THE EFFECTS ON INDIVIDUAL PHYSICIANS, ACEP LEADERSHIP, ACEP ADVOCACY EFFORTS, OF THE ACTIONS OF PRIVATE EQUITY GROUPS, INSURANCE COMPANY OWNERSHIP, HOSPITAL OWNERSHIP, CORPORATE NON-PHYSICIAN OWNERSHIP AND MANAGEMENT OF EMERGENCY PHYSICIAN GROUPS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP RESOURCES TO PROTECT, ADVOCATE TO PRESERVE ACCESS TO EMERGENCY CARE FOR PATIENTS AND PROTECT THE CAREERS OF EMERGENCY PHYSICIANS IN THE EVENT OF CONTRACT TRANSITIONS, BANKRUPTCY, ETC. OR OTHER ADVERSE EVENTS OF THEIR EMPLOYER/MANAGEMENT COMPANY; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH THE AMERICAN MEDICAL ASSOCIATION AND OTHER INTERESTED NATIONAL MEDICAL SPECIALTY SOCIETIES TO PETITION AND WORK WITH THE APPROPRIATE STATE AND FEDERAL AGENCIES TO DETERMINE THE CIRCUMSTANCES UNDER WHICH PRIVATE EQUITY INVESTMENT IN HEALTH CARE REPRESENTS A MARKET FAILURE THAT INCREASES THE COST OF HEALTH CARE TO CONSUMERS WITHOUT A COMMENSURATE INCREASE IN ACCESS OR QUALITY; AND BE IT FURTHER

RESOLVED, THAT SHOULD THERE BE CIRCUMSTANCES UNDER WHICH PRIVATE EQUITY INVESTMENT IN HEALTH CARE REPRESENTS A MARKET FAILURE, THAT ACEP WORK WITH OTHER INTERESTED PARTIES TO ADVOCATE FOR CORRECTIONS FOR THAT MARKET FAILURE.

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

RESOLVED, THAT ACEP STUDY AND REPORT ANNUALLY THE MARKET PENETRATION OF NON-PHYSICIAN OWNERSHIP, NAMELY PRIVATE EQUITY, INSURANCE COMPANY OWNERSHIP, HOSPITAL OWNERSHIP, AND CORPORATE NON-PHYSICIAN OWNERSHIP AND MANAGEMENT OF EMERGENCY GROUPS; AND BE IT FURTHER

RESOLVED, THAT ACEP STUDY AND REPORT THE EFFECTS ON INDIVIDUAL PHYSICIANS, ACEP ADVOCACY EFFORTS, OF THE ACTIONS OF PRIVATE EQUITY GROUPS, INSURANCE COMPANY OWNERSHIP, HOSPITAL OWNERSHIP, CORPORATE NON-PHYSICIAN OWNERSHIP AND MANAGEMENT OF EMERGENCY PHYSICIAN GROUPS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE TO PRESERVE ACCESS TO EMERGENCY CARE FOR PATIENTS AND PROTECT THE CAREERS OF EMERGENCY PHYSICIANS IN THE EVENT OF CONTRACT TRANSITIONS, BANKRUPTCY, ETC. OR OTHER ADVERSE EVENTS OF THEIR EMPLOYER/MANAGEMENT COMPANY; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH THE AMERICAN MEDICAL ASSOCIATION, OTHER INTERESTED NATIONAL MEDICAL SPECIALTY SOCIETIES, AND OTHER APPROPRIATE BODIES TO DETERMINE THE CIRCUMSTANCES UNDER WHICH CORPORATE OR PRIVATE EQUITY INVESTMENT COULD LEAD OR HAS LED TO MARKET EFFORTS THAT INCREASES THE COST OF HEALTH CARE TO CONSUMERS WITHOUT A COMMENSURATE INCREASE IN ACCESS OR QUALITY; AND BE IT FURTHER

RESOLVED, THAT SHOULD THERE BE CIRCUMSTANCES UNDER WHICH CORPORATE OR PRIVATE EQUITY INVESTMENT IN HEALTH CARE COULD LEAD OR HAS LED TO NEGATIVE MARKET EFFECTS THAT ACEP WORK WITH OTHER INTERESTED PARTIES TO ADVOCATE FOR CORRECTIONS TO THE MARKET.

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

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

RESOLVED, THAT ACEP STUDY AND REPORT AT AN APPROPRIATE INTERVAL REVIEW THE MARKET PENETRATION OF NON-PHYSICIAN OWNERSHIP, NAMELY PRIVATE EQUITY, INSURANCE COMPANY OWNERSHIP, HOSPITAL OWNERSHIP, AND CORPORATE NON-
PHYSICIAN OWNERSHIP AND MANAGEMENT OF EMERGENCY GROUPS. The motion was not adopted.

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

RESOLVED, THAT ACEP STUDY THE MARKET AND PATIENT CARE EFFECTS OF PRIVATE EQUITY INVESTMENTS IN HEALTH CARE; AND BE IT FURTHER
RESOLVED, THAT ACEP IDENTIFY ANY DELETERIOUS EFFECTS OF PRIVATE EQUITY UPON ACCESS TO HEALTH CARE AND PHYSICIAN LIVELIHOODS. The motion was not adopted.

It was requested that the Council vote on the first three resolveds and the last two resolveds separately.

It was moved THAT THE FIRST THREE RESOLVEDS BE ADOPTED AS AMENDED. The motion was adopted.

It was moved THAT THE LAST TWO RESOLVEDS BE ADOPTED AS AMENDED. The motion was adopted.

REFERENCE COMMITTEE C

Dr. Turturro 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 43, Amended Resolution 45, Amended Resolution 48, Amended Resolution 49, Amended Resolution 50, Substitute Resolution 52, Amended Resolution 53

Not for adoption: Resolution 54.

For referral: Amended Resolution 42.

Amended Resolution 45 and Amended Resolution 53 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 43
RESOLVED, THAT ACEP CREATE A POLICY STATEMENT REGARDING THE SAFETY AND EFFECTIVENESS OF THE USE OF DROPERIDOL FOR VARIOUS INDICATIONS IN THE ED; AND BE IT FURTHER
RESOLVED, THAT ACEP DEVELOP A CLINICAL POLICY TO GUIDE ITS MEMBERS ON THE SAFE AND EFFECTIVE USE OF DROPERIDOL FOR VARIOUS INDICATIONS IN THE ED BASED ON EXISTING MEDICAL EVIDENCE.

AMENDED RESOLUTION 48
RESOLVED, THAT ACEP ATTEMPT CONTINUE TO COLLABORATE WITH THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS TO PROMOTE MATERNAL AND INFANT HEALTH; AND BE IT FURTHER
RESOLVED, THAT ACEP WORK WITH THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND OTHER STAKEHOLDERS TO PROVIDE EDUCATIONAL MATERIALS, SUCH AS TOOLKITS, TO EMERGENCY PHYSICIANS REGARDING HOW TO PROVIDE CARE THAT IS UP-TO-DATE AND CONSISTENT WITH BEST CLINICAL PRACTICES FOR THESE VULNERABLE POPULATIONS).

AMENDED RESOLUTION 49
RESOLVED, THAT ACEP ADOPT THE FOLLOWING POLICY STATEMENT AND DISSEMINATE ITS CONTENT TO ITS MEMBERS AND OTHER PARTIES: “IT IS THE POSITION OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS THAT EMERGENCY PHYSICIANS WHO PROVIDE SERVICES TO PATIENTS DURING A TIME OF CONTRACT TRANSITIONS
SHOULD BE FULLY COMPENSATED FOR THEIR PROFESSIONAL EFFORTS WITHOUT DELAY, BARRIER, OR REQUIREMENT TO CONTINUE EMPLOYMENT WITH A SPECIFIC PARTY. THIS COMPENSATION SHOULD INCLUDE MONETARY COMPENSATION AS WELL AS UNINTERRUPTED PROVISION OF BENEFITS AND MALPRACTICE COVERAGE. PARTIES INVOLVED IN CONTRACT TRANSITIONS, INCLUDING CONTRACT MANAGEMENT GROUPS AND THE HOSPITALS AND HEALTH SYSTEMS INVOLVED, HAVE A RESPONSIBILITY TO MEET THESE OBLIGATIONS IMMEDIATELY AND NOT USE SUCH A TRANSITION AS LEVERAGE IN THE CONTRACT PROCESS.

AMENDED RESOLUTION 50

RESOLVED, THAT ACEP PROMOTE THE CONSISTENT INCLUSION OF SOCIAL WORKERS AND/OR CARE MANAGERS COORDINATORS IN THE TEAM OF CLINICIANS CARING FOR PATIENTS IN THE ED; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE EDUCATIONAL MATERIALS TO MEMBERS TO ASSIST IN ADVOCATING EDUCATE HOSPITALS TO HOSPITAL ADMINISTRATORS ON THE NEED TO INCLUDE SOCIAL WORKERS AND/OR CARE MANAGERS COORDINATORS ON ED CARE TEAMS; AND BE IT FURTHER

RESOLVED, THAT ACEP COMPILE INFORMATION ON BEST PRACTICES RELATED TO ED CARE MODELS THAT INCLUDE SOCIAL WORKERS AND CARE MANAGERS COORDINATORS AND CREATE RESOURCES TO ASSIST MEMBERS IN IMPLEMENTING MULTIDISCIPLINARY CARE MODELS.; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR PAYMENT FOR CARE COORDINATION SERVICES IN EMERGENCY MEDICINE.

SUBSTITUTE RESOLUTION 52

RESOLVED, THAT UNLESS A POLICY STATEMENT SPECIFICALLY INDICATES THAT IT ONLY APPLIES TO IN-PERSON EMERGENCY SERVICES, ACEP EXTEND ALL ACEP POLICIES THAT INCLUDE OR REFER TO EMERGENCY PHYSICIANS TO SPECIFICALLY APPLY TO ALL EMERGENCY PHYSICIANS REGARDLESS OF WHETHER THEIR SERVICES ARE PROVIDED REMOTELY OR IN-PERSON.

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT SPECIFICALLY INDICATING THAT IT ITS POLICIES APPLY TO ALL LOCATIONS OF EMERGENCY MEDICINE PRACTICE WHETHER PROVIDED REMOTELY OR IN-PERSON.

AMENDED RESOLUTION 42 ARTIFICIAL AUGMENTED INTELLIGENCE IN EMERGENCY MEDICINE

RESOLVED, THAT ACEP CONVENE AN EMERGENCY MEDICINE ARTIFICIAL AUGMENTED INTELLIGENCE (EMAI) SUMMIT AND/OR A TASK FORCE; AND BE IT FURTHER

RESOLVED, THAT THE PURPOSE OF CONVENING AN EMERGENCY MEDICINE ARTIFICIAL AUGMENTED INTELLIGENCE (EMAI) SUMMIT IS TO PRODUCE AN INFORMATION PAPER TO INCLUDE RECOMMENDATIONS BASED ON THE BEST AVAILABLE KNOWLEDGE OR OPINION ON THE ISSUES AND CONCERNS SURROUNDING ARTIFICIAL INTELLIGENCE AND MAKE RECOMMENDATIONS FOR HOW THE COLLEGE WILL CONTINUE TO BE INFORMED AND ADVISED ON MATTERS RELATED TO EMAI; AND BE IT FURTHER

RESOLVED, THAT THE BOARD OF DIRECTORS CONSIDER UPDATING THE COLLEGE’S STRATEGIC PLAN TO INCLUDE ARTIFICIAL INTELLIGENCE; AND BE IT FURTHER

RESOLVED, THAT DURING THE LEADERSHIP & ADVOCACY CONFERENCE 2020 AND/OR ACEP20, A PRESENTATION ON ARTIFICIAL INTELLIGENCE IN EMERGENCY MEDICINE, PANEL DISCUSSION, TOWN HALL, OR SIMILAR SESSION ON EMERGENCY MEDICINE ARTIFICIAL INTELLIGENCE BE OFFERED.

The committee recommended that Resolution 40 be referred to the Board of Directors.

It was moved THAT RESOLUTION 40 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Substitute Resolution 41 be adopted.
It was moved THAT SUBSTITUTE RESOLUTION 41 BE ADOPTED:

RESOLVED, THAT ACEP ESTABLISH AN ADVISORY BOARD TO MONITOR, COORDINATE, AND ADVOCATE FOR CLINICAL INITIATIVES AND HEALTH POLICIES THAT WOULD IMPROVE THE DELIVERY OF EMERGENCY CARE IN RURAL AREAS.

RESOLVED, THAT ACEP WORK WITH STAKEHOLDERS WITHIN THE COLLEGE INCLUDING THE RURAL EMERGENCY MEDICINE SECTION AND CHAPTERS TO PROVIDE A REGULAR MECHANISM TO SEEK INPUT FROM RURAL PHYSICIANS ON LEGISLATION THAT IMPACTS RURAL COMMUNITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP SEEK RURAL PHYSICIAN REPRESENTATION ON THE STATE LEGISLATIVE/REGULATORY COMMITTEE AND THE FEDERAL GOVERNMENT COMMITTEE TO REFLECT THE FACT THAT NEARLY HALF OF U.S. EMERGENCY DEPARTMENTS ARE LOCATED IN RURAL AREAS. The motion was adopted.

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

It was moved THAT RESOLUTION 44 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 45 be adopted.

It was moved THAT AMENDED RESOLUTION 45 BE ADOPTED:

RESOLVED, THAT ACEP MAKE DEVELP A PUBLIC POLICY STATEMENT IN SUPPORT OF MEDICAL NEUTRALITY.

It was moved THAT THE WORDS “WHEN PERSONNEL COORDINATE THEIR ACTIVITIES THROUGH ESTABLISHED CHANNELS VIA NON-GOVERNMENTAL ORGANIZATIONS, GOVERNMENT ORGANIZATIONS, OR OTHER OFFICIAL RESPONSE AGENCIES” BE ADDED AFTER THE WORD “NEUTRALITY.” The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 46 be adopted.

It was moved THAT AMENDED RESOLUTION 46 BE ADOPTED:

RESOLVED, THAT ACEP WILL SUPPORT INCREASING THE CAPACITY OF CURRENT CONVENTIONAL MENTAL HEALTH FACILITIES TO PROVIDE CARE FOR CHILDREN PATIENTS WITH SPECIAL NEEDS; AND BE IT FURTHER

RESOLVED, THAT ACEP WILL SUPPORT POLICIES THAT ALLOW A PATIENT TO BE ADMITTED TO A CONVENTIONAL MENTAL HEALTH FACILITY AND RECEIVE TREATMENT WHILE REMAINING “ON THE LIST” FOR A BED AT A NEUROPSYCHIATRIC FACILITY. The motion was adopted.

The committee recommended that Amended Resolution 47 be adopted.

It was moved THAT AMENDED RESOLUTION 47 BE ADOPTED:

RESOLVED, THAT ACEP STUDY, TRACK, AND TREND STATISTICAL DATA REGARDING ACCIDENTAL SELF-HARM PROMOTED BY SOCIAL MEDIA POSTS IN COLLABORATION WITH THE CENTERS FOR DISEASE CONTROL; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP GUIDELINES FOR THE RECOGNITION OF SELF-HARM CONTENT AND DEVELOP PROGRAMS TO ADVANCE AWARENESS AMONGST ADOLESCENTS; SUPPORT ENHANCING PUBLIC AWARENESS, PHYSICIAN EDUCATION, AND RESEARCH CONCERNING INTERNET CHALLENGES AND VIRAL SOCIAL MEDIA POSTS ENCOURAGING HAZARDOUS BEHAVIORS OR SELF-HARM, AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE LEGISLATION THAT PROTECTS PATIENTS FROM SELF-
HARM MATERIALS AND PROHIBITS THE POSTING OF SELF-HARM CHALLENGE CONTENT AND VIDEOS ON SOCIAL MEDIA SITES AND THE INTERNET. The motion was adopted.

The committee recommended that Amended Resolution 51 be adopted.

It was moved THAT AMENDED RESOLUTION 51 BE ADOPTED:

RESOLVED, THAT ACEP PROMOTE TELEHEALTH RESEARCH AWARENESS TO ITS MEMBERS, MAINTAIN A DATABASE OF TELEHEALTH PROGRAMS AND INTERESTED RESEARCHERS, AND MAKE INTRODUCTIONS BETWEEN INTERESTED PARTIES; AND BE IT FURTHER

RESOLVED, THAT ACEP ALLOCATE LOBBYING RESOURCES AT THE FEDERAL LEVEL FOR PROMOTING THE INCREASE OF FEDERAL FUNDING TOWARD TELEHEALTH RESEARCH IN EMERGENCY MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OUTSIDE ORGANIZATIONS, SUCH AS THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, THE SOCIETY FOR ACADEMIC EMERGENCY MEDICINE, AMERICAN TELEMEDICINE ASSOCIATION, HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY, AND OTHERS TO COORDINATE RESEARCH AWARENESS AND LOBBYING EFFORTS TO INCREASE THE NUMBER OF QUALITY RESEARCH STUDIES IN EMERGENCY TELEHEALTH.

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

RESOLVED, THAT ACEP CREATE AND MAINTAIN A DATABASE OF TELEHEALTH PROGRAMS AND INTERESTED RESEARCHERS AND MAKE INTRODUCTIONS BETWEEN INTERESTED PARTIES; AND BE IT FURTHER

RESOLVED, THAT ACEP ALLOCATE RESOURCES AT THE FEDERAL LEVEL FOR PROMOTING THE INCREASE OF FEDERAL FUNDING TOWARD TELEHEALTH RESEARCH IN EMERGENCY MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OUTSIDE ORGANIZATIONS, SUCH AS THE SOCIETY OF ACADEMIC EMERGENCY MEDICINE (SAEM), AMERICAN TELEMEDICINE ASSOCIATION (ATA), HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY (HIMSS), AND OTHERS TO COORDINATE EFFORTS TO INCREASE RESEARCH IN EMERGENCY TELEHEALTH.

The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 53 be adopted.

It was moved THAT AMENDED RESOLUTION 53 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT THE ELIMINATION OF NON-MEDICAL EXCLUSIONS FOR VACCINES; AND BE IT FURTHER

RESOLVED, THAT ACEP MAKE A PUBLIC STATEMENT OF SUPPORT FOR THE SAFETY AND EFFICACY OF VACCINES IN PREVENTING DISEASE.

It was moved THAT THE RESOLUTION BE AMENDED BY ADDITION OF A SECOND RESOLVED TO READ:

RESOLVED, THAT ACEP MAKE A STATEMENT OF SUPPORT AGAINST NON-MEDICAL EXCLUSIONS FOR VACCINES AND THE SAFETY AND EFFICACY OF VACCINES IN PREVENTING DISEASE. The motion was adopted.

The amended main motion was then voted on and adopted.

********************************************************************************************

Dr. Jaquis, president-elect, addressed the Council.
The Tellers, Credentials, & Elections Committee conducted the Vice Speaker election. Dr. Gray-Eurom was elected.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Goodloe, Dr. Kelen, and Dr. Stanton were elected to a three-year term. Dr. Schmitz was re-elected to a three-year term.

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

There being no further business, Dr. McManus adjourned the 2019 Council meeting at 4:40 pm on Saturday, October 26, 2019. The next meeting of the ACEP Council is scheduled for October 24-25, 2020, at the Omni Dallas Hotel, in Dallas, TX.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary and Executive Director

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker
Steering Committee Conference Call  
January 22, 2020

Minutes

Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 9:03 am Central time on Wednesday, January 22, 2020.

Steering Committee members present for all or portions of the meeting were: Angela Cornelius, MD, FACEP; Justin Fairless, DO, FACEP; Dan Freess, MD, FACEP; Kelly Gray-Eurom, MD, FACEP; Muhammad Husainy, DO, FACEP; Gary Katz, MD, FACEP, speaker; Rami Khoury, MD, FACEP; Jeffrey Linzer, MD, FACEP; Kurtis Mayz, MD, FACEP; Gregg Miller, MD, FACEP; Christina Millhouse, MD, FACEP; Aimee Moulin, MD, FACEP; James Mullen, MD, FACEP; Randy Pilgrim, MD, FACEP; Matthew Rudy, MD, FACEP; Karina Sanchez, MD; James Shoemaker, MD, FACEP; and Arvind Venkat, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Jon Mark Hirshon, MD, FACEP, chair of the Board; William Jaquis, MD, FACEP, president; Christopher Kang, MD, FACEP, secretary-treasurer; Mark Rosenberg, DO, FACEP, president-elect; and Ryan Stanton, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; Sandy Schneider, MD, FACEP; Travis Schulz, MLS, AHIP; Sam Shahid, MBBS, MPH; Dean Wilkerson, JD, MBA, CAE; Carole Wollard; and Laura Wooster, MPH.

Officer and Staff Reports

Speaker

Dr. Katz reported on the recent Board of Directors retreat. He also discussed the complaints from some of the candidates about alleged campaign violations that occurred during ACEP19 and the investigation that he and Dr. Gray-Eurom conducted. The Candidate Forum Subcommittee will review potential changes to the Candidate Campaign Rules to address several issues, including negative campaigning.

Vice Speaker

Dr. Gray-Eurom thanked everyone for their participation and commitment to the College.

President

Dr. Jaquis reported on ACEP’s federal strategy to address out-of-network balance billing, discussions with United Healthcare and about downcoding practices, and the meeting held on January 21 with the Society of Hospital Medicine. Three new task forces will be appointed to address rural emergency medicine, the future of emergency medicine, and Amended Resolution 58(19) Private Equity in Emergency Medicine. An RFP is being developed for a consultant to conduct market analysis to assist the private equity task force in their work.

President-Elect

Dr. Rosenberg discussed his plans to establish an ACEP Innovation Center during his term as president.
Executive Director

Mr. Wilkerson provided an update on several ACEP initiatives: ACEP19 success and planning underway for ACEP20 in Dallas, Clinical Emergency Data Registry, the pain management accreditation program, JACEP Open launch, strategic planning for FY 20-21, and the executive director search process. He briefly discussed ACEP’s membership challenges and the plans to test some membership models in cooperation with chapters. Dr. Linzer suggested targeting pediatric fellows for membership recruitment and engagement.

Steering Committee Expectations

Dr. Katz reminded the Steering Committee of their expectation to attend the April 26, 2020, Steering Committee meeting in Washington, DC and the entire Leadership & Advocacy Conference April 27-28. The Steering Committee will also meet at 6:00 pm on Friday, October 23, 2020, in Dallas, the evening prior to the Council meeting. Steering Committee members were also reminded that supporting NEMPAC and EMF is strongly encouraged as part of their leadership role.

Councillor Allocation

Dr. Katz reported that councillor allocation for 2020 is 443, which is an increase of 10 councillors than were allocated for the 2019 meeting. AR, CO, DC, FL, KS, MA, MI, NM, NY, PA, VT, and WA each gained one councillor. CT lost one councillor and Government Services lost two councillors. The new Aerospace Medicine Section has not yet met the minimum membership requirement of 100 members and was not allocated a councillor for the 2020 meeting. All other sections met the minimum membership requirement and will have a councillor for the 2020 Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Gray-Eurom presented the report from the Tellers, Credentials, & Elections Committee from the 2019 Council meeting, including the results of the demographic data questions. There were 433 councillors allocated for the 2019 meeting and 433 were credentialed. There were no problems identified regarding the electronic voting system, including voting on resolutions and the elections. The summary of responses to the demographic questions were provided to the Steering Committee. It was suggested that a report be prepared comparing the responses to the demographic questions that have been asked every year for the past several years.

2019 Council Meeting Minutes

The Steering Committee reviewed the draft 2019 Council meeting minutes. The minutes will be provided to the 2020 Council for approval at the annual meeting.

2019 Council Meeting

Dr. Katz and Dr. Gray-Eurom discussed various aspects of the 2019 Council meeting and requested suggestions for potential changes for the 2020 meeting. Several ideas were discussed such as convening the Council meeting earlier to allow additional times for Reference Committee hearings. The Annual Meeting Subcommittee will review the Council meeting agenda and provide suggestions for potential changes to the agenda for the Steering Committee to consider at the April meeting. There was consensus to maintain the Town Hall meeting as an interactive session and allow time for questions and answers. Several topics were suggested for the 2020 Town Hall meeting: private equity in emergency medicine, emergency medicine workforce, and out-of-network/surprise billing legislation. The Annual Meeting Subcommittee will provide additional suggestions for the Town Hall meeting topic. The subcommittee will also review the demographic data questions and provide suggestions for the 2020 questions.

Elections Process

Dr. Katz led a discussion of the campaign and elections process. There was consensus to continue the current
format of the Candidate Forum. It was noted that during the candidate opening statements to the Council, the speaker timers did not show negative time when the time limit was exceeded. Staff will work with the audio visual vendor to ensure that the timers are set appropriately. The Candidate Forum Subcommittee will review the Candidate Campaign Rules and provide suggestions for revisions, including a reference in item 16.a. that the candidate will be interrupted when the time limit has been exceeded, and determine if any clarifications are needed regarding limitations for electronic communications. The subcommittee will also review the forms for the candidate campaign materials and provide recommendations for revisions to the Steering Committee.

**Potential Council Standing Rules Amendments**

The Steering Committee discussed the advisability of submitting a Council Standing Rules (CSR) amendment to specify that additional resolution cosponsors cannot be added after the resolution deadline. Ms. Montgomery explained that requests to add cosponsors after the deadline has increased over the past few years. It was suggested that the “Resolution Checklist” and the “Guidelines for Writing Resolutions” be distributed to chapters in addition to posting the information on the ACEP website. Additionally, it was suggested that the list of chapter executives, chapter presidents, and section chairs be made available with their contact information so that resolution authors can obtain the information more easily.

Ms. Montgomery asked the Steering Committee to consider submitting a CSR amendment to codify that commendation and memorial resolutions are not assigned to a Reference Committee.

Dr. Katz discussed expanding the use of the Unanimous Consent Agenda to include all recommendations from the Reference Committees, except for Bylaws resolutions since a 2/3 vote is required for adoption, with a proviso that the amendment would become effective after the 2020 Council meeting if adopted.

There was consensus for the Bylaws & Council Standing Rules subcommittee to prepare draft resolutions on these three issues for the Steering Committee to consider at the April 26, 2020, meeting.

Dr. Katz requested input from the Steering Committee about submitting a Bylaws and CSR amendment to update ACEP’s parliamentary authority to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*. There was consensus that a change is not needed until advised by ACEP’s parliamentarian.

**Council Forum at the 2020 Leadership & Advocacy Conference (LAC)**

Dr. Katz led a discussion regarding the Council Forum Session he is planning to hold at LAC. The Steering Committee expressed support for holding the session again this year to provide a brief orientation about the Council, discuss how to get involved in the Council, discuss current issues that may necessitate a resolution, and discuss resolution development.

**Action on Resolutions**

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2019, 2018, and 2017 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

**Subcommittee Appointments**

Dr. Katz announced that three Steering Committee subcommittees will be appointed: Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, and the Candidate Forum Subcommittee. Ms. Montgomery will email the objectives and deadlines for each subcommittee. Dr. Katz asked Steering Committee members to notify her with their interests in serving on two subcommittees. The subcommittee reports will be discussed at the April 26, 2020, Steering Committee meeting.
Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, April 26, 2020, at the Grand Hyatt in Washington, DC.

With no further business, the meeting was adjourned at 11:52 am Central time on Wednesday, January 22, 2020.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary and Executive Director

Approved by,

Gary R. Katz, MD, MBA, FACEP
Council Speaker and Chai
Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 1:00 pm Central time on Monday, April 27, 2020.

Steering Committee members present for all or portions of the meeting were: Angela Cornelius, MD, FACEP; Justin Fairless, DO, FACEP; Dan Freess, MD, FACEP; Kelly Gray-Eurom, MD, FACEP; Muhammad Husainy, DO, FACEP; Gary Katz, MD, FACEP, speaker; Rami Khoury, MD, FACEP; Jeffrey Linzer, MD, FACEP; Kurtis Mayz, MD, FACEP; Gregg Miller, MD, FACEP; Christina Millhouse, MD, FACEP; Aimee Moulin, MD, FACEP; James Mullen, MD, FACEP; Randy Pilgrim, MD, FACEP; Matthew Rudy, MD, FACEP; Karina Sanchez, MD; James Shoemaker, MD, FACEP; and Arvind Venkat, MD, FACEP.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP; Alison Haddock, MD, FACEP; Jon Mark Hirshon, MD, FACEP, chair of the Board; William Jaquis, MD, FACEP, president; Christopher Kang, MD, FACEP, secretary-treasurer; Mark Rosenberg, DO, FACEP, president-elect; Gillian Schmitz, MD, FACEP, vice president; Ryan Stanton, MD, FACEP; and Aisha Terry, MD, FACEP.

Staff present for all or portions of the meeting were: Michele Byers, CAE, CMP; Mary Ellen Fletcher, CPC, CEDC; Pawan Goyal, MD, MHA, FHIMSS; Maude Suprenant Hancock; Robert Heard, MBA, CAE; Harry Monroe; Margaret Montgomery, RN, MSN; Sonja Montgomery, CAE; Leslie Moore, JD; Sandy Schneider, MD, FACEP; Travis Schulz, MLS, AHIP; Sam Shahid, MBBS, MPH; Dean Wilkerson, JD, MBA, CAE; and Carole Wollard.

The minutes of the January 22, 2020, Steering Committee meeting were approved as written.

Officer and Staff Reports

Speaker

Dr. Katz informed the Steering Committee that staff are working with the Association of Academic Chairs in Emergency Medicine and the Society for Academic Emergency Medicine to confirm that a majority of their physician members are also members of ACEP. This verification is necessary per the College Manual so that both organizations can continue to be represented in the ACEP Council. A third party vendor has been suggested to verify the membership data and the fee for the verification will be split between the organizations.

Dr. Katz announced the 2020 Council awards recipients:

Council Meritorious Service Award – Michael McCrea, MD, FACEP
Council Teamwork Award – Harrison Alter, MD, FACEP; Mark Futernick, MD, FACEP; Aimee Moulin, MD, FACEP; and John Rogers, MD, CPE, FACEP
Council Horizon Award – Theresa Tran, MD, MBA, FACEP
Council Champion in Diversity & Inclusion Award – Andrea Green, MD, FACEP
Council Curmudgeon Award – William Mallon, MD, FACEP

Dr. Katz reported that the Nominating Committee met by conference call this morning to discuss the slate of candidates. The candidates have until May 4, 2020, to confirm acceptance of their candidacy. The slate will be announced once the candidates are confirmed.
Vice Speaker

Dr. Gray-Eurom provided highlights from the April 15, 2020, Board of Directors meeting.

President

Dr. Jaquis reported on the virtual Hill Visits scheduled for April 28, 2020, funding for COVID-19 treatment, and decreases in ED volume. He discussed the virtual interview process used for interviewing and selecting ACEP’s new Executive Director.

President-Elect

Dr. Rosenberg discussed his goals during his year as president and changes that will occur as a result of COVID-19. He expressed his concerns about emergency physician wellness and the potential for many members to combat PTSD as a result of COVID-19 while at the same time emergency physicians are receiving recognition as heroes during the pandemic and emergency medicine continues to be the safety net for health care. He reported on his hospital’s work in addressing the shortage of equipment and supplies to treat COVID-19 patients. He mentioned that the Board has not yet decided whether ACEP20 will be held in person or virtually and plans are in development to hold virtual chapter visits from ACEP Board members.

Executive Director

Mr. Wilkerson provided an update on several ACEP initiatives. He praised members and staff on their work during the past six weeks in developing COVID-19 resources that are being utilized by members and non-members. ACEP’s COVID-19 Field Guide was released recently and is the most popular resource at this time. Council Vice Speaker Kelly Gray-Eurom was one of the principal authors along with ACEP Board members Jeff Goodloe, MD, FACEP and Alison Haddock, MD, FACEP. Many medical organizations are providing links to this excellent resource. Mr. Wilkerson reported on the work underway by the Washington Office staff in sending letters to Congress on behalf of members, responding to media inquiries, and issuing press releases. The Corporate Development staff worked with various hotel chains and food delivery services to provide discounted or free services to members. ACEP is doing well financially because revenue from ACEP19, ACEPNow, and the Clinical Emergency Department Data Registry is higher than anticipated, staff were able to work with the various hotels to alleviate the hotel attrition penalties for the spring meeting cancellations, and because of reductions in travel and other expenses. The Finance Committee and the Board have approved pursuing a line of credit with a very low interest rate for cash flow. ACEP staff will continue to work from home until at least May 15. He gave some background information about ACEP’s new Executive Director Sue Sedory.

Mr. Heard reported on ACEP20 planning and contingency discussions for holding a virtual meeting. The Education Committee and its subcommittees are heavily involved in planning the meeting, however, pricing for virtual meetings is difficult to anticipate. Staff are working with the Exhibit Advisory Committee, comprised of key exhibitors for ACEP’s meetings, to explore options for a virtual exhibit hall that will retain engagement between attendees and exhibitors. He reported that the Scientific Assembly exhibit hall typically accounts for $2.5 million in revenue for ACEP.

Annual Meeting Subcommittee

Dr. Husainy presented the subcommittee’s report on their assigned objectives. The subcommittee reviewed the format and topics from previous Town Hall meetings and provided suggestions for the 2020 Town Hall meeting topic. It was suggested that this year’s Town Hall meeting focus on a unifying topic for emergency medicine. The subcommittee did not identify any changes to the format of the Town Hall meeting to recommend to the Steering Committee. The Council officers will make the final determination about the format, topic, and speakers this summer.

The subcommittee reviewed the Board’s actions on 2017-2019 resolutions and concurred that the actions taken to date are appropriate. The Actions on Resolutions reports will be updated this summer to reflect additional
activity that may have occurred since January 2020. The updated reports will be provided to the Council and will also be available in the Council section of the ACEP Website. Dr. Katz will highlight actions on some of the resolutions during his report to the Council.

The subcommittee reviewed the demographic questions from prior years and concurred that certain demographic questions should be asked every year to analyze changes within the Council. The subcommittee provided suggestions for questions related to COVID-19 and future pandemic response. The final questions will be developed this summer for approval by the Council officers.

The subcommittee reviewed the Council meeting agenda and did not identify any changes to recommend to the Steering Committee.

**Bylaws & Council Standing Rules Subcommittee**

Dr. Venkat presented the subcommittee’s report on their assigned objectives. The subcommittee recommended submitting a resolution to the 2020 Council to amend the Council Standing Rules (CSR) “Resolutions” section to codify that commendation and memorial resolutions are not assigned to a Reference Committee for deliberation and recommendation to the Council. There was consensus from the Steering Committee to submit the proposed resolution.

The subcommittee discussed the resolution deadline and whether additional cosponsors should be allowed after the deadline. The subcommittee agreed that a CSR amendment and a companion Bylaws amendment should be submitted to the 2020 Council clarifying that all resolution cosponsors must be confirmed at the time the resolution is submitted. There was consensus from the Steering Committee to submit the proposed resolutions.

The subcommittee discussed ways to streamline the process for resolution authors to obtain resolution cosponsors, including distributing the “Resolution Checklist” and the “Guidelines for Writing Resolutions” to chapters in addition to posting the information on the ACEP website. Additionally, it was suggested that the list of chapter executives, chapter presidents, and section chairs be made available with their contact information to assist resolution sponsors in contacting potential cosponsors.

The subcommittee discussed use of the Unanimous Consent Agenda and recommended submitting a resolution to the 2020 Council to amend the CSR so that all resolutions assigned to a Reference Committee, except Bylaws resolutions, will be placed on the Unanimous Consent Agenda. The proposed resolution contains a proviso that the changes will become effective after the 2020 Council meeting. There was consensus from the Steering Committee to submit the proposed resolution.

The subcommittee also discussed the CSR provision for limiting debate/voting immediately. Some subcommittee members were supportive of submitting a CSR amendment to change the requirements, although there was not a majority of support and no specific language was proposed. It was noted that the “Voting Immediately” section in the CSR specifies that “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.”

Dr. Venkat informed the Steering Committee that the Ethics Committee and the Bylaws Committee have been working on resolutions for amendments to the College Manual and the Bylaws regarding the Procedures for Addressing Charges of Ethical Violations and Other Misconduct. A similar College Manual resolution was submitted to the Council in 2019 but was withdrawn after concerns were raised about some of the language and the lack of a companion Bylaws resolution. The proposed revised Procedures and the accompanying proposed resolutions will be reviewed by the Board of Directors at their meeting in June. If approved, the resolutions will be cosponsored by the Board of Directors, the Bylaws Committee, and the Ethics Committee. The Steering Committee expressed support for the resolutions but did not desire to be a cosponsor.
Candidate Forum Subcommittee Report

Dr. Gray-Eurom presented the subcommittee’s report on their assigned objectives. The majority of the subcommittee’s objectives will be completed this summer and during the 2020 Council meeting.

The subcommittee provided suggestions for changes to items 13.h. and 16.a. of the Candidate Campaign Rules for the Steering Committee to consider. There was consensus to approve the proposed changes. It was suggested that the subcommittee conduct a comprehensive review of the Candidate Campaign Rules in 2021 and provide recommendations to the Steering Committee regarding any proposed revisions, including virtual campaigning such as video conferencing.

The subcommittee provided suggestions for changes to the Candidate Data Sheet and the Candidate Disclosure Statement for the Steering Committee to consider. There was consensus to support the changes to the Candidate Data Sheet regarding current emergency medicine practice and expert witness experience.

It was moved THAT THE STEERING COMMITTEE APPROVE THE CHANGES TO THE CANDIDATE DISCLOSURE STATEMENT. The motion was not adopted.

The Steering Committee recommended that CVs of all candidates be provided to the Council.

The assignments and duties for Candidate Forum moderators, coordinators, and door monitors were reviewed and will be reviewed again at the October 23 subcommittee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Friday, October 23, 2020, at the Omni Dallas Hotel in Dallas, TX. Dr. Katz stated it may be necessary for the Steering Committee to hold a conference call meeting prior to October 23 if it is determined that ACEP20 will be held as a virtual conference.

With no further business, the meeting was adjourned at 3:07 pm Central time on Monday, April 27, 2020.

Respectfully submitted,

Gary R. Katz, MD, MBA, FACEP
Council Speaker and Chair

Kelly Gray-Eurom, MD, MMM, FACEP
Council Vice Speaker and Vice Chair
Steering Committee Conference Call
June 9, 2020

Minutes

Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 7:05 pm Central time on Tuesday, June 9, 2020.

Steering Committee members present for all or portions of the meeting were: Justin Fairless, DO, FACEP; Dan Freess, MD, FACEP; Kelly Gray-Eurom, MD, FACEP; Muhammad Husainy, DO, FACEP; Gary Katz, MD, FACEP, speaker; Rami Khoury, MD, FACEP; Jeffrey Linzer, MD, FACEP; Kurtis Mayz, MD, FACEP; Gregg Miller, MD, FACEP; Christina Millhouse, MD, FACEP; Aimee Moulin, MD, FACEP; James Mullen, MD, FACEP; Randy Pilgrim, MD, FACEP; Karina Sanchez, MD; James Shoemaker, MD, FACEP; and Arvind Venkat, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Alison Haddock, MD, FACEP; Jon Mark Hirshon, MD, FACEP, chair of the Board; Christopher Kang, MD, FACEP, secretary-treasurer; Gabe Kelen, MD, FACEP; Mark Rosenberg, DO, FACEP, president-elect; Gillian Schmitz, MD, FACEP, vice president; and Aisha Terry, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Pawan Goyal, MD, MHA, FHMSS; Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; and Sandy Schneider, MD, FACEP.

Potential Modifications to the Candidate Campaign Rules for the 2020 Elections

Dr. Katz explained the concerns regarding requests from some chapters and sections for candidates to provide additional written materials such as responses to questions and newsletter articles. The Steering Committee acknowledged the need to maintain a high level of engagement with the candidates that allows members to discern the differences between candidates. There was consensus that a request for additional materials from candidates should be discouraged but not prohibited. It was noted that candidates’ participation in virtual chapter meetings or conference calls and providing additional materials is optional but declining could have unintended consequences. Additionally, it would be overwhelming if all chapter and sections made such requests, it could impede the candidate process by creating an additional burden, and could potentially deter members from seeking nomination in the future. The Council officers agreed to prepare a message to chapters and sections asking them to consider ways to engage with candidates, such as through the virtual town hall meetings hosted by the candidates or by their participation in a section or chapter leadership meeting, instead of requesting the submission of additional written materials. Additionally, chapters and sections should extend the offer to all candidates to participate in their leadership meetings.

Contingency Planning for 2020 Council Meeting

Dr. Katz reported on the American Medical Association’s (AMA) virtual House of Delegates meeting that was held on June 7, 2020. He participated as a voting delegate; Dr. Gray-Eurom, Ms. Fletcher, and Ms. Montgomery participated as observers. The AMA used the LUMI platform and had a limited agenda for the annual meeting. It is not known at this time whether the CommPartners platform, which has been used for the past several years, can accommodate the requirements for a virtual Council. Meeting. The Board of Directors will hold a special meeting on June 11, 2020 to determine whether ACEP20 will be held in-person, as a hybrid experience, or completely virtual. Per the Bylaws, the Council meeting agenda is determined by the Council officers, but the Board has the responsibility to determine the date and location of the annual Council meeting. The Steering Committee discussed the feasibility of holding the Council meeting in person meeting if ACEP20 is virtual. Staff will investigate the cost of the LUMI platform as an option for a virtual Council meeting.
With no further business, the meeting was adjourned at 8:30 pm Central time on Tuesday, June 9, 2020.

Respectfully submitted,

[Signatures]

Gary R. Katz, MD, MBA, FACEP  
Council Speaker and Chair

Kelly Gray-Eurom, MD, MMM, FACEP  
Council Vice Speaker and Vice Chair
Steering Committee Conference Call  
August 25, 2020

Minutes

Speaker Gary Katz, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 10:05 am Central time on Tuesday, August 25, 2020.

Steering Committee members present for all or portions of the meeting were: Angela Cornelius, MD, FACEP; Justin Fairless, DO, FACEP; Dan Freess, MD, FACEP; Kelly Gray-Eurom, MD, FACEP; Gary Katz, MD, FACEP, speaker; Jeffrey Linzer, MD, FACEP; Kurtis Mayz, MD, FACEP; Gregg Miller, MD, FACEP; Christina Millhouse, MD, FACEP; James Mullen, MD, FACEP; Matthew Rudy, MD, FACEP; Karina Sanchez, MD; James Shoemaker, MD, FACEP; and Arvind Venkat, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Sonja Montgomery, CAE; and Susan Sedory, MA, CAE.

Dr. Katz and Dr. Gray-Eurom updated the Steering Committee about implementation plans for the virtual Council meeting regarding the LUMI platform, the Council meeting agenda, Reference Committee hearings, discussion of Reference Committee reports, the Candidate Forum for the president-elect candidates and Board of Directors candidates, and the need to develop Temporary Council Standing Rules for this year only. The Temporary Council Standing Rules are being drafted by ACEP’s Parliamentarian, Jim Slaughter and will be distributed to the Council on September 24, 2020 with the Council meeting materials.

With no further business, the meeting was adjourned at 11:00 am Central time on Tuesday, August 25, 2020.

Respectfully submitted,

Gary R. Katz, MD, MBA, FACEP  
Council Speaker and Chair

Kelly Gray-Eurom, MD, MMM, FACEP  
Council Vice Speaker and Vice Chair
DEFINITION OF COUNCIL ACTIONS

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

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

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

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

NOT ADOPT
Defeat (or reject) the resolution in original or amended form.
2020 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-23

Andrea L. Green, MD, FACEP (TX), Chair
Bradley Burmeister, MD (WI)
Angela P. Cornelius, MD, FACEP (TX)
Douglas M. Char, MD, FACEP (MO)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Michael Ruzek, DO, FACEP (NJ)

Leslie Moore, JD
Maude Surprenant Hancock
Shari Purpura

Reference Committee B
Advocacy & Public Policy
Resolutions 24-39

Ashley Booth-Norse, MD, FACEP (FL), Chair
Sara A. Brown, MD, FACEP (IN)
John M. Gallagher, MD, FACEP (KS)
William D. Falco, MD, FACEP (WI)
Heidi C. Knowles, MD, FACEP (TX)
Jay Mullen, MD, FACEP (ME)

Ryan McBride, MPP
Jeff Davis
Brad Gruehn

Reference Committee C
Emergency Medicine Practice
Resolutions 40-52

Hilary Fairbrother, MD, FACEP (TX) Chair
Shamie Das, MD, FACEP (GA)
Heather M. Heaton, MD, FACEP (MN)
Todd Slesinger, MD, FACEP (FL)
Alison Smith, MD, MPH, (UT)
Nicole A. Veitinger, DO, FACEP (OH)

Margaret Montgomery, RN, MSN
Paul Krawietz
Mandi Mims, MLS
Travis Schulz, MLS, AHIP
Background information has been prepared on the resolutions that were submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting.

Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council and are for information only.

Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Here is our plan for conducting the Reference Committees this year:
1. October 14 (or sooner if possible) – a communication portal will be open where members can provide testimony or recommendations for amendments on any of the resolutions assigned to a Reference Committee. A notification will be sent when this communication portal is open.
2. October 21 – the asynchronous testimony will end at 12:00 pm Central (1:00 pm Eastern, 11:00 am Mountain, 10:00 am Pacific, 7:00 am Hawaii) and the Reference Committees will meet by Zoom to deliberate and develop a preliminary report that will be published to the Council the following day.
3. The preliminary report will serve as the launching point for synchronous “live” testimony during the virtual Reference Committee hearings on Saturday, October 24, the first day of the Council meeting.
4. October 24 – The Reference Committee hearings will occur in succession – A, B, C – so everyone can participate. One hour per Reference Committee has been allotted. It is expected that everyone will make good use of the asynchronous communication prior to the meeting to make their statements and will not repeat those statements during the virtual hearings on Saturday.
5. After the virtual hearings, each Reference Committee will convene in executive session to amend their preliminary report based on the live testimony. The final report will be published to the Council that evening.
6. October 25 – During Sunday’s Council meeting, the Reference Committee chairs will present the final Reference Committee reports in succession – A, B, C. One hour per Reference Committee has been allotted.

Your Council officers,

Gary R. Katz, MD, MBA, FACEP
Speaker

Kelly Gray-Eurom, MD, MMM, FACEP
Vice Speaker
## 2020 Council Resolutions

<table>
<thead>
<tr>
<th>Resolution #</th>
<th>Subject/Submitted by</th>
<th>Reference Committee</th>
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| 1           | Commendation for Stephen H. Anderson, MD, FACEP  
*Washington Chapter* |                     |
| 2           | Commendation for James J. Augustine, MD, FACEP  
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| 3           | Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP  
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| 4           | Commendation for Janyce M. Sanford, MD, MBA, FACEP  
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| 5           | Commendation for Dean Wilkerson, JD, MBA, CAE  
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| 6           | In Memory of Walter J. Bradley, III, MD, MBA, FACEP  
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| 7           | In Memory of Lorna Breen, MD, FACEP  
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| 11          | Council Resolution Sponsors and Cosponsors - Bylaws Amendment  
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David W. Wright, MD, FACEP | |
RESOLUTION: 1(20)

SUBMITTED BY: Washington Chapter

SUBJECT: Commendation for Stephen H. Anderson, MD, FACEP

WHEREAS, Stephen H. Anderson, MD, FACEP, has served the American College of Emergency Physicians with highest distinction since becoming a member in 1997; and

WHEREAS, Dr. Anderson provided outstanding leadership to the Washington Chapter through his service as an alternate councillor in 2008, councillor 2009-14, the Board of Directors 2008-17, as chapter president 2011-12, and has maintained an active presence in the chapter; and

WHEREAS, While serving on the Washington Chapter’s Board of Directors, Dr. Anderson fought flawed public policies surrounding restricted access to care for state Medicaid patients, boarding of behavioral health patients in the ED, and co-authored the “Washington State 7 Best Practices,” which many states now use as a template to increase patient access, coordinate care of high utilizers, save lives, and save Medicaid costs; and

WHEREAS, Dr. Anderson was elected to the national ACEP Board of Directors in 2014, re-elected in 2017, served as Secretary-Treasurer 2017-18, and as chair of the Board 2018-19; and

WHEREAS, Dr. Anderson has served as a member and Board Liaison to numerous ACEP committees, task forces, and sections; and

WHEREAS, Dr. Anderson served on the Emergency Medicine Foundation Board of Trustees 2016-20 and as its chair in 2019 and continues to support his commitment to emergency medicine through contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. Anderson has shown his commitment to emergency medicine advocacy initiatives by his contributions to the National Emergency Medicine Political Action Committee; and

WHEREAS, Dr. Anderson has been an articulate spokesperson for ACEP and received ACEP’s Spokesperson of the Year Award in 2013; and

WHEREAS, Dr. Anderson is a passionate advocate for patients and is committed to addressing coordination of care and social determinants of care with particular emphasis on opioid use disorder and behavioral health emergencies; and

WHEREAS, Dr. Anderson has diligently devoted his heart, energy, humor, and dedication; and

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

RESOLVED, That the American College of Emergency Physicians commends and thanks Stephen H. Anderson, MD, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.
RESOLUTION: 2(20)

SUBMITTED BY: Ohio Chapter

SUBJECT: Commendation for James J. Augustine, MD, FACEP

WHEREAS, James J. Augustine, MD, FACEP, has been a steadfast member of the American College of Emergency Physicians since 1983; and

WHEREAS, Dr. Augustine has extensive service in leadership roles for the Ohio Chapter and served on the chapter’s Board of Directors 1989-02 and as chapter president 1994-95; and

WHEREAS, Dr. Augustine served on the national ACEP Board of Directors 2013-19 and brought the breadth and depth of his experience to his role on the Board of Directors; and

WHEREAS, Dr. Augustine has shown exemplary leadership and outstanding service with his dedication, tireless efforts, and expertise by serving as a member and Board liaison to a variety of ACEP committees, task forces, sections, and as a member of the ACEP Now Editorial Advisory Board; and

WHEREAS, ACEP’s Clinical Emergency Data Registry was created in 2014 and Dr. Augustine has been instrumental in guiding its development, expansion, and success as a critical resource for ACEP and emergency medicine for quality measurement; and

WHEREAS, Dr. Augustine is a recognized pioneer and leader in the field of EMS and disaster medicine, serving as the first chair of the Ohio EMS Board, and as chair of ACEP’s EMS-Prehospital Care Section 1995-96; and

WHEREAS, Dr. Augustine is a national consultant, author, and speaker on emergency department operations and design; and

WHEREAS, Dr. Augustine’s commitment to emergency medicine advocacy and research initiatives is exemplified by his contributions to the National Emergency Medicine Political Action Committee, the Emergency Medicine Foundation, and through his participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. Augustine has had a profound, positive, and enduring impact on emergency medicine, has been a mentor to many, and will continue to serve the College and the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends James J. Augustine, MD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.
RESOLUTION: 3(20)

SUBMITTED BY: Maryland Chapter

SUBJECT: Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP

WHEREAS, Jon Mark Hirshon, MD, MPH, PhD, FACEP, has served the American College of Emergency Physicians with honor and dedication since becoming a member in 1991; and

WHEREAS, Dr. Hirshon has enjoyed a distinguished career in emergency medicine by continually striving for excellence as a compassionate and skilled emergency physician and is dedicated to improving access to high quality acute care in the United States and internationally; and

WHEREAS, Dr. Hirshon has a passion for learning as evidenced by his completion of residencies in emergency medicine and preventive medicine, earning a master’s degree in public health with special emphasis on international health, and a Doctor of Philosophy degree in epidemiology; and

WHEREAS, Dr. Hirshon is a federally funded researcher and teacher and has been the principal investigator/program director on more than $8 million in federal research and training grants and contracts and has been co-investigator on numerous other funded projects; and

WHEREAS, Dr. Hirshon is a recognized public health expert, served on ACEP’s Public Health Committee 1996-06 and as chair 1998-99 and 2003-06, and served as ACEP’s liaison representative to the American Public Health Association 2001-10; and

WHEREAS, Dr. Hirshon was elected to the national ACEP Board of Directors in 2014, was re-elected in 2017, and was elected by his peers on the Board of Directors to serve as Vice President 2018-19 and as Chair of the Board 2019-20; and

WHEREAS, Dr. Hirshon has served as a member, chair, and Board Liaison on numerous committees, task forces, expert panels, and sections; and

WHEREAS, Dr. Hirshon was a vital member of ACEP’s second National Report Card on the State of Emergency Medicine, served as chair of the third task force, and participated in multiple media interviews regarding the Report Card; and

WHEREAS, Dr. Hirshon demonstrated leadership through chapter involvement as a member of the Maryland Chapter, serving on the Board of Directors 2000-09, as chapter president 2004-07, and maintaining an active presence in the chapter during his tenure on the national ACEP Board of Directors; and

WHEREAS, Dr. Hirshon is a leader in international emergency medicine, is an active member of ACEP’s International Emergency Medicine Section, serves on the International Ambassador Program Committee, and is the College’s international ambassador to the emergency medicine communities in Egypt and Sudan; and

WHEREAS, Since 2015, Dr. Hirshon has served as chair of the Emergency Department Sickle Cell Care Coalition, which is comprised of multiple stakeholder groups from emergency medicine, pediatrics, hematology, and patient advocacy, and is focused on providing a national forum for the improvement of the ED care of patients with Sickle Cell Disease in the United States; and
Resolution (20) Commendation for Jon Mark Hirshon, MD, MPH, PhD, FACEP
Page 2

WHEREAS, Dr. Hirshon has contributed to the growth and maturation of emergency medicine and will continue to serve the College and the specialty of emergency medicine in the future; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Jon Mark Hirshon, MD, MPH, PhD, FACEP, for his devotion as an emergency physician, educator, and leader in emergency medicine.
RESOLUTION: 4(20)

SUBMITTED BY: Alabama Chapter

SUBJECT: Commendation for Janyce M. Sanford, MD, MBA, FACEP

WHEREAS, Janyce M. Sanford, MD, MBA, FACEP, served with distinction and dedication as the Chair and Chief of Service for the Department of Emergency Medicine at the University of Alabama at Birmingham for 12 years; and

WHEREAS, Dr. Sanford played a critical role in the evolution and current success of the Department of Emergency Medicine at the University of Alabama at Birmingham across three missions of service, teaching, and research; and

WHEREAS, Dr. Sanford provided critical leadership during a period of unprecedented growth, the number of visits to the University Emergency Department has increased over 100%, additional clinical sites have been added, and the faculty has doubled as well; and

WHEREAS, Dr. Sanford cultivated an emergency medicine residency program that has become one of the most competitive and respected training programs in the Southeast and the research program of the department is currently ranked #11 in the country in terms of National Institutes of Health funding; and

WHEREAS, Dr. Sanford has been a mentor for hundreds of emergency physicians, encouraging their interests, helping them find their voice, and guiding their careers; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Janyce M. Sanford, MD, MBA, FACEP, for her service as Chair and Chief of Service for the Department of Emergency Medicine at the University of Alabama at Birmingham.
RESOLUTION: 5(20)

SUBMITTED BY: Board of Directors
Council Officers

SUBJECT: Commendation for Dean Wilkerson, JD, MBA, CAE

WHEREAS, Dean Wilkerson, JD, MBA, CAE, served the American College of Emergency Physicians with honor and distinction as its Executive Director and Council Secretary from April 2004 to July 2020; and

WHEREAS, During Mr. Wilkerson’s tenure, ACEP achieved unprecedented growth as an organization from 23,000 members and a budget of $18 million to more than 40,000 members and a budget of $44 million; and

WHEREAS, As ACEP’s membership grew, the composition of the Council increased from 269 councillors allocated in 2004 to 443 councillors allocated for the 2020 annual meeting; and

WHEREAS, ACEP’s annual meeting attendance increased from 4,492 registrants in 2004 to an all-time high of 7,479 in 2018; and

WHEREAS, Mr. Wilkerson developed an outstanding professional staff and increased staffing to provide additional services and value to members; and

WHEREAS, Mr. Wilkerson led ACEP to increase its presence and recognition within the media, embraced an increased social media presence, expanded ACEP’s pursuit and procurement of grants, and magnified advocacy initiatives at the state and federal levels; and

WHEREAS, Under Mr. Wilkerson’s direction, ACEP held its first rally on Capitol Hill on September 27, 2005, with more than 4,000 physicians, nurses, and other emergency health care professionals participating to advocate for the “Access to Emergency Medical Services Act of 2005,” which generated significant media coverage to highlight emergency medicine and access to care; and

WHEREAS, The “Access to Emergency Medical Services Act” was reintroduced multiple times and was subsequently included in the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148); and

WHEREAS, Mr. Wilkerson championed providing additional services to chapters such as the state public policy tracking service, development of chapter newsletters and chapter websites, supported chapter advocacy efforts and established the State Public Policy Grant Program; and

WHEREAS, Mr. Wilkerson guided ACEP through several major overhauls of the ACEP website, creation of the daily customized news briefing EM Today, the reengineering of ACEP Now into a premier publication for emergency medicine, and the launch of ACEP’s open access journal JACEP Open; and

WHEREAS, Mr. Wilkerson directed ACEP to publish the first National Report Card on the State of Emergency Medicine, published in 2005, with media coverage on network television, radio, and in major news publications, and additional reports were published in 2009 and 2014 that helped drive ACEP’s advocacy agenda; and

WHEREAS, In 2009, Mr. Wilkerson was selected as #37 on the Top 100 Most Influential People in Healthcare by Modern Healthcare magazine; and
Resolution 5(20) Commendation for Dean Wilkerson, JD, MBA, CAE
Page 2

WHEREAS, Through Mr. Wilkerson’s leadership, The Future of Emergency Medicine paper was published in 2010; and

WHEREAS, After adoption of the Affordable Care Act, the Emergency Medicine Action Fund (now known as the Emergency Medicine Policy Institute), was created in 2011 and has funded many important projects including the Value of Emergency Medicine Study conducted by the RAND Corporation and published in 2013; and

WHEREAS, Through Mr. Wilkerson’s guidance, ACEP provided the initial funding for the Emergency Medicine Foundation endowment fund in 2012; and

WHEREAS, The Clinical Emergency Data Registry was created in 2014 and is now a cornerstone asset of ACEP and emergency medicine as quality measurement and improvement continues to be important to the specialty and payers; and

WHEREAS, Mr. Wilkerson was responsible for numerous innovative projects within ACEP such as the Geriatric Emergency Department Accreditation Program, the Pain and Addiction Care in the ED Accreditation Program, the Emergency Medicine Practice Research Network, emergency medicine point-of-care tools for use at the bedside, and multiple other clinical resources for emergency physicians; and

WHEREAS, Mr. Wilkerson was instrumental in the decision to build a new headquarters for national ACEP that reflects the bold and progressive character of emergency medicine and the project was completed on time and under budget in 2016; and

WHEREAS, Besides demonstrating his exemplary leadership qualities at ACEP, Mr. Wilkerson also served in significant positions in the association community by serving on the Board of Directors of the Texas Society of Association Executives (2010-13), the American Society of Association Executives (2011-14); the Foundation for Advancing Alcohol Responsibility National Advisory Board (2017-present), the HeartGift Foundation (2017-present), the Council of Medical Specialty Societies Nominating Committee (2018-22), the Visit Dallas Leadership Council (2019-present) and served as chair of the Specialty Society CEO Coalition (S2C2 Group) (2010-12) and chair of the Key Professional Associations Committee of the American Society of Association Executives (2012-13); and

WHEREAS, Mr. Wilkerson led ACEP skillfully during the COVID-19 pandemic of 2020; and

WHEREAS, Mr. Wilkerson provided strong and trusted counsel to the physician leadership of the College and contributed to the growth and maturation of emergency medicine; and

WHEREAS, The patients seeking emergency care in the United States have benefited from his focus on our College as a standard bearer for high quality emergency medicine; and

WHEREAS, The specialty of emergency medicine has benefited tremendously from Mr. Wilkerson’s vision, dedication, and leadership during the past sixteen years; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Dean Wilkerson, JD, MBA, CAE, for his outstanding contributions to ACEP and the specialty of emergency medicine.
WHEREAS, The specialty of emergency medicine lost a beloved leader who provided over 25 years of distinguished service to Emergency Medical Services and emergency preparedness when Walter J. Bradley, III, MD, MDA, FACEP, passed away on February 9, 2020, at the age of 63; and

WHEREAS, Dr. Bradley chaired the Illinois College of Emergency Physicians (ICEP) EMS Committee and Illinois EMS Forum for six years and was a member and officer of the ICEP Board of Directors from 2000-2007 when he stepped down to be appointed Senior Medical Administrator for the Illinois Department of Public Health (IDPH); and

WHEREAS, After leaving IDPH, Dr. Bradley served as Director of the Illinois State Police Tactical Response Team; he was as a leader in the tactical medicine community for more than 15 years including being a contributor to the Tactical Medicine Essentials textbook endorsed by ACEP and published in 2011, and he remained as Medical Director for the Illinois State Police until the time of his death; and

WHEREAS, Dr. Bradley also served as Chair of the Board of International Trauma Life Support (ITLS) for four years and he traveled the world, including to Mexico, England and Poland to bring trauma care education to new markets and under his leadership ITLS grew to be the leading pre-hospital trauma education program in the world; and

WHEREAS, Dr. Bradley was recognized with numerous awards including being the inaugural recipient of the National Association of Emergency Medical Technicians (NAEMT) Richard Ferneau EMS Medical Director of the Year award, the IDPH Directors Award for Outstanding Services and Leadership in EMS, and the ICEP Downstate Member of the Year Award; and

WHEREAS, Dr. Bradley was a mentor and member of 100 Black Men, a group dedicated to providing and promoting educational opportunities for young Black men; and

WHEREAS, Despite his many medical struggles, Dr. Bradley always had a joke to share or a story to tell; he was a lover of vintage cars, fine wine, and Harley Davidsions; he made regular trips to Sturgis, SD, for the famous annual motorcycle rally, and “SwatDoc” was a charter member of the Renegade Pigs Motorcycle Club; therefore be it

RESOLVED, That the American College of Emergency Physicians (ACEP) cherishes the memory of Walter J. Bradley, III, MD, MBA, FACEP, whose philosophy and approach to patient care was “Whatever the hour you may come, you will find light, hope, and human kindness,” and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to his wife Meme, son Ryan, and the extended Bradley and Wood families gratitude for his tremendous service to emergency medicine and EMS.
RESOLUTION: 7(20)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Lorna Breen, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a dedicated, compassionate physician and colleague in Lorna Breen, MD, FACEP, who passed away on April 26, 2020, at the age of 49; and

WHEREAS, Dr. Breen received her medical degree from the Medical College of Virginia and completed a combined residency in emergency medicine and internal medicine at Hofstra Northwell Health Long Island Jewish Medical Center in Queens, NY, where she served as Chief Resident in 2003, and currently was pursuing an Executive MBA/MS in Healthcare Leadership at Cornell SC Johnson College of Business; and

WHEREAS, Dr. Breen served as the Site Director at the New York-Presbyterian – Allen Hospital Department of Emergency Medicine and was a distinguished faculty member and an assistant professor of emergency medicine at Columbia University Vagelos College of Physicians and Surgeons; and

WHEREAS, Dr. Breen served as a physician educator since 2004 to numerous residents, medical students, advanced practice practitioners, nurses, and staff of the Columbia University Department of Emergency Medicine; and

WHEREAS, Dr. Breen devoted herself as a staunch advocate of her patients and colleagues and made enduring contributions to the operations and teaching programs at Columbia University Irving Medical Center; and

WHEREAS, Dr. Breen served as a member of the New York ACEP Board of Directors from 2007 to 2010, was a member of the New York ACEP Practice Management Committee, was a contributor to the New York ACEP EPIC newsletter, and served on the national ACEP Emergency Medicine Practice Committee; and

WHEREAS, Dr. Breen’s spirit, dedication, and passion for her work was contagious and she made others strive to be better, regardless of the role or discipline; and

WHEREAS, Dr. Breen was a loving and devoted daughter, sister, and friend who will be missed by family and colleagues; therefore be it

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Lorna Breen MD, FACEP, our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of New York and the United States.
RESOLUTION: 8(20)

SUBMITTED BY: Government Services Chapter

SUBJECT: In Memory of Col (ret) Christopher Scharenbrock MD, CPE, FACEP

WHEREAS, The specialty of emergency medicine and the Government Services Chapter of the American Emergency Physicians (GSACEP) lost a compassionate physician, military officer and leader, colleague, and friend in Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, who passed away unexpectedly on November 4, 2019, at the age of 53; and

WHEREAS, Colonel Scharenbrock was a distinguished graduate of the United States Air Force Academy and Uniformed Services University of the Health Sciences School of Medicine starting as a General Medical Officer in emergency medicine and subsequently completing his emergency medicine residency top of his class at the San Antonio Uniformed Services Health Education Consortium; and

WHEREAS, Dr. Scharenbrock was respected for his sharp clinical acumen, platinum standard patient care, calm under fire, selfless service, humility, and compassion to patients and colleagues always with his trademark continuous smile and optimism; and

WHEREAS, Dr. Scharenbrock was equally as impressive as a leader, a certified physician executive, twice Emergency Department Director, and ultimately Chief Medical Officer (CMO) at David Grant Medical Center leading to the hospital being recognized as 2012 Best Air Force Hospital and Best Inpatient Safety Program; and

WHEREAS; Colonel Scharenbrock was a combat warrior, five times deploying in harm’s way, first Air Force physician to volunteer for Afghanistan Provincial Reconstruction Team with over 286 combat missions “outside the wire” while training Afghan nationals to build a healthcare system, earning him the 2007 Lt Gen Paul Meyers Award; and

WHEREAS; Dr. Scharenbrock was a renaissance man who loved travel, sharing wine with friends, gardening, and could fix anything, he found his resilience through his greatest priority and joy in life – his beloved daughters and wife; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Colonel (ret) Christopher G Scharenbrock, MD, CPE, FACEP, as one of the leaders in emergency medicine and military medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to his wife Mary, his daughters Emily and Anna, his extended family, colleagues, and friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine, military medicine, and to the countless patients and physicians across the world whom he selflessly served.
2020 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-23

Andrea L. Green, MD, FACEP (TX), Chair
Bradley Burmeister, MD (WI)
Angela P. Cornelius, MD, FACEP (TX)
Douglas M. Char, MD, FACEP (MO)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Michael Ruzek, DO, FACEP (NJ)

Leslie Moore, JD
Maude Surprenant Hancock
Shari Purpura
RESOLUTION: 9(20)

SUBMITTED BY: Board of Directors
Bylaws Committee
Todd B. Taylor, MD, FACEP

SUBJECT: ACEP Committee Quorum Requirement – Housekeeping Amendment

PURPOSE: Amends the Bylaws to define the quorum requirement for all ACEP committees as a majority of the voting membership of the committee.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws and add the clarification to the Committee Manual.

WHEREAS, Parliamentary procedure is important in deliberations by all ACEP committees; and

WHEREAS, The quorum requirement for ACEP committees is not defined in the Bylaws; and

WHEREAS, This lack of definition has created some confusion, especially considering there are often both voting and non-voting members of committees and committee chairs and staff may not always be fully cognizant of the default quorum requirements within ACEP’s designated parliamentary authority; and

WHEREAS, This amendment is a simple, straightforward housekeeping amendment that will help to avoid such confusion; therefore be it

RESOLVED, That the ACEP Bylaws Article XI – Committees, Section 1 – General Committees, be amended to read:

The president shall annually appoint committees and task forces to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. **A majority of the voting membership of a committee shall constitute a quorum.**

The president shall appoint annually committees on Compensation, Bylaws, and Finance.

Background

This resolution amends the Bylaws to specify that the quorum requirement for all ACEP committees is a majority of the voting membership of the committee.

Committee quorum requirements are not currently defined in the Bylaws. The lack of definition has created some confusion because many of ACEP’s committees have voting and non-voting members. ACEP’s designated parliamentary authority, *The Standard Code of Parliamentary Procedure*, suggests that an organization’s Bylaws “should state the number or proportion of members that constitutes the quorum. In the absence of such a provision, parliamentary law fixes the quorum at a majority of the members.” A quorum is required for a committee to conduct official committee business. The proposed Bylaws amendment defines the quorum requirement for all ACEP committees as a majority of the voting membership of the committee. By clearly stating the quorum requirement in the Bylaws, the College will ensure that any committee recommendations to the Board of Directors are valid.
ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Bylaws and add the clarification to the Committee Manual

Prior Council Action

None specific to defining a quorum in the Bylaws for ACEP committees.

Prior Board Action

June 2020, approved cosponsoring the “ACEP Committee Quorum Requirement – Bylaws Housekeeping Amendment” with the Bylaws Committee for submission to the 2020 Council.

Background Information Prepared by: Leslie P. Moore, JD
General Counsel and Chief Legal Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 10(20)

SUBMITTED BY: Council Steering Committee

SUBJECT: Commendation and Memorial Resolutions

PURPOSE: Amends the Council Standing Rules to codify that commendation and memorial resolutions are not assigned to a Reference Committee for deliberation and recommendation to the Council.

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

WHEREAS, The Council Standing Rules specify that resolutions submitted by the deadline will be assigned to a Reference Committee for deliberation and recommendation to the Council; and

WHEREAS, Traditionally, commendation and memorial resolutions, whether submitted by the deadline, or submitted as a late or emergency resolution, are not assigned to a Reference Committee for discussion and recommendation to the Council; and

WHEREAS, The Council Standing Rules should be amended to codify this practice; therefore be it

RESOLVED, That the Council Standing Rules, “Reference Committees” section, paragraph one, be amended to read:

“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, except for commendation and memorial resolutions. Reference Committee meetings are open to all members of the College, its committees, and invited guests.”; and be it further

RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

“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 component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body.

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

Background information, including financial analysis, will be prepared by staff on all resolutions, except for commendation and memorial 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, except for commendation and memorial resolutions. 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, except for commendation and memorial resolutions. 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.
Resolution 10(20) Commendation and Memorial Resolutions
Page 3

Background

This resolution amends the Council Standing Rules to codify that commendation and memorial resolutions are not assigned to a Reference Committee for deliberation and recommendation to the Council.

Traditionally, since 2004, commendation and memorial resolutions, whether submitted by the deadline, or as late or emergency resolutions, are not assigned to a Reference Committee for discussion. The Council Standing Rules (CSR) currently specify that resolutions submitted by the deadline, will have background information prepared, including a financial analysis, and will be assigned to a Reference Committee for deliberation and recommendation to the Council. Late and emergency resolutions, if accepted by the Council, do not have background information prepared, but are assigned to a Reference Committee.

Prior to 2004, commendation and memorial resolutions were assigned to a Reference Committee. The resolutions rarely, if ever, received any testimony and all were adopted by the Council. Background information was not prepared on commendation and memorial resolutions and has not been prepared on these resolutions since 2004. All memorial resolutions are adopted by the Council observing a moment of silence on the first day of the Council meeting; all commendation resolutions are adopted by acclamation during the Council Awards Luncheon on the second day of the Council meeting.

The Steering Committee discussed commendation and memorial resolutions at their meetings in January and April 2020 and determined that a CSR amendment should be submitted to the 2020 Council. ACEP’s parliamentarian has not advised that any changes are needed in the CSR to reflect this traditional practice, however, he has not advised against it either. There have not been any questions or complaints from the Council since commendation and memorial resolutions were removed from Reference Committee deliberation beginning in 2004.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

None specific to commendation and memorial resolutions in the Council Standing Rules.

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

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

Reviewed by:  Gary Katz, MD, MBA, FACEP, Speaker  Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker  Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 11(20)

SUBMITTED BY: Council Steering Committee

SUBJECT: Council Resolution Sponsors and Cosponsors

PURPOSE: Amends the Bylaws to specify that all resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting; and

WHEREAS, For the past few years there have been an increasing number of requests to add cosponsors to resolutions after the submission deadline; and

WHEREAS, Staff have accommodated all requests to add cosponsors after the submission deadline because the Bylaws and the Council Standing Rules do not prohibit it; and

WHEREAS, The leniency in allowing additional cosponsors after the resolution deadline creates an impression that the deadline can be extended to garner additional support for a resolution; therefore be it

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 6 – Resolutions, paragraph one, be amended to read:

Resolutions pertinent to the objectives of the College or in relation to any report by an officer or committee of the College shall be submitted in writing at least 90 days in advance of the Council meeting at which they are to be considered. Resolutions submitted within 90 days of the Council meeting shall be considered only as provided in the Council Standing Rules. Each resolution must be signed by at least two members of the College. All resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.

Background

This resolution amends the Bylaws to specify that all resolution sponsors and cosponsors (i.e., “submitters”) must be confirmed at the time the resolution is submitted. There is also a companion Council Standing Rules (CSR) resolution.

The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting, and must be submitted (sponsored) by at least two members of the College. For the past few years there has been an increasing number of requests to add names of cosponsors, whether individuals or component bodies, to resolutions after the submission deadline. Although only two members are required to submit a resolution, having multiple cosponsors for a resolution indicates that the resolution has significant support. Staff have accommodated all requests to add cosponsors after the submission deadline because the Bylaws and the Council Standing Rules (CSR) do not prohibit it. However, there is a potential for error if the resolution file has already been sent to staff to develop background information and multiple resolution files are in circulation. The leniency in allowing additional cosponsors after the deadline creates an impression that the deadline can be extended to garner additional support for
the resolution before the resolutions are released to the Council, which occurs not less than 30 days prior to the Council meeting.

The Steering Committee discussed resolution sponsors and cosponsors at their meetings in January and April 2020 and determined that a Bylaws amendment and companion CSR amendment should be submitted to the 2020 Council.

**ACEP Strategic Plan Reference**

None

**Fiscal Impact**

Budgeted staff resources to update the Bylaws.

**Prior Council Action**

Resolution 14(11) Endorsements for Council Resolutions and Bylaws Amendments not adopted. This proposed Bylaws resolution sought to change the requirements for submission of all Council resolutions to include sponsorship from the president or chair representing a component body of the Council, the national Board of Directors, or a committee of the College and would have eliminated the ability of only two members submitting a resolution.

Resolution 3(79) amended the Constitution and Bylaws to require that resolutions must be submitted by at least two members of the College.

**Prior Board Action**

None

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

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
**Council Standing Rules Amendment**

**RESOLUTION:** 12(20)

**SUBMITTED BY:** Council Steering Committee

**SUBJECT:** Council Resolution Sponsors and Cosponsors

<table>
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<tr>
<th>PURPOSE: Amends the Council Standing Rules to specify that all resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.</th>
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<td>FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules.</td>
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WHEREAS, The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting; and

WHEREAS, For the past few years there have been an increasing number of requests to add cosponsors to resolutions after the submission deadline; and

WHEREAS, Staff have accommodated all requests to add cosponsors after the submission deadline because the Council Standing Rules and the Bylaws do not prohibit it; and

WHEREAS, The leniency in allowing additional cosponsors after the resolution deadline creates an impression that the deadline can be extended to garner additional support for a resolution; therefore be it

RESOLVED, That the Council Standing Rules, “Resolutions” section, be amended to read:

“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 component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body. **All resolution sponsors and cosponsors must be confirmed at the time the resolution is submitted.**

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

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

**Background**

This resolution amends the Council Standing Rules to specify that all resolution sponsors and cosponsors (i.e., “submitters”) must be confirmed at the time the resolution is submitted. A companion Bylaws resolution has also been submitted.
Resolution 12(20) Council Resolution Sponsors and Cosponsors – CSR Amendment

The deadline for all Council resolutions, as delineated in the Bylaws, is at least 90 days prior to the Council meeting, and must be submitted (sponsored) by at least two members of the College. For the past few years there has been an increasing number of requests to add names of cosponsors, whether individuals or component bodies, to resolutions after the submission deadline. Although only two members are required to submit a resolution, having multiple cosponsors for a resolution indicates that the resolution has significant support. Staff have accommodated all requests to add cosponsors after the submission deadline because the Bylaws and the Council Standing Rules (CSR) do not prohibit it. However, there is a potential for error if the resolution file has already been sent to staff to develop background information and multiple resolution files are in circulation. The leniency in allowing additional cosponsors after the deadline creates an impression that the deadline can be extended to garner additional support for the resolution before the resolutions are released to the Council, which occurs not less than 30 days prior to the Council meeting.

The Steering Committee discussed resolution sponsors and cosponsors at their meetings in January and April 2020 and determined that a Bylaws amendment and companion CSR amendment should be submitted to the 2020 Council.

ACEP Strategic Plan Reference
None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 14(11) Endorsements for Council Resolutions and Bylaws Amendments not adopted. This proposed Bylaws resolution sought to change the requirements for submission of all Council resolutions to include sponsorship from the president or chair representing a component body of the Council, the national Board of Directors, or a committee of the College and would have eliminated the ability of only two members submitting a resolution.

Resolution 3(79) amended the Constitution and Bylaws to require that resolutions must be submitted by at least two members of the College.

Prior Board Action

Not applicable – the Board does not take action on Council Standing Rules resolutions.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

Bylaws Amendment

RESOLUTION: 13(20)

SUBMITTED BY: Zachary Jarou, MD, MBA
Kurtis Mayz, JD, MBA, FACEP
Emergency Medicine Residents’ Association
Young Physicians Section

SUBJECT: Counting Fellowship Training Time Toward FACEP

PURPOSE: Amends the Bylaws to permit candidate physician members in post-residency training programs immediately following an emergency medicine residency program who have opted to continue as candidate members have the time spent in the fellowship training program count toward the three years of continuous membership immediately prior to election to ACEP Fellow status.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws. Potential increased revenue for FACEP application fees.

WHEREAS, Upon the completion of residency, many emergency physicians complete fellowships in subspecialty areas of emergency medicine; and

WHEREAS, Upon the completion of residency, fellows are eligible to continue their ACEP membership by either becoming a “regular” member of ACEP or by continuing as a “candidate” member; and

WHEREAS, Most fellows are paid salaries according to institutional pay scales and receive compensation similar to residents; and

WHEREAS, Candidate membership is more affordable for fellows; and

WHEREAS, Candidate membership includes EMRA membership, which allows fellows to continue to receive the majority of benefits they received as residents; and

WHEREAS, Candidate members may make significant post-residency contributions to the College while completing additional fellowship training; and

WHEREAS, Other emergency medicine organizations provide members with “fellow status” immediately upon graduation from residency; and

WHEREAS, Attaining FACEP status may increase long-term membership retention and involvement with ACEP; therefore be it

RESOLVED, That the ACEP Bylaws, Article V – ACEP Fellows, Section 1 - Eligibility, be amended to read:

ARTICLE V — ACEP FELLOWS
Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, 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.

Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate, and determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee.

Background

This resolution amends the Bylaws to permit candidate physician members in post-residency training programs immediately following an emergency medicine residency program who have opted to continue as candidate members have the time spent in the fellowship training program count toward the three years of continuous membership immediately prior to election to ACEP Fellow status.

ACEP candidate members who enter fellowship training programs directly after completion of an emergency medicine residency program have the option of transitioning to regular membership (pay regular dues) or remain as a candidate member (pay candidate dues) until completion of the fellowship training program. Members who remain in the candidate member category while completing the fellowship training program do not currently have that time count toward the three years of continuous membership to qualify for ACEP Fellow status. Since 3.A. stipulates "exclusive of residency training," this proposed change in the ACEP Fellow requirements cannot be misinterpreted to include all candidate physician members.

There are currently 639 candidate members in a fellowship program based on ACEP membership statistics as of August 31, 2020.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement
   Objective B – Increase total membership and retain graduating residents.
Resolution 13(20) Counting Fellowship Training Time Toward FACEP – Bylaws Amendment
Page 3

Fiscal Impact

Budgeted staff resources to update the Bylaws. Potential increased revenue for FACEP application fees.

Prior Council Action

The Council has discussed and adopted numerous resolutions regarding ACEP Fellows (FACEP) requirements, but none that are specific to allowing candidate physician members to qualify.

Amended Resolution 7(13) Candidate Members in Fellowship Training adopted. This Bylaws amendment clarified that residents entering a fellowship program directly upon completing an emergency medicine residency have the option to remain a candidate member or transition to active membership.

Prior Board Action

Amended Resolution 7(13) Candidate Members in Fellowship Training adopted.

February 2013, approved cosponsoring the resolution Candidate Members in Fellowship Training with the Bylaws Committee for submission to the 2013 Council.

June 2011, assigned an objective to the Bylaws Committee to propose Bylaws revisions to allow candidate members entering a fellowship, after completion of an emergency medicine residency, the option of active membership.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 14(20)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Ethics Procedures

PURPOSE: Amends the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due process to ensure it is fair to both the complainant and respondent; and

WHEREAS, A review by legal counsel, the ACEP Board of Directors, and a subcommittee comprised of members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee determined that a more efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually; and

WHEREAS, The ACEP Board of Directors has approved a revision to the Procedures for Addressing Charges of Ethical Violations and Other Misconduct, which creates a subcommittee appointed to review ethics complaints and make determinations regarding disciplinary action against members; and

WHEREAS, The current Bylaws state that only the ACEP Board of Directors has the power to impose disciplinary action on a member, and as such, a revision to the Bylaws is required to reflect the Board’s right to appoint a designated body to make such determinations on its behalf; therefore be it

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 3 – Agreement, and Section 4 – Disciplinary Action, be amended to read:

Section 3 — Agreement

Acceptance of membership in the College shall constitute an agreement by the member to comply with the ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member’s right to be or to remain a member, subject to Article IV, Section 4 of these Bylaws and the due process as described in the College Manual.

All right, title, and interest, both legal and equitable, of a member in and to the property of this organization shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of the member's name from the roll of members; c) the member’s death or resignation.

Section 4 — Disciplinary Action

Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors, or a designated body appointed by the Board of Directors for such purpose, for good cause. Procedures for such disciplinary action shall be stated in the College Manual.
Resolution 14(20) Ethics Procedures
Page 2

Background

This resolution amends the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual. A companion College Manual resolution has also been submitted.

The Board of Directors submitted a College Manual resolution to the 2019 Council to amend by substitution the Procedures for Addressing Charges of Ethical Violations and Other Misconduct for consideration. Upon review by the Bylaws Committee and prior to the 2019 Council meeting, concerns were raised that the revised Procedures may be in conflict with the Bylaws because the Bylaws currently state that only the Board of Directors has the power to impose disciplinary action on a member. The Bylaws Committee recommended adding a provision to the Bylaws allowing a “designated body appointed by the Board of Directors” to review ethics complaints and make determinations regarding disciplinary action against members. As such, the resolution was withdrawn from the 2019 Council meeting based on these recommendations. A subcommittee was then assigned, comprised of members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee to revise the Procedures and draft revisions to the Bylaws to address this issue. The College Manual amendment is submitted as Resolution 15(20) Procedures for Addressing Ethical Violations & Other Misconduct.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement
   Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

None that is specific to designating a body appointed by the Board of Directors to render a decision regarding disciplinary action.

Prior Board Action

June 2020, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting College Manual and Bylaws resolutions to the 2020 Council.

Background Information Prepared by: Leslie Patterson Moore, JD
   General Counsel and Chief Legal Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
   Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
   Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 15(20)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Procedures for Addressing Charges of Ethical Violations and Other Misconduct

PURPOSE: Amend by substitution the Procedures for Addressing Charges of Ethical Violations and Other Misconduct to create a more efficient complaint review process and clarify procedural issues.

FISCAL IMPACT: Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due process to ensure it is fair to both the complainant and respondent; and

WHEREAS, A review by legal counsel, the ACEP Board of Directors, and a subcommittee comprised of members of the Ethics Committee, Bylaws Committee and the Medical-Legal Committee determined that a more efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually; and

WHEREAS, The ACEP Board of Directors approved a revision to the Procedures for Addressing Charges of Ethical Violations and Other Misconduct at its meeting in June 2020; and

WHEREAS, Approval by the ACEP Council is required to include the revised document in the College Manual; therefore be it

RESOLVED, That the College Manual be amended by substitution of the Procedures for Addressing Charges of Ethical Violations and Other Misconduct to read:

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in accordance with College policy.

A. Definitions

1. ACEP means the American College of Emergency Physicians.
3. Procedures means the Procedures for Addressing Charges of Ethical Violations and Other Misconduct.
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.
5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
6. Board Hearing Panel conducts all hearings and consists of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee.
7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

B. Complaint Received

A complaint may be initiated by an ACEP member, chapter, committee, or section. No others have standing to present a complaint.

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, current ACEP "Principles- Code of Ethics for Emergency Physicians," other current ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within twelve (12)-ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, the Ethics Committee, the Bylaws Committee, the Board of Directors, any additional ACEP review body listed in these Procedures, and to the respondent should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to the complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgment to the complainant confirming the complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing and identifying the elements, guidelines and timetables that must be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the Procedures.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” (“Procedures”) Procedures.
3. Notifies the ACEP President and the eChair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the eChair of the Ethics and/or Committee, the Bylaws Committee, or other committee desigee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics for Emergency Physicians, or ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
   b. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee chair, or other committee desigee, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics for Emergency Physicians, and if so, forwards the complaint and the response together, as soon as after both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose. Complaint Review Panel, or
c. Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee or other committee designee, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as after both are received, to each member of the Bylaws Committee, or at the discretion of the Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or

d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Board of Directors Ethics Complaint Review Panel or the Bylaws Committee will review the President’s action, at the next regularly scheduled Board meeting. The President’s action can be overturned by a majority vote of the Board, or applicable ACEP review body.

e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

5. Within ten (10) business days after the determinations specified in Section B.C.4.b. or Section B.C.4.c. of these Procedures, forwards the complaint to the respondent by certified U.S. mail USPS Certified Mail with a copy of these Procedures and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the Board applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent’s rights in the hearing, and a list of the names of the members of the ACEP Ethics Committee or the ACEP Bylaws Committee, as appropriate, ACEP review body, including, and the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.

6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics Committee Complaint Review Panel or the Bylaws Committee, or the subcommittee appointed to review the complaint, as appropriate.

D. Ethics Committee Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section B.C.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of current the ACEP “Principles Code of Ethics for Emergency Physicians” or other current ACEP ethics policies as they existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current Applicable version of the ACEP “Principles Code of Ethics for Emergency Physicians” or other current ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of current the applicable version of the ACEP “Principles Code of Ethics for Emergency Physicians” or other current ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.
7. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors Decides to:
a. Dismiss the complaint; or
b. **Take Ethics Complaint Review Panel renders a decision to impose disciplinary action, the**
specifies of which shall be included in the committee’s report, **based on the written record.**

8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a
subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall
appoint this subcommittee and designate one of its members to chair the subcommittee. The
subcommittee may seek counsel from other consultants with particular expertise relevant to the matter
under consideration. In the event that a subcommittee is appointed, it shall deliver its report and
recommendations to the Board of Directors.

6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to
Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review
Panel’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written
record.

7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint
Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will
implement its decision to impose disciplinary action based on the written record.

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**E. Bylaws Committee Complaint Review Process [within sixty (60) days of the forwarding of the**
complaint/response specified in Section B.C.4.b.c. above] **

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed
at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third
parties, or experts regarding the complaint.
4. Considers whether:
   a. **Current Applicable version of the ACEP Bylaws apply.**
   b. Alleged behavior constitutes a violation of **current the applicable version of the ACEP Bylaws.**
   c. Alleged conduct warrants censure, suspension, or expulsion.

5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action. A minority reports may also
be presented.

7. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In
its report, the Bylaws Committee shall recommend that the Board of Directors

**Decides to:**
   a. Dismiss the complaint; or
   b. **Take Bylaws Committee renders a decision to impose disciplinary action, the specifics of which**
shall be included in the committee’s report, **based solely on the written record.**

8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a
subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall
appoint this subcommittee and designate one of its members to chair the subcommittee. The
subcommittee may seek counsel from other consultants with particular expertise relevant to the matter
under consideration. In the event that a subcommittee is appointed, it shall deliver its report and
recommendations to the Board of Directors.

6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the
respondent will be provided with notification of the Bylaws Committee’s determination and the
option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee’s decision based solely on the written record.

7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee
decision based solely on the written record, the Bylaws Committee will implement its decision to
impose disciplinary action based on the written record.

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E. Board of Directors
1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.

2. May request further information in writing from the complainant and/or respondent.

3. Decides to:
   a. Dismiss the complaint; or
   b. Render a decision to impose disciplinary action based on the written record.

4. If the Board determines to impose disciplinary action pursuant to Section E.3.b., the respondent will be provided with notification of the Board’s determination and the option of:
   a. A hearing; or
   b. The imposition of the Board decision based solely on the written record.

5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.

6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee

1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.

2. The Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.

3. The Ad Hoc Committee:
   a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.
   b. May request further information in writing from the complainant and/or respondent.
   c. Decides to:
      i. Dismiss the complaint; or
      ii. Render a decision to impose disciplinary action based on the written record.
   d. If the Ad Hoc Committee determines to impose disciplinary action pursuant to Section F.3.c.ii., the respondent will be provided with notification of the Ad Hoc Committee’s determination and the option of:
      i. A hearing conducted by the Ad Hoc Committee; or
      ii. The imposition of the Ad Hoc Committee decision based solely on the written record.
   e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below.
   f. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated.
   g. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.
\section{F. Right of Respondent to Request a Hearing}

If the Board Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the option described in Section E.3.b., or an Ad Hoc Committee chooses the option described in Section F.3.c., the Executive Director will send to the respondent a written notice by certified U.S. mail USPS Certified Mail of the right to request a hearing, or to have the Board or the Ad Hoc Committee impose its decision based solely on the written complaint. This notice will list the respondent’s hearing rights as set forth in Section \section{G.} below. The respondent’s request for a hearing must be submitted in writing to the Executive Director within thirty (30) business days of receipt of the notice of right to a hearing. In the event of no response, the ACEP President may determine the manner of proceeding applicable ACEP review body will implement its final decision.

\section{G. Hearing Procedures}

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by certified U.S. mail USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F., Hearing Panel intends to call in the hearing.

2. The Executive Director will send a notification by USPS Certified Mail of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by certified U.S. mail.

3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.

4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.

5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.

6. The hearing may be conducted by the entire Board, by a subcommittee of three to five members of the Board of Directors, at the discretion of and as appointed by the chair of the Board of Directors or, if required pursuant to Section F., by an Ad Hoc Committee described in Section F. If the hearing is conducted by a subcommittee or by an Ad Hoc Committee that includes one or more Board members as described in Section F., the presiding officer of the hearing will be a Board member designated by the chair of the Board. The chair of the Board of Directors will act as the presiding officer throughout the hearing conducted by the full Board unless the chair is unable to serve or is disqualified from serving, in which case the ACEP President will designate a member of the Board of Directors to chair the hearing. If all Board members have recused themselves, the Ad Hoc Committee members shall choose an individual from among themselves to chair the hearing. If a subcommittee of the Board or an Ad Hoc Committee conducts the hearing, such hearing must take place with all of the parties and all the members of the subcommittee or ad hoc committee present in person. If the full Board conducts the hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take place by telephone conference call will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is impossible or commercially impracticable for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.

7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.

8. The Board, its appointed subcommittee, or an Ad Hoc Committee Hearing Panel will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.

9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee’s recommendation or
the Ad Hoc Committee’s decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.

10-9. The decision of the Board or Ad Hoc Committee Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board's or Ad Hoc Committee Board Hearing Panel's decision will be sent by certified U.S. mail USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board's or Ad Hoc Committee's Board Hearing Panel's decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the applicable ACEP review body in its review of the complaint. The Board shall review the Procedures used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these Procedures were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action: Censure, Suspension, or Expulsion and Disclosure to ACEP Members

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct is in conformity with the College’s ethical standards; it may detail the manner in which the Board—ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. The content of the written request by a member of ACEP, ACEP may confirm the censure; however, contents of the a private letter of censure shall not be disclosed provided, but the fact that such a letter has been issued shall be disclosed.
      ii. Public Censure: a public letter of censure informs in writing all members that a member’s conduct is in violation of the College’s ethical standards set forth in Section A.B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action.

2. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. ACEP President. At the end of the twelve (12) month period of suspension, the suspended member shall be offered, may request, reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to
the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

3. c. **Expulsion** from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. The expulsion of a member petitioned for reinstatement and, if so, the Board's decision on such petition shall be disclosed. If the five year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ACEP is also required to report the expulsion from membership and a description of the conduct that led to the Boards of Medical Examiners in the states in which the physician is licensed, which shall inform ACEP members that they may request further information about the disciplinary action to the National Practitioner Data Bank.

1. **Nature of Disciplinary Action**

   a. **Private censure**: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be. The published announcement shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed, also state which ACEP policy or Bylaws provision was violated by

   b. **Public censure**: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.

   c. **Suspension**: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which shall inform ACEP members that they may request further information about the disciplinary action to the National Practitioner Data Bank.

   d. **Expulsion**: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. **Scope and Manner of Disclosure**

   a. **Disclosure to ACEP members** Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section I.1.1.

   b. **Public-Disclosure to Non-Members**: If a non-member The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided.

K.1. **Ground Rules**

1. All proceedings are confidential until a final decision on the complaint is rendered by the Board of Directors or an Ad Hoc Committee pursuant to Section F, applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.

2. Timetable guidelines are counted by calendar days unless otherwise specified.

3. The Ethics Committee Complaint Review Panel, the Bylaws Committee, or the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee Hearing Panel, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee’s, Board’s, subcommittee’s, or Ad Hoc Committee’s overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board.
Resolution 15(20) Procedures for Addressing Charges of Ethical Violations and Other Misconduct
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424 beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee. ACEP review body’s overall time to complete its task.
425 4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
426 5. If a participant in this process (such as a member of the Ethics Committee Complaint Review Panel, the Bylaws Committee, or the Board of Directors Hearing Panel) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board, at which time the ACEP President will appoint a replacement.
427 6. Once the Board Ethics Complaint Review Panel or the Bylaws Committee has made a decision or implemented a decision of an Ad Hoc Committee pursuant to Section F, on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
428 7. The Board’s Ethics Complaint Review Panel or the Bylaws Committee’s decision or the decision of an Ad Hoc Committee pursuant to Section F to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
429 8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the Board or an Ad Hoc Ethics Complaint Review Panel, the Bylaws Committee, pursuant to Section F, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.
430 9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.
431 10. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

Background

This resolution amends by substitution the Procedures for Addressing Charges of Ethical Violations and Other Misconduct to create a more efficient complaint review process and clarify procedural issues. A companion Bylaws resolution has also been submitted.

In 1997, ACEP established procedures by which its members may initiate complaints against fellow members for violations of ACEP’s Code of Ethics for Emergency Physicians (“Code of Ethics”). These procedures have been revised several times, most recently in 2013. In accordance with the Procedures for Addressing Charges of Ethical Violations and Other Misconduct (the “Procedures”), the current structure for review of ethics complaints is:

1. ACEP’s President, Chair of the Ethics Committee, and its Executive Director conduct an initial review of a filed complaint, with input from the General Counsel. This review is limited to providing a determination as to whether the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in ACEP’s Code of Ethics or Bylaws or if it should move forward for additional review by ACEP’s Ethics Committee or subcommittee.1
2. Should the case proceed to a formal review, a subcommittee of the Ethics Committee examines the complaint and response of the accused. It then provides the Board of Directors with a written recommendation to either dismiss the complaint or take disciplinary action.

1 The Procedures also provide an opportunity for members to file complaints regarding violations of ACEP’s Bylaws; however, no complaint of this nature has ever been filed. As such, a discussion regarding complaints alleging violations of ACEP’s Bylaws have been omitted from this memo.
3. The Board of Directors reviews the complaint, response, and any additional information it deemed relevant. At its next meeting, the Board deliberates the ethics case and renders a determination to dismiss the complaint or impose disciplinary action.

4. If the respondent requests a hearing after receipt of notice regarding disciplinary action taken against him or her, an in-person hearing is held before the Board of Directors or a subcommittee of the Board.

Following establishment of the Procedures, 20 cases have been decided by the Board of Directors, 4 of which have resulted in hearings. The frequency of complaints varies annually; however, on average 1-2 cases are reviewed per year. During the 2017-18 fiscal year, the Board reviewed 3 cases, one of which required a hearing.

A 2017 survey of Ethics Committee members who have served on the complaint subcommittee revealed that each member spends an average of 8-12 hours reviewing case documents, as well as participating in a 90-120-minute conference call to deliberate the facts of the case and vote on a recommendation to the Board of Directors. This does not include additional hours required of the Chair of the subcommittee to collaborate with staff in drafting the recommendation, as well as participate in the Board deliberations and possible hearing.

The Board of Directors also spends a commensurate amount of time reviewing documents and preparing for ethics complaint deliberations. Should the respondent request a hearing in the case, a Board member will likely spend several hours refamiliarizing him/herself with the facts of the case. At Board meetings, deliberations and hearings can take up to 3 hours.

Because of the burden these responsibilities place on the Board and Ethics Committee, the committee was requested to develop an alternative process by which ethics complaints could be adjudicated in a manner that still provides adequate due process to the parties as required under the Health Care Quality and Improvement Act. After studying review processes used by other medical societies, researching ACEP’s legal responsibilities, and discussing the needs of the College, the following revised process is proposed:

Step 1. A broad review of the complaint by the ACEP President, Chair of the Ethics Committee, Chair of the Bylaws Committee, or other committee designee and ACEP’s Executive Director, with input from the General Counsel, to determine if the complaint alleges conduct that constitutes a violation of the Code of Ethics or other ACEP ethics policies, or of the ACEP Bylaws.

Step 2. The Ethics Complaint Review Panel or the Bylaws Committee will review the complaint and response from the parties and make its determination, which will be forwarded to the parties.

Step 3. Should a hearing be requested, a Board Hearing Panel consisting of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee will conduct the hearing and render its decision.

Step 4. At the next Board meeting following a final determination from the applicable ACEP review body, the Board will review the case for procedural matters only. It will not review the facts or merits of the case.

It is important that the Board maintain oversight of the process; however, this streamlined version should substantially reduce the amount of time and preparation required of the Board, as its role will be limited solely to ensuring the reviewing body acted in compliance with the Procedures. Several medical specialty societies, such as the American Academy of Otolaryngology and the Society of Thoracic Surgeons, engage in similarly structured reviews.

The Board of Directors submitted a similar resolution to the 2019 Council for consideration. Upon review by the Bylaws Committee and prior to the 2019 Council meeting, concerns were raised that the revised Procedures may be in conflict with the Bylaws because the Bylaws currently state that only the Board of Directors has the power to impose disciplinary action on a member. The Bylaws Committee recommended adding a provision to the Bylaws allowing a “designated body appointed by the Board of Directors” to review ethics complaints and make determinations regarding disciplinary action against members. As such, the resolution was withdrawn.
from the 2019 Council meeting based on these recommendations. A subcommittee was then assigned, comprised of members of the Ethics Committee, Bylaws Committee, and the Medical-Legal Committee to revise the Procedures and draft revisions to the Bylaws to address this issue. The Bylaws amendment is submitted as Resolution 14(20) Ethics Procedures.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement
   Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

Prior Council Action

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the ethics procedures in the College Manual. The changes addressed the timeliness of filing allegations, clarifications of aspects of the process, ensuring that deadlines are reasonable in light of process and review requirements, a respondent’s membership status during the pendency of an ethics complaint, and clarifications of the scope and disclosure of disciplinary actions.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to deadlines and provided mechanisms in the event that the number of Board recusals impacts the Board’s ability to act on ethics complaints.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to due process and the hearing procedures.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes related to the categories of sanctions and clarifying when disclosure of such sanctions may be appropriate or necessary.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes included enhancements related to communications, responsibilities, timelines, and voting.

Resolution 5(99) College Manual adopted that included the “Procedures for Addressing Ethics and Other Disciplinary Charges.” The resolution established the College Manual and defined the method for amending it.

Prior Board Action

June 2020, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting College Manual and Bylaws resolutions to the 2020 Council.

June 2019, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting a College Manual resolution to the 2019 Council.

December 2018, discussed revising the Procedures for Addressing Charges of Ethical Violations and Other Misconduct” to create a more efficient review process.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.
June 2013, reviewed the proposed changes to the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and approved submitting a College Manual resolution to the 2013 Council. Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

April 2010, reviewed the proposed changes to the “Procedures for Addressing Ethics and Other Disciplinary Charges” and approved submitting a College Manual resolution to the 2010 Council.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2007, reviewed the proposed changes to the “Procedures for Addressing Ethics and Other Disciplinary Charges” and requested additional changes to be reviewed and approved by the Board. Approved submitting a College Manual resolution to the 2007 Council.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.


**Background Information Prepared by:** Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
Bylaws Amendment

RESOLUTION: 16(20)

SUBMITTED BY: Board of Directors

SUBJECT: Special Board of Directors Meetings

PURPOSE: Amends the Bylaws to allow special meetings of the Board to be called by the chair of the Board in addition to the president with not less than 48 hours notice.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, Currently, only the president or one-third of the current members of the Board may call for a special meeting of the Board of Directors; and

WHEREAS, There are times when a special meeting of the Board needs to occur with less than 10 days notice; and

WHEREAS, If a special meeting of the Board of Directors is necessary with less than 10 days notice, Board members must agree to waive the 10-day notice requirement; therefore be it

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 3 – Meetings be amended to read:

Section 3 — Meetings

The Board of Directors shall meet at least three times annually. One of these meetings shall take place not later than 30 days following the annual meeting of the College. The other meetings shall take place at such other times and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A majority of the Board shall constitute a quorum.

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the members of the Board of Directors at a meeting of the Board of Directors.

Special meetings of the Board of Directors may be called by the president or the chair of the Board with not less than 48 hours not more than 50 days notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.
Background

This resolution amends the Bylaws to allow special meetings of the Board to be called by the chair of the Board in addition to the president with not less than 48 hours notice.

The current Bylaws stipulate that only the president or one-third of the current members of the Board may call for a special meeting of the Board of Directors. Since the chair of the Board is responsible for presiding at Board meetings, the chair should also have the ability to call a special meeting. The current requirement of “not less than 10 days” notice for a special Board meeting is not conducive for the Board to be able to act quickly on an emergent issue in today’s fast paced environment. The provision of “nor than 50 days notice” is unnecessary since email communications, notices on the ACEP website, and through ACEP’s all member engagED platform can quickly disseminate information about special Board of Directors meetings to members of the Board and the general membership.

Amended Resolution 3(89) Board of Directors Special Meetings, which was adopted by the Council and the Board of Directors, added the current language in the Bylaws regarding special meetings. This language was developed on the advice of an attorney based on a discussion of Resolution 17(88) Meetings of the Board of Directors (and other resolutions regarding meetings of the Board of Directors) that was referred to the Constitution & Bylaws Committee. At that time, the Texas Non-Profit Corporation Act required that notice be given with respect to special meetings and ACEP’s Bylaws did not contain a such a provision. ACEP’s Bylaws also contained a provision, and still does in Article III – College Meetings, stipulating that all meetings of the Board of Directors of the College are open to all members of the College except for closed sessions that may be called. In 1989, notification of special meetings was conducted by mail, telegram, fax, or notice in printed ACEP publications and a longer time period for notification was required.

ACEP’s parliamentary authority, The Standard Code of Parliamentary Procedure, provides additional guidance regarding special meetings of the Board of Directors by clarifying that any Board member that participates in a special meeting, and does not protest the lack of appropriate notice, waives notice by the fact of their attendance and participation. Any Board member who is unable to participate in the special meeting and does not object to the special meeting being held must provide a written waiver of notice prior to the special meeting. Quorum requirements for the special meeting still must be met.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Amended Resolution 3(89) Board of Directors Special Meetings adopted. The resolution amended the Bylaws to include the current language “with not less than 10 nor more than 50 days notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.”

Resolution 17(88) Meetings of the Board of Directors referred to the Constitution & Bylaws Committee.

Resolution 12(79) Meetings of the Board of Directors not adopted. The resolution sought to amend the Bylaws to allow special meetings to be called at the request of one-third of the members of the Board or by the president.
Prior Board Action

Amended Resolution 3(89) Board of Directors Special Meetings adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
Council Standing Rules Amendment

RESOLUTION: 17(20)

SUBMITTED BY: Council Steering Committee

SUBJECT: Unanimous Consent Agenda

PURPOSE: Amends the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, including recommendations for amendment or substitution of the resolution. Contains a proviso that changes are effective after the 2020 Council meeting.

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

WHEREAS, Use of the Unanimous Consent Agenda increases the efficiency of the Council; and

WHEREAS, Use of the Unanimous Consent Agenda for Reference Committee recommendations has increased over the past few years; and

WHEREAS, Many councillors have suggested that the Unanimous Consent Agenda be used for all resolutions, except for Bylaws resolutions, which require a two-thirds affirmative vote for adoption; and

WHEREAS, A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report; therefore be it

RESOLVED, That the Council Standing Rules, “Unanimous Consent Agenda” section, be amended to read as follows with the proviso that the changes will become effective after the 2020 Council meeting:

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

All resolutions assigned to a Reference Committee, except for Bylaws resolutions, and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee’s recommendation for adoption, referral, amendment, substitution, or defeat not for adoption for each resolution listed. A request for extraction of any resolution from a the 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.

Background

The resolution amends the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codifies that recommendations for amendment or substitution of the
resolution will be included on the Unanimous Consent Agenda, although amended and substitute resolutions have been included on the Unanimous Consent agenda in previous years.

Currently, the Unanimous Consent Agenda is used for resolutions that are non-controversial, or generated little/no debate, or had a clear consensus of opinion in favor, opposed, or for referral. If one person objects, then it is not unanimous, the item is removed from the Unanimous Consent Agenda, and the item is then debated and voted on by the Council. Use of the Unanimous Consent Agenda for Reference Committee recommendations has increased over the past few years with tremendous success in streamlining the Council meeting agenda. Many councillors have suggested that the Reference Committees place all resolutions on the Unanimous Consent Agenda, except for Bylaws resolutions since they require a 2/3 vote for adoption. There are multiple opportunities to provide feedback to the Reference Committee about a resolution whether through comments on the Council engagED platform, written testimony submitted in advance of the Council meeting, or in person testimony during the Reference Committee hearing.

The Steering Committee discussed use of the Unanimous Consent Agenda at their meetings in January and April 2020 and determined that a Council Standing Rules amendment should be submitted to the 2020 Council.

**ACEP Strategic Plan Reference**

None

**Fiscal Impact**

Budgeted staff resources to update the Council Standing Rules.

**Prior Council Action**

Resolution 14(17) Unanimous Consent not adopted. This resolution intended to amend the Council Standing Rules by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda with the Reference Committee’s recommendation for adoption, not adoption, or referral for each resolution and requiring a second for extraction.

Resolution 3(16) Unanimous Consent not adopted. The resolution intended to amend the Council Standing Rules to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction and, after reading the summary of the testimony from the Reference Committee report, a one-third affirmative vote of the councillors present and voting would be required to remove the item from consent.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. Revised several sections of the Standing Rules, including Unanimous Consent. The changes to this section were primarily editorial to provide clarity and also revised the section title from “Consent Calendar” to “Unanimous Consent Agenda.”

Resolution 19(02) Consent Calendar adopted. The resolution removed the statement “At the speaker’s discretion, without objection, such an item is extracted from the consent calendar.” If any credentialed councillor can request an item to be removed from consent, it is not at the speaker’s discretion.

**Prior Board Action**

Not applicable – the Board does not take action on Council Standing Rules resolutions.

**Background Information Prepared by:** Sonja Montgomery, CAE

Governance Operations Directors

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 18(20)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Emergency Medicine Residents’ Association
District of Columbia Chapter
Puerto Rico Chapter

SUBJECT: ACEP Membership and Leadership

PURPOSE: 1) Set benchmarks for improving racial/ethnic and gender diversity of its members, committee members, councillors, Council Officers, and Board of Directors; and 2) encourage community and academic emergency medicine groups to collect and publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity amongst its members.

FISCAL IMPACT: Budgeted resources for developing reports and encouraging other emergency medicine groups to collect and publish demographic data. Potential unbudgeted costs for obtaining demographic data from other sources for use in comparing ACEP’s data to assist with setting benchmarks.

WHEREAS, Diverse organizations have been shown to be more productive and satisfying to its members1; and

WHEREAS, A diverse ACEP membership and leadership will provide the collective perspective and diverse set of experiences to adequately address the disparities in health care and health outcomes; and

WHEREAS, ACEP is committed to increasing diversity and inclusion, including multigenerational diversity within the organizationii; and

WHEREAS, ACEP collection of member demographic data was found to be inadequate and incomplete by the ACEP Diversity and Inclusion Task Force in 2017; and

WHEREAS, ACEP does not routinely publish granular member demographic data; and

WHEREAS, ACEP does not set benchmarks for improving the diversity of its membership and leadership; and

WHEREAS, ACEP does not encourage community or academic emergency medicine groups to collect or publish demographic data about its members, or set benchmarks for improving their diversity; and

WHEREAS, The Leadership Diversity Task Force (LDTF) was assigned by the ACEP Board to fulfill the following objectives: 1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices. 2. Survey current pipeline programs within Council component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership. 3. Identify barriers to becoming a councillor, Council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type; and

WHEREAS, In June 2018, the Board of Directors approved the LDTF’s recommendations: 1. Collection of demographic data, including the proportion of underrepresented populations within ACEP’s overall membership and leadership (including the Board of Directors, Council, sections, and committees) and including, but not limited to, domains such as gender, race, ethnicity, sexual orientation, and age. 2. Reviewing diversity data every three years and
presenting the findings to the ACEP Council to determine whether efforts have been effective in promoting increased
diversity within ACEP leadership and to inform future initiatives to increase diversity; and

WHEREAS, Two years after the adoption of these recommendations, ACEP has yet to effectively
operationalize these measures as requested by the ACEP Council; and

WHEREAS, ACEP sets the philosophical and ethical standard for our specialty and must hold itself
accountable for evaluating and addressing its lack of diversity; and

WHEREAS, Only with structure and transparency will these ongoing barriers to inclusion be torn down;
therefore be it

RESOLVED, That ACEP set benchmarks for improving racial/ethnic and gender diversity of its members,
committee members, councillors, Council Officers, and Board of Directors; and be it further

RESOLVED, That ACEP encourage community and academic emergency medicine groups to collect and
publish demographic data about its members and set benchmarks for improving racial/ethnicity and gender diversity
among its members.

ii Rebecca Parker et al, “Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians’ Future

Background

This resolution requests ACEP to: 1) set benchmarks for improving racial/ethnic and gender diversity of its members,
committee members, councillors, Council Officers, and Board of Directors; and 2) encourage community and
academic emergency medicine groups to collect and publish demographic data about its members and set benchmarks
for improving racial/ethnicity and gender diversity among its members.

A comprehensive report of ACEP’s membership is available in the Council meeting materials as directed by
Amended Resolution 12(19) ACEP Composition Annual Report. The report includes demographics of councillors and
alternate councillors by chapter, ACEP’s committee and section leaders, Board of Directors, and general membership
stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.
The data is limited to the extent that members provide this information in their membership profile. Many members
choose not to answer certain profile questions, which can account for a higher number of “not specified” or
“unknown.” This report will serve as the foundation for comparison of the data in future years.

An infographic of the demographics of ACEP’s Board of Directors is posted on the ACEP Website.

As mentioned in the Whereas statement, ACEP has not established benchmarks for improving diversity of members
and leaders in the College. Such benchmarks would need to be set by the Board of Directors.

ACEP is committed to increasing the diversity of members in all leadership positions in the Council, the national
Board of Directors, committees, sections, and chapters. It is important for residents, young physicians, and others who
represent a minority of members of the College, to become active in their chapters and sections, seek appointment or
election as a councillor or alternate councillor within their chapter(approximately half of the ACEP chapters elect
councillors and alternate councillors and half appoint them) or section, and to apply for and be selected to serve on
national ACEP committees. It should be noted that committee members are selected from the applications submitted
by members who are interested in serving. Committee members are appointed based on their qualifications and
subject matter expertise.
The Nominating Committee’s role is limited to vetting candidates submitted by component bodies or self-nominations for leadership positions elected by the Council, which include the Board of Directors, President-Elect, Speaker, and Vice Speaker. No candidates have ever been excluded from nomination because of gender, ethnicity, political or religious beliefs, or sexual orientation.

Amended Resolution 14(18) Diversity of ACEP Councillors directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members. A notice was sent to chapters on March 27, 2019, reminding them of the adopted resolution. A follow up message was sent to chapters on February 17, 2020.

Resolution 12(18) Nominating Committee Revision to Promote Diversity amended the Council Standing Rules to provide further guidance to the Nominating Committee regarding candidate qualifications to increase leadership diversity.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership directed the ACEP Board of Directors to work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation. The resolution was addressed through the work of the Diversity & Inclusion Task Force, the Leadership Development Advisory Group (now formalized as the Leadership Development Advisory Committee), the Leadership Diversity Task Force (LDTF), and the National/Chapter Relations Committee. The Board of Directors accepted the final report from the Diversity & Inclusion Task Force in September 2018 and the final report of the Leadership Diversity Task Force in January 2019. The Diversity, Inclusion, & Health Equity Section continues to work on the strategies developed by the Diversity & Inclusion Task Force.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted resources for developing reports and encouraging other emergency medicine groups to collect and publish demographic data. Potential unbudgeted costs for obtaining demographic data from other sources for use in comparing ACEP’s data to assist with setting benchmarks.

Prior Council Action

Amended Resolution 12(19) ACEP Composition Annual Report adopted. Directed that ACEP provide the Council with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP’s committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 12(18) Nominating Committee Revision to Promote Diversity adopted. This Council Standing Rules amendment added further guidance regarding candidate qualifications to increase leadership diversity.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members.
Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership.

Prior Board Action


May 2018, approved the Leadership Diversity Task Force recommendations to collect demographic data, including the proportion of underrepresented populations within ACEP’s overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council.

April 2017, approved the Diversity & Inclusion Task Force’s recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges to the membership.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 19(20)

SUBMITTED BY: California Chapter
Maryland Chapter
Massachusetts College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians

Pennsylvania College of Emergency Physicians
New York Chapter
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
Emergency Medicine Residents’ Association

SUBJECT: Framework to Assess the Work of the College Through the Lens of Health Equity

PURPOSE: Develop a framework to assess the work of the College through an equity lens and provide to members biannually (every six months) an assessment of the work of the College through the lens of health equity.

FISCAL IMPACT: Budgeted staff resources. Potential unbudgeted additional resources needed to create the framework. Actual costs will be determined based on the scope of the framework created and whether honorarium or additional fees will be necessary to complete the development of the framework and production of the biannual report.

WHEREAS, A health disparity is defined as “a higher burden of illness, injury, disability, or mortality experienced by one group relative to another” (KFF); and

WHEREAS, Prior to the COVID-19 pandemic, significant disparities in emergency care already existed, as are described in the 2017 ACEP Information Paper, “Disparities in Emergency Care”; and

WHEREAS, The groups affected by healthcare disparities include (but are not limited to) racial and ethnic minority populations, the LGBTQ community, people with intellectual and physical disabilities, persons living with a mental health diagnosis; and

WHEREAS, The COVID-19 pandemic has highlighted and exacerbated health disparities affecting racial and ethnic minority groups, for example, the death rate of COVID-19 in some predominantly black counties is six-fold higher than in predominantly white counties; and

WHEREAS, Racial and ethnic minority groups in the U.S. disproportionately live in at-risk communities placing them at a greater risk for disease and have disproportionately more barriers to accessing care; and

WHEREAS, Addressing health equity and working to eliminate health disparities will require a multifaceted approach with an understanding that decisions in healthcare – from direct clinical care to how care is delivered, what care is delivered, and how care is paid for – have an impact on disparities; therefore be it

RESOLVED, That ACEP create or select a framework to assess the work of the College (position statements, adopted resolutions, task forces) through the lens of health equity; and be it further

RESOLVED, That ACEP provide to members a biannual assessment of the work of the College as it pertains to health equity.

Resources:
Background

This resolution calls for the College to develop a framework to assess the work of the College through an equity lens, (including position statements, adopted resolutions, task forces) and provide to members a biannual (every six months) assessment of the work of the College through the lens of health equity.

The Equitable Evaluation Initiative developed a framework in which organizations can evaluate assets and services to ensure they conceptualize and implement using an equitable lens. The framework is utilized by organizations to address the cultural appropriateness and validity of their methods. The framework is based on three principles:

1. Evaluation and evaluative work should be in service of equity.
2. Evaluative work can and should answer critical questions about the history and structure that contribute to the issues being addressed, effect of a strategy on different populations, and how cultural context is addressed.
3. Evaluative work should be designed and implemented commensurate with the values underlying equity work.

The information paper “Disparities in Emergency Care” complied and distributed information on health care disparities and strategies to address disparities. The areas addressed were:

1. Disparities in Practice
2. Disparities in Pre-Hospital Care
3. Disparities in Utilization
4. Disparities in Outcomes

Health disparities specifically related to COVID-19 are referenced in the ACEP COVID-19 Field Guide. The chapter on Racial and Ethnic Minority Groups explains the special considerations that need to be taken by physicians when screening and treating these patients.

ACEP is committed to increasing the diversity of members in leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. It is important for members of underrepresented groups of the College to become active in their chapters and sections, seek appointment or election as a councillor or alternate councillor, and to apply and be elected to serve on national ACEP committees.

Demonstrating the ongoing importance of this issue, 14 of ACEP’s committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted staff resources. Potential unbudgeted additional resources needed to create the framework. Actual costs will be determined based on the scope of the framework created and whether honorarium or additional fees will be necessary to complete the development of the framework and production of the biannual report.

Prior Council Action

None that is specific to assessing the work of the College through the lens of health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members. The policy statement is in development. The Diversity, Inclusion, & Health Equity Section continues to promote the Unconscious Bias in Clinical Practice course.
Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity

Amended Resolution 12(19) ACEP Composition Annual Report adopted. The resolution directed ACEP to provide an annual report to the Council on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP’s committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. A report has been prepared for the 2020 Council.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members. There was unanimous support for the intent of the resolution to increase diversity within the Council. The majority of those testifying believed that the language was not appropriate for the ACEP Bylaws. Testimony on behalf of state chapters emphasized the importance of chapter independence and that this would create roadblocks for small chapters because of the limited number of councillors allotted to them and it would force them to substitute a more knowledgeable councillor for those with less experience.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership. The Diversity & Inclusion Task Force and the Leadership Diversity Task Force were appointed in response to this resolution.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

April 2020, approved the revised policy statement “Cultural Awareness and Emergency Care;” reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

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

Amended Resolution 12(19) ACEP Composition Annual Report adopted

January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.

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

May 2018, approved the Leadership Diversity Task Force recommendations to collect demographic data. including the proportion of underrepresented populations within ACEP’s overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council. This action has been superseded by Amended Resolution 12(19) ACEP Composition Annual Report.


October 2017, reviewed the information paper “Disparities in Emergency Care.”
April 2017, reviewed the information paper “Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management.”

April 2017, approved the Diversity & Inclusion Task Force’s recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges to the membership.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted.

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

**Background Information Prepared by:** Riane Gay, MPA  
Senior Manager, Development & Special Projects

**Reviewed by:**  
Gary Katz, MD, MBA, FACEP, Speaker  
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION:  20(20)

SUBMITTED BY:  John Bibb, MD, FACEP
               Fred Dennis, MD, MBA, FACEP
               Emergency Medicine Residents’ Association
               California Chapter
               Florida College of Emergency Physicians
               Pain Management & Addiction Medicine Section

SUBJECT:  Kayce Anderson Award for Excellence in Innovations in the ED Care of Patients with Substance Use & Behavioral Health Issues

PURPOSE:  Create an annual award to honor emergency physicians named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

FISCAL IMPACT:  Budgeted staff resources for development and administration of the award. Approximately $500 for a master plaque at ACEP headquarters with the names of each year’s recipient(s). Potential $2,300 additional costs to include in the annual budget for cost of the award and travel expenses and waived registration fee to attend Scientific Assembly the year the award is received.

WHEREAS, The U.S. death toll from substance use and suicide exceeds 160,000 people annually causing the average life span to decline; and

WHEREAS, These afflictions are often chronic and relapsing and it is difficult to substantially alter the course in one ED visit; and

WHEREAS, Effective treatment and referral are necessary for long-term beneficial outcomes; and

WHEREAS, Successful innovations have been initiated by ED physicians in recent years, for example, the provision of ED social workers, effective referrals to outpatient care, and the initiation of buprenorphine in appropriate patients; and

WHEREAS, These advances in ED care have significantly improved the lives of many patients; and

WHEREAS, The joy of the practice of emergency medicine has been augmented by being able to offer these patients better care; and

WHEREAS, There is still a very substantial unmet need in the care of these patients; and

WHEREAS, These innovations should be publicized to further improve care; and

WHEREAS, An award for emergency physicians who have made innovations in the care of these patients may be used by the College to promote public relations; and

WHEREAS, Kayce Anderson, daughter of Stephen Anderson, MD, FACEP, and Kathy Anderson died of an opioid overdose, and her loss is symbolic of the profound effect mental health disorders and substance use disorders have on our patients, our own families, and each of us personally; therefore be it

RESOLVED, That ACEP honor emergency physicians with an annual award named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.
Background

This resolution seeks to create an annual award to honor emergency physicians named in memory of Kayce Anderson who have led the way in improving the care of patients with substance use and behavioral health issues.

ACEP has a robust awards program that recognizes leadership and excellence and provides an opportunity to recognize members for significant professional contributions as well as service to the College. Ten awards are administered by the Awards Committee, five awards by the Academic Affairs Committee, one award by the Disaster Preparedness & Response Committee, two awards by the Emergency Medicine Practice Committee, one award by the National/Chapter Relations Committee, two awards by the Public Relations Committee, one award by the Well-Being Committee, and 5 awards by the Council Awards Committee.

It is not known whether eligibility for this proposed award is intended to be limited to ACEP members or if non-members would also be eligible for nomination. The actual award criteria, eligibility, and benefits associated with receiving the award would need to be determined by the Board of Directors.

ACEP has several awards named in honor of prominent individuals who have had a significant impact on the College and emergency medicine:

- The John G. Wiegenstein Leadership Award is named after one of ACEP’s eight founding members and first president. It is ACEP’s highest award.
- The James D. Mills Outstanding Contribution to Emergency Medicine Award is named after ACEP’s second president and the designer of the “Alexandria Plan” for staffing emergency facilities with full-time practitioners of emergency medicine.
- The John A. Rupke Legacy Award is named after one of ACEP’s eight founding members and is given for outstanding lifetime contributions to the College.
- The Pamela P. Bensen Trailblazer Award is named after the first woman resident in emergency medicine who was also the first woman elected to the national ACEP Board of Directors.
- The Judith E. Tintinalli Award for Outstanding Contribution in Education is named after the author of one of the premier emergency medicine textbooks.
- The Colin C. Rorrie, Jr, PhD Award for Excellence in Health Policy is named after ACEP’s second executive director who was instrumental in the development of ACEP’s Washington office and in elevating the stature of emergency medicine’s advocacy efforts.
- The Diane K. Bollman Chapter Advocate Award is named after the former executive director of the Michigan College of Emergency Physicians who served in that role for 25 years.

ACEP sections also have the ability to create and administer awards. Another option for administration of this award is through the Pain Management & Addiction Medicine Section.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective F – Provide and enhance leadership development and recognition and strengthen liaison relationships with other emergency medicine organizations.

Fiscal Impact

Budgeted staff resources for development and administration of the award. Approximately $500 for a master plaque at ACEP headquarters with the names of each year’s recipient(s). Potential $2,300 additional costs to include in the annual budget for cost of the award and travel expenses and waived registration fee to attend Scientific Assembly the year the award is received.
Resolution 20(20)   Kayce Anderson Award for Excellence in Innovations in the ED Care of Patients with Substance Use & Behavioral Health Issues

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Prior Council Action

None that is specific to recognizing innovations in the ED care of patients with substance use and behavioral health issues.

Prior Board Action

The Board has approved the creation of many awards but none that is specific to recognizing innovations in the ED care of patients with substance use and behavioral health issues.

The Board approves ACEP award recipients each year.

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

Reviewed by:  Gary Katz, MD, MBA, FACEP, Speaker
    Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
    Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 21(20)

SUBMITTED BY: Marc Futernick, MD, FACEP
Katelyn Moretti, MD, MS
Nikhil Ranadive, MD, MS
Caitlin Rublee, MD, MPH
Joshua Weil, MD
California Chapter
Wisconsin Chapter

SUBJECT: Medical Society Consortium on Climate & Health

PURPOSE: Requests that ACEP become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

FISCAL IMPACT: Approximately $1,000 for travel costs to attend the annual meeting and unknown cost for the registration fee. Potential membership fee to join as a member society.

WHEREAS, According to the World Health Organization, climate change is “the greatest threat to global health in the 21st century” and
WHEREAS, In the United States, adverse public health impacts resulting from climate change include, but are not limited to: 1) the increasing exposure of an aging population to increasingly severe and frequent heatwaves; 2) decreasing worker productivity due to extreme heat; and 3) substantial premature mortality attributable to fine particulate air pollution; and
WHEREAS, According to the Intergovernmental Panel on Climate Change, climate-related risks to human health are projected to increase, and we are currently not meeting national and global emission targets to adequately mitigate the harmful health effects of climate change; and
WHEREAS, Given the role of emergency medicine in pre-hospital and acute care, emergency departments will bear a large burden of the adverse influences of climate change, particularly due to the increasing frequency and severity of climate hazards (extreme heat, extreme weather events, and ecological changes) and the increasing incidence and prevalence of climate-sensitive diseases (acute heat illness, respiratory disease, cardiovascular disease, waterborne communicable diseases, vector-borne diseases, trauma); and
WHEREAS, Given the de facto role of emergency medicine as a “safety-net” specialty, emergency physicians care for the communities and populations most vulnerable to climate change including the elderly, individuals of low socioeconomic status, and patients with multiple comorbidities; and
WHEREAS, ACEP has previously committed to advocating “for policies and practices to mitigate and address the effects of climate change on human health, health care systems, and public health infrastructure”; and
WHEREAS, ACEP has previously committed to advocating “for initiatives to reduce the carbon footprint of emergency departments and their affiliated institutions through energy conservation and health care waste reduction and/or recycling”; and
WHEREAS, ACEP could make a powerful contribution to national climate change adaptation and mitigation efforts by joining the Medical Society Consortium on Climate & Health – a network of medical societies encompassing over 600,000 clinicians that has, since its founding, logged 1,091 environmental health-related
Resolution 21(20) Medical Society Consortium on Climate & Health
Page 2

activities across 39 states and these have included 338 policy activities, 38 research publications, 293 media articles and interviews, and 422 presentations\(^1\); and

WHEREAS, Twenty-nine other medical societies have already joined the Medical Society Consortium on Climate & Health, including the California Chapter of the American College of Emergency Physicians, the American Medical Association, the American Academy of Dermatology, the American Academy of Family Physicians, the American Academy of Ophthalmology, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the Infectious Diseases Society of America, and the Society of General Internal Medicine\(^2\); and

WHEREAS, The requirement for membership is: “The Consortium will be governed by a Steering Committee composed of one representative from each participating medical society, and one representative of George Mason University’s Program on Climate & Health. Each participating Medical Society will designate a member of their Society to serve on the Steering Committee for a term of two years (renewable), and a second member to act as an alternate, when necessary. The Steering Committee will convene quarterly via conference call and have one in person meeting at the Consortium annual meeting. The annual meeting will be held each spring in Washington, DC.” (Roles and Responsibilities, Medical Society Consortium on Climate & Health.); and

WHEREAS, This furthers ACEP’s mission to “be a leading advocate for emergency physicians, their patients, and the public” amplifying our voices on a multidisciplinary national level; therefore be it

RESOLVED, That ACEP become an official member of the Medical Society Consortium on Climate & Health; and be it further

RESOLVED, That ACEP support one ACEP member representative by paying registration and travel expenses to attend the Medical Society Consortium on Climate & Health annual meeting starting in 2021.

References:

Background

This resolution requests that ACEP become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Climate change can be a controversial topic. However, both domestic and global organizations are addressing the effect of climate change on public health, disaster response, disease prevalence, and clinical implications. This involves research and response to the direct and indirect medical impact related to climate change.
ACEP and several other prominent medical organizations, including, but not limited to, the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American Lung Association, and the American Public Health Association, the World Association for Disaster and Emergency Medicine, and the World Health Organization have policy statements regarding the impacts of climate change on human health.

The Medical Society Consortium on Climate & Health was launched in 2016 and membership currently includes 29 national medical societies and 55 partner organizations. Their mission “is to organize, empower and amplify the voice of America’s doctors to convey how climate change is harming our health and how climate solutions will improve it.” According to their Website:

“To facilitate the medical community’s awareness-raising efforts, the Medical Society Consortium on Climate and Health (Consortium) brings together associations representing over 600,000 clinical practitioners to carry three simple messages:

- Climate change is harming Americans today and these harms will increase unless we act;
- The way to slow or stop these harms is to decrease the use of fossil fuels and increase energy efficiency and use of clean energy sources; and
- These changes in energy choices will improve the quality of our air and water and bring immediate health benefits.

This is especially important to vulnerable Americans and communities who are experiencing a disproportionate impact today from climate change.”

ACEP has liaison relationships with many medical organizations but none that are associated with climate change.

ACEP Strategic Plan Reference

None

Fiscal Impact

Approximately $1,000 for travel costs to attend the annual meeting and unknown cost for the registration fee. Potential membership fee to join as a member society.

Prior Council Action

None that are specific to joining the Medical Society Consortium on Climate & Health.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors.

Prior Board Action

The Board approves all formal liaison relationships with other organizations but has not previously considered a liaison with the Medical Society Consortium on Climate & Health.

June 2018, adopted the policy statement “Impact of Climate Change on Public Health and Implications for Emergency Medicine.”

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 22(20)

SUBMITTED BY: Illinois College of Emergency Physicians
Massachusetts College of Emergency Physicians
Minnesota Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: State Media Training for Emergency Physicians

PURPOSE: Develop and promote media training for members with a focus on social media for ACEP chapters and sections and provide such training in conjunction with Scientific Assembly or other ACEP meetings.

FISCAL IMPACT: Approximately $3,500 – $5,000 for each hybrid training session for up to 100 participants that includes traditional media and social media would cost. Adding a training session to another meeting beyond Scientific Assembly will double the annual cost to $7,000 – $10,000.

WHEREAS, Emergency physicians are on the frontlines of the healthcare system; and

WHEREAS, Emergency physicians frequently receive requests by media to educate the public on healthcare related issues, including, but not limited to, public health and policy issues; and

WHEREAS, Social media platforms have become a common place for the public to seek information related to healthcare related issues; and

WHEREAS, During pandemics, emergency physicians on the frontlines treat most of the patients affected by pandemics; and

WHEREAS, During pandemics, the public and the media frequently look to and trust emergency physicians to report on their experiences in treating patients affected by pandemic diseases in an objective, unbiased manner; and

WHEREAS, Many emergency physicians are asked by media at the state and local level to perform interviews on television or radio, or on social media; and

WHEREAS, ACEP has a national media training platform (“how to become a spokesperson”) mostly focused on television and radio mediums; and

WHEREAS, The ACEP national training platform does not explicitly market training in effective social media messaging; and

WHEREAS, Certain public health or policy issues are most impactful or important at the state or local level; and

WHEREAS, ACEP does not have dedicated media training for emergency physicians at the state or local level, and

WHEREAS, ACEP constituent chapters and sections may not have the financial resources to develop media training individually; therefore be it

RESOLVED, That ACEP develop a dedicated media training course for emergency physicians to respond to
requests from state or local media outlets via ACEP constituent chapters and sections with an emphasis on specific
talking points pertinent to the key issues affecting those physicians at that level; and be it further

RESOLVED, That ACEP develop a media training course specifically focused on effective, unbiased, fact-based social media delivery; and be it further

RESOLVED, That ACEP partner with state chapters and sections to effectively market a media training
course for chapter and section leaders and encourage that chapter and section officers are offered the opportunity to
enroll in such training in conjunction with ACEP *Scientific Assembly* or other ACEP meetings.

**Background**

This resolution calls for the College to develop and promote media training for members with a focus on social media for ACEP chapters and sections and provide such training in conjunction with *Scientific Assembly* or other ACEP meetings.

Given the influx of media attention on emergency physicians because of the COVID-19 pandemic, there are new and influential opportunities for ACEP members and chapters to continue to elevate themselves, the College, and the specialty as thought leaders in public health crises and pandemic preparedness. While much of the conversations about the pandemic and general health care issues occur in mainstream news outlets, there are growing communications happening between the emergency medicine community, press, policymakers, and the public on social media platforms such as Facebook, Twitter, and LinkedIn. While ACEP does traditionally offer in-person media training during *Scientific Assembly*, that training has not previously included social media. Historically, the in-person training at *Scientific Assembly* meeting has been 90-120 minutes (the same training is offered twice to enable maximum participation) and includes the essentials of how to prepare and successfully conduct traditional media interviews. ACEP has not charged for members to participate in this training.

Moving forward, ACEP, could revamp the media training to decrease the focus on traditional media interviews and include social media strategy and best practices that would result in a higher level overview of both topics, or include an additional training (at additional cost) that would enable participants to do a deeper dive into traditional media and social media.

*Note: Funds for media training in the 2019-20 budget were eliminated because of budget constraints and media training was not provided at ACEP19. Funds for media training were restored in the 2020-21 and a virtual course will be held during ACEP20. It is not known at this time whether funds will be included in the FY 2021-22 budget.*

**ACEP Strategic Plan Reference**

Goal 1 – Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.

Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

**Fiscal Impact**

Approximately $3,500 – $5,000 for each hybrid training session for up to 100 participants that includes traditional media and social media would cost. Adding a training session to another meeting beyond *Scientific Assembly* will
double the annual cost to $7,000 – $10,000.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Maggie McGillick
Public Relations Director

**Reviewed by:**
Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 23(20)

SUBMITTED BY: Tracy Legros, MD, PhD, FACEP
J. Richard Walker, III, MD, MS, FACEP
Undersea & Hyperbaric Medicine Section

SUBJECT: Subspecialty Faculty for ACEP Educational Programs

PURPOSE: Develop a process to collaborate with sections to identify individuals to serve as faculty in subspecialty content areas for in-person and virtual education and serve as authors of educational publications with priority given to subject matter experts that are board certified emergency physicians who are recognized as national or international leaders in the subspecialty field of the topic presented or authored with preference to those subspecialty trained or endorsed by the section.

FISCAL IMPACT: Unbudgeted staff and technology resources. Additional FTE to research and verify credentials of all subspecialty subject matter experts, including verification of publications and lectures, and review of prior course and speaker evaluations outside of ACEP to ensure the quality of presentations. Additional technology resources to collect and maintain this information. Additional costs for increased faculty at ACEP meetings.

WHEREAS, Emergency medicine is recognized by the American Board of Medical Specialties as an independent specialty with a recognized, unique knowledge base and procedural skill set that is certifiable by board examination; and

WHEREAS, Emergency medicine now has a number of nationally recognized subspecialties for which board certification is available; and

WHEREAS, Board certification by the American Board of Emergency Medicine is one mechanism that is generally recognized to establish subject matter expertise in a field; and

WHEREAS, The need for academic integrity and accuracy of content is paramount in the American College of Emergency Physicians’ Scientific Assembly lecture series; and

WHEREAS, There is fellowship specialty training for many additional subspecialties that are not currently board certifiable specialties, but may be one day, and currently do provide additional training, skills, and experience; and

WHEREAS, There are board certified emergency physician researchers who have, through their peer-reviewed publications and long standing dedication to the field, established a national or international reputation as a subject matter expert in certain areas; and

WHEREAS, The expectation of patients who utilize emergency departments for their emergency medical care is that there is seamless, high quality medical care provided by physicians who have maintained currency through high quality continuing medical education; therefore be it

RESOLVED, That ACEP develop a process to collaborate with ACEP sections to identify and retain subspecialty content expert lecturers based on training, extensive experience, and subspecialty-certification (when applicable) for in-person and virtual education as well as publications; and be it further

RESOLVED, That priority be given to subject matter experts when selecting faculty lecturers at the Scientific Assembly to include in the following order:
1. Board certified emergency physicians who are recognized as national or international leaders in the subspecialty field, typically by their scientific contributions and unique experiences, and/or those who have received the formal endorsement of the ACEP section of greatest interest; or
2. Fellowship trained board diplomates in the subspecialty subject matter area with authorship of subject matter peer reviewed publications; or
3. Fellowship trained board diplomates in the subspecialty subject matter area; or
4. Fellowship trained board certified or board eligible diplomates in the subspecialty subject matter area; or
5. Board certified emergency physicians who can demonstrate subject matter expertise in the area in question, such as a regional or national reputation, extensive experience and/or with authorship of subject matter peer-reviewed publications.

**Background**

This resolution first calls for the College to develop a process to collaborate with ACEP sections to identify and retain individuals to serve as faculty in subspecialty content areas for in-person and virtual education and serve as authors of educational publications. The resolution also specifies prioritization criteria to use when selecting faculty lecturers for *Scientific Assembly*. This background information will first comment on the current processes for soliciting subject matter experts and course proposals and contents and will then address the specific issue of the prioritization concept.

ACEP operates under several processes when soliciting course proposals and faculty from sections, committees, and individual members along with their faculty recommendations.

- The Education Committee and each of its subcommittees strives to serve the dynamic education needs of ACEP members. Feedback and evaluation data from members is reviewed and incorporated into the content and speaker selection process. Members drive the educational offerings and are instrumental in efforts to increase diversity in presenters and content. This is demonstrated by ongoing membership engagement through consistent growth in the number of paid registrants to ACEP educational meetings.

- The Educational Meetings Subcommittee’s current and long-standing practice is to select speakers based on subject matter expertise, section recommendations and input, and reputation as a national-caliber speaker and/or recognized expert on the subject matter in the identification of faculty. Faculty and courses are evaluated thoroughly with course and faculty evaluations for each course presented at ACEP meetings and by a member of the subcommittee who monitors audits each course to assess the presentations. The average score of *Scientific Assembly* faculty is a 98% rating with demonstrated subject matter expertise, excellent teaching skills, achieving the stated learning objectives, PowerPoints enhanced learning experience, and free of commercial bias, based on conference evaluations of each speaker and course.

- There are processes in place for members of the Educational Meetings Subcommittee, Online Education Subcommittee, Publications Subcommittee, and Continuous Competency and Certification Subcommittee to collaborate with sections and committees as necessary to identify faculty and authors who are subject matter experts and national caliber speakers and authors. The Education Committee has an ongoing objective and strategy to ensure diversity among speakers at ACEP meetings as one of many factors that are considered when selecting speakers.

- Specific to sections, the Education Committee has been assigned an additional objective for the FY 2020-21 committee year to “develop and implement a process to collaborate with ACEP sections in the development of subspecialty education content and selection of faculty.” Currently, there are section liaisons assigned to the Education Steering Committee. These processes could be enhanced if each section and committee developed a list of potential speakers and authors that includes subspecialty qualifications of subject matter experts with expertise as national-caliber speakers and identifying specific topics each can present to form a speakers’ list and provided annual updates to that list.
Implementing the Proposed Faculty Prioritization Criteria

Based on the above processes and data year over year, it is unclear that implementation of this resolution would improve these already high faculty scores. Instead, the process suggested could inadvertently place limitations on the work of the Education Committees, its subcommittees, and staff and add significant additional time and expense to implement.

Limitations of programming could emerge when planning novel educational delivery formats for meetings. For example, the subcommittee often plans debates and controversies as a presentation format. Often, controversies are presented by at least one member who is not subspecialty trained but these are exceptional learning experiences for the membership. Likewise, some of emergency medicine’s most respected experts and speakers are not subspecialty trained and would not be considered to speak on current topics for which they are so successful. For example, a well-known and respected speaker is not trained in critical care but is one of the College’s most revered and prolific speakers and authors and is more than qualified as a subject matter expert in this area. Scientific Assembly is also a superb opportunity for junior faculty to compete in the Drop the Mic competition of new speakers and be vetted by the subcommittee and given speaking opportunities at future annual meetings.

Limitations may also occur beyond the scope of the Educational Meetings Subcommittee. For example, recently the Online Education Subcommittee has focused on recruiting promising junior faculty as determined by section leadership to contribute to online courses and webinars. This has allowed for the development of new, high-quality content for membership as well as professional development opportunities for junior faculty. Such professional development opportunities can be critical to an individual’s career. Opportunities to contribute can also be educational. Consider PEER, through a rigorous editing system each question undergoes several iterations. Many times these questions are written by residents or junior faculty. As their questions move through the editing process to more advanced editors, they receive feedback on the medical content, overall question quality, and even writing style. These are all skills that are undoubtedly beneficial to their development as young physicians. It is also likely other areas of the College would face the same challenge as Educational Meetings – limited expertise and time. Critical Decisions in Emergency Medicine, is a monthly publication that relies on the contributions of several authors each month. By further limiting the pool of qualified authors it may become difficult to identify enough contributors to meet the needs of the publication each month.

Education expertise must also be considered. Ability to synthesize and communicate/educate the audience effectively is paramount. There are operational and research leaders that are expert educators in some formats, but this is not assured of all subspecialty experts. They must be effective speakers, comfortable teaching to large audiences, and excel at educational knowledge transfer. Content expertise must also be considered. Emergency Medicine is a vast field with new advancements made each day. These advancements do not always emerge quickly in Emergency Medicine. Limiting selection of non-emergency medicine faculty for education could have a negative impact on the infusion of cutting-edge information from all fields necessary for the improvement of emergency medicine patient care and practice.

Requiring or prioritizing subspecialty training to the many factors already considered when selecting these subject matter experts as speakers and/or authors may further reduce the cadre of members who are qualified and willing to volunteer their time for educational meetings and products and may, therefore, have the unintended consequence of diminishing important diversity of thought at ACEP meetings.

The research of speakers’ credentials once courses are identified would delay the completion of planning by the Educational Meetings Subcommittee and staff to plan the program and identify speakers for each course within the necessary timeline for speaker invitations and early marketing of the meeting.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
   Objective C – Provide robust communications and educational offerings, including novel delivery methods.
   Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.
Fiscal Impact

Unbudgeted staff and technology resources. An additional FTE would be needed to research and verify the credentials of all subspecialty subject matter experts, including verification of publications and lectures, and review of prior course and speaker evaluations outside of ACEP to ensure the quality of presentations. This level of review would be essential to ensure the high quality of presentations currently experienced at Scientific Assembly and other meetings and products. Additional technology resources would be required to collect and maintain this information. These expenses could not be accommodated in the current fiscal year budget.

There would also be additional costs to increase the number of faculty presenters at Scientific Assembly and other educational meetings to meet the requirement of this resolution. Currently, many faculty present on multiple topics. Additional faculty would be required to meet the subspecialty requirements in this resolution, i.e., more speakers with narrowly-focused speaking abilities and knowledge would require more speakers to present on other topics.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by:  Debbie Smithey, CMP, CAE
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Reviewed by:  Gary Katz, MD, MBA, FACEP, Speaker
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2020 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 24-39

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RESOLUTION: 24(20)

SUBMITTED BY: Adam Ash, DO, FACEP
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Puerto Rico Chapter
Vermont Chapter
Wyoming Chapter

SUBJECT: 911 Awareness and Policy

PURPOSE: 1) Promote awareness that healthcare providers are calling 911 on behalf of patients who cannot or will not call themselves; and 2) Promote awareness that medical directors of Public Safety Access Points and EMS may need to develop policies to address patients’ medical information and patients’ medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, ACEP represents emergency physicians practicing in all emergency care environments; and

WHEREAS, ACEP represents emergency physicians who support and endorse good policies in emergency medical systems and 911 Public Safety Access Points (PSAPs) through its lobbying and public awareness; and

WHEREAS, There are roughly 6,100 PSAPs in the U.S. that have different office, regional, state, and federal guidelines and policies; and

WHEREAS, Medical professionals often treat patients who are in different locations in an emergency and there are known methods for calls to be routed to correct PSAPs pertaining to the patient location; and

WHEREAS, Patients are at times reluctant or unable to call or activate 911 themselves and communication is shown to be better when between a treating medical professional and 911 dispatchers; and

WHEREAS, The COVID-19 pandemic has increased the cases where doctors are treating patients remotely and are directly activating 911 on behalf of patients and in such cases treating doctors are often still communicating with patients when EMS arrives, are able to communicate with EMS, expedite emergency response, and convey valuable medical information and recommendations to improve care; and

WHEREAS, 911 EMS National and State Guide cards, International Academies of Emergency Dispatch protocols, were reviewed and none of them had much guidance or training on healthcare professionals calling 911 on behalf of patients in different areas; and

WHEREAS, Guide cards contain standard emergency medical questions for patients such as chest pain with algorithms on determining if ALS or BLS units were needed but lacked guide cards and protocols for doctors calling on behalf of patients in different locations; and

WHEREAS, Twenty-two emergency 911 call audio recordings were reviewed by ACEP members for 911 calls placed by providers calling on behalf of patient addresses located in New Jersey, New York, Texas, Connecticut, Florida, and Pennsylvania and common cases included suicidal ideation, altered mental status, and shortness of breath; 911 PSAP dispatchers activated ambulances however there were delays due to not having protocols in place; example responses...
included “how are you calling me,” “can I talk to the patient,” and “let me see what the procedure is” and one such case had a patient in SVT diagnosed over Mobile Cardiac Telemetry (MCT) where the treating provider activated 911 and needed an ALS response yet there was no dispatcher guide card or procedure in place for the scenario of a doctor calling them; and

WHEREAS, ACEP’s EMS section has 1,143 members including 40 international EMS doctors from the five continents (Argentina, Australia, South Africa, Bahrain, United Arab Emirates, Saudi Arabia, Canada, Ireland, Germany, Brazil, Lebanon, Belgium, Taiwan, Panama, Israel, Austria, New Zealand, Trinidad and Tobago, Chile, India, and Philippines) and lack of awareness and protocols for doctor initiated 911 activations on behalf of patients is a global problem; therefore be it

RESOLVED, That ACEP promote awareness that healthcare providers are calling 911 on behalf of patients who cannot call 911 themselves, will not call 911 themselves, or have inadequate communication when speaking to 911 dispatchers themselves; and be it further

RESOLVED, That ACEP promote awareness that medical directors of Public Safety Access Points and EMS may need to build policies to take into strong consideration the patients’ medical information and patients’ medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

Background

This resolution calls on ACEP to promote awareness that healthcare providers are calling 911 on behalf of patients who cannot or will not call themselves. Additionally, the resolution requests that ACEP promote awareness that medical directors of Public Safety Access Points and EMS may need to develop policies to address the patients’ medical information and patients’ medical needs provided by the treating doctor who activates the 911 emergency on behalf of a patient.

Many members of ACEP’s EMS-Prehospital Care Section are EMS medical directors who oversee Public Safety Answering Points (PSAP)/911 and Emergency Medical Dispatch (EMD) centers or work closely with other physicians that oversee them. Most PSAP/EMD systems address handling 911 calls from third parties but how these procedures are implemented locally are not uniform across the county. In some areas 911/PSAP’s are under the control of the fire department or law enforcement and the EMS EMD personnel may not be able to speak directly with the caller on every call received. The EMS medical director also may not have control or oversight on some of these systems.

ACEP can work with other EMS organizations to promote awareness of the issue and identify appropriate actions to collaborate with other organizations to address it going forward.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 27(17) 9-1-1 Number Access and Prearrival Instructions adopted. Directed ACEP to advocate and promote efforts that support achieving 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point (PSAP) or EMS dispatch center provides appropriate medical pre-arrival
instructions with EMS physician oversight. Also directed the College to work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that incorporates EMS physician involvement.

Resolution 24 (91) Universal Access to 911 adopted. Directed ACEP to promote the availability of basic 911 access for all communities and encourage the establishment of enhanced levels of 911 in all communities where feasible.

**Prior Board Action**

June 2018, approved the policy statement “Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch, and Public Emergency Aid Training,” which replaced the rescinded policy statement “Public Training in Cardiopulmonary Resuscitation” and “Public Access Defibrillation.”

October 2017, approved the policy statement “The Role of the Physician Medical Director in Emergency Medical Services Leadership” replacing five policy statements that were rescinded or sunsetted.

Resolution 27(17) 9-1-1 Number Access and Prearrival Instructions adopted.

Resolution 24 (91) Universal Access to 911 adopted.

**Background Information Prepared by:** Rick Murray, EMT-P
Director, EMS & Disaster Preparedness

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 25(20)

SUBMITTED BY: Arizona College of Emergency Physicians
Florida College of Emergency Physicians
Illinois College of Emergency Physicians
Indiana Chapter
Ohio Chapter
Air Medical Transport Section

Pennsylvania College of Emergency Physicians
Texas College of Emergency Physicians
Virginia College of Emergency Physicians
Wisconsin Chapter

SUBJECT: Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage

PURPOSE: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

FISCAL IMPACT: Budgeted task force and staff resources. Additional unbudgeted costs of $10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated $50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

WHEREAS, The deliberate consolidation of healthcare insurers has reduced competition in the healthcare insurance marketplace and has reduced healthcare insurance options for our patients; and

WHEREAS, Healthcare insurers have reduced the actual healthcare insurance coverage of illness and injury with high-deductible plans, increased patient cost-sharing and increased out-of-pocket expenses; and

WHEREAS, Healthcare insurers have implemented many strategies to reduce physician reimbursement including:
- termination or non-renewal of contracts to preemptively reduce compensation and decrease median in- and out-of-network rates
- automatically down-coding or denying payment by using exempted diagnosis lists
- retrospectively denying higher-acuity emergency physician service payment by failing to acknowledge the increased acuity of conditions presenting to the emergency department over the past decade
- bundling services (e.g., electrocardiogram interpretation) to avoid payment for cognitive services
- consistent cost shifting by The Employee Retirement Income Security Act (ERISA) plan administrators to increase the costs to employers and employees
- disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on discharge diagnosis; and

WHEREAS, Health insurers are required to cover emergency services but have insufficient in-network emergency physicians to provide these services and no requirement to contract with emergency physicians or to negotiate in good faith to pay for EMTALA mandated care; and
WHEREAS, Healthcare insurers are reporting record profits including profit of $18.4 billion for Centene, $14 billion for United Health Group, $5.1 billion for CIGNA, $4.8 billion for Anthem and $1 billion for CVS in 2019; and

WHEREAS, During the COVID-19 pandemic when emergency physicians were focused on caring for emergency patients, insurers were reporting record profits due to reduced payment for suspended elective non-emergent procedures, while they continued to promote inequitable surprise billing legislation; and

WHEREAS, The Affordable Care Act (ACA) requires health insurers to pay annual premium rebates when the Medical Loss Ratio (MLR) for groups or health insurance policies issued in a state is below 85% for large employer group policies and 80% for small employer group policies and individual policies; by failing to meet this threshold, it is estimated the healthcare insurers will be required to rebate approximately $2.7 billion in 2020 due to failure to meet the MLR requirement; and

WHEREAS, Health insurers have established large employer third-party administrators (TPAs), acquired Pharmacy Benefit Management companies (PBMs) and medical practices, and that these entities accounted for more profit than the core insurance business lines; and

WHEREAS, Insurance companies by owning or influencing both medical practices, TPA’s and PBM’s they are potentially “price-setting” and “self-referring” and these are not subject to MLR therefore they may be unilaterally and arbitrarily increasing the costs of medical care with potentially little to negative effects on quality; therefore be it

RESOLVED, That ACEP create a task force and commission an independent study on the extraordinary financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians; and be it further

RESOLVED, That ACEP engage an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care; and be it further

RESOLVED, That ACEP advocate for higher standards and additional scrutiny of health insurer spending, including the Medical Loss Ratio (MLR) standards, to ensure more resources are dedicated to the patient health services and not diverted for other business pursuits without clear benefit to their patient population; and be it further

RESOLVED, That ACEP work with other similarly affected professional organizations, consumer advocacy groups, and the American Medical Association (AMA) to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Background

This resolution directs ACEP to: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Recent Advocacy Efforts to Combat Unfair Insurer Practices
ACEP has continued to push back against burdensome and illegal insurer financial influence on reimbursement for emergency medicine as part of the strategic plan. These efforts included an ACEP-EDPMA Joint Task Force, formed in 2015, in part to combat unfair insurer practices against the specialty. While the task force is now defunct, ACEP and EDMPA have included a representative on each other’s respective reimbursement and state and regulatory
committees to continue to push back against new and existing issues. ACEP and EDPMA have sent joint letters to Optum, United Health Care, Centene, and various Medicaid plans conveying concerns about their payment policies. Many ACEP chapters have sent letters to CMS and individual states regarding insurance denials and other specific reimbursement issues.

The continued termination or non-renewal of contracts, down-coding, or denial of payment via diagnosis lists, retrospective denial of higher-acuity emergency physician service payment, bundling services to avoid payment, consistent cost shifting by ERISA plans, and disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on discharge diagnosis will continue to be issues that ACEPs State Legislative and Regulatory Affairs, Public Affairs, and Reimbursement Departments budget time and staff resources for advocacy efforts.

ACEP also advocates for higher standards and scrutiny of insurer policies and spending through its representation at the American Medical Association (AMA), and along with other similarly affected specialties, advocates for policies that seek to restrict and/or prevent damaging insurer policies.

This resolution would take these efforts a step further by contracting with a respected healthcare economist to conduct an independent study to analyze challenges and adverse financial impacts to reimbursement from insurer policies.

Recent Advocacy Efforts to Uphold Legal Rights Established by EMTALA and Prudent Layperson (PLP)

Despite the longstanding legal precedence of protecting patients and physicians from unwarranted third-party payer denials established by EMTALA and PLP, significant numbers of denials continue to persist.

ACEP has continued to fight for the inclusion of the EMTALA provision in third-party payer policies, especially those from managed care plans, which have significantly increased their market share since EMTALA was mandated by law. Although PLP laws have largely eliminated the issue of prior authorization denials for emergency services, many third-party payers have continued to make after-the-fact decisions to deny payment for services resulting in loss of revenue for physicians and an unnecessary financial burden on patients.

ACEP also has continued tracking third-party payer denials and has successfully lobbied on behalf of members in states where policies were announced that would have led to a process of automatic denials. Letters have been sent to third-party payers that make up a large percentage of total market share in the U.S. with varying degrees of success. A lawsuit against BCBS in GA has been pending since 2018 and letters sent to UHC (multiple states) and Anthem BCBS (23 states) in the past year successfully defeating automatic denials and unfair down coding policies.

The College has continued to monitor and influence both the legislative and regulatory process related to EMTALA and PLP. We have successfully lobbied both Congress and the Centers for Medicare and Medicaid Services (CMS) on several issues of importance to emergency medicine, including removing criminal penalties against physicians, adding on-call requirements to the law, instituting whistleblower protections, and PRO review requirements. ACEP regulatory affairs staff have submitted formal comments to CMS and met with them on numerous occasions over the years to discuss the law, the regulations, and enforcement issues.

ACEP developed a toolkit in 2018 to reach out to third-party stakeholders to track and collect payment denials by Anthem Blue Cross Blue Shield in 23 states where the policy had taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the prudent layperson standard.

Pursuing Strategies for Ensuring Fair Payment and Practice Sustainability

The current tactics for ensuring fair payment for services include:

- Engaging ACEP chapters, CMS, and the National Association of State Medicaid Officials in initiating and supporting efforts to minimize the impact of state Medicaid cuts on access to emergency care and to protect the prudent layperson standard.
- Collaborating with the AMA, state medical societies, and other medical organizations on payment and practice sustainability issues, including interaction with entities such as FAIR Health, NCOIL, NAIL, and PAI, as appropriate.
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- Identifying payers that do not pay fairly and consider compliance disputes and legal actions through the most strategic available mechanisms, via the ACEP Coding & Nomenclature Advisory Committee, Reimbursement Committee, State Legislative/Regulatory Committee, and ACEP staff time devoted to advocacy efforts.

The proposed additional tactics of creating a task force and engaging a healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine as well as the effect of commercial health insurance and reimbursement policies on emergency care are new tactics that could fit into the current ACEP Strategic Plan, although some of the associated expenses are unbudgeted.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
  Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted task force and staff resources. Additional unbudgeted costs of $10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated $50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

Prior Council Action

Amended Resolution 38(19) Standards for Insurance Denials adopted. Directed ACEP to work with legislators to enact legislation that makes it illegal for a payor to engage in automatic denials; and that to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and that patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by payors; and that ACEP work towards getting an affirmation in writing from payors that they will adopt this as policy.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted. Directed ACEP to convene a work group of subject matter experts to identify the impact that high deductible insurance plans have on patients seeking emergency care, emergency physicians, and emergency departments, and create a paper to inform stakeholders about such impact.
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Resolution 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, a payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate EMTALA recommendations to CMS’ regulatory advisory committee including physician on-call responsibilities, greater consistency of enforcement, and more effective involvement of peer review organizations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Reaffirmed that EDs are an essential part of the health care safety net for all populations, including foreign nationals, and in advocacy efforts ACEP recognizes uncompensated care for foreign nationals as one example of the many factors that threaten the health care safety net.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed ACEP to champion the principle that emergency care is an essential public service.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and provide a report at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. Directed ACEP develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed that any government agency, legislative body, insurance carrier, third-party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products; and support legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity that mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Prior Board Action

February 2020, approved prudent layperson model state legislation stipulating that “the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway.”

January 2020, ACEP and EDPMA sent a letter to Optum conveying concerns about Optum’s payment policies.

Amended Resolution 38(19) Standards for Insurance Denials adopted.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem’s Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.
Resolution 25(20) Adverse Impact of Healthcare Insurers on EM Reimbursement & Optimal Patient Coverage

February 2018, reaffirmed the policy statement “Assignment of Benefits;” reaffirmed April 2012; originally approved April 2006.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

April 2017, approved the revised policy statement “Fair Coverage When Services Are Mandated;” reaffirmed April 2011 and September 2005 with the title “Compensation When Services are Mandated;” originally approved September 1992.


May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are “out of network” because of a medical emergency.

April 2016, approved the revised policy statement “Fair Payment for Emergency Department Services;” originally approved April 2009.

April 2016, approved the revised policy statement “Balance Billing;” revised and approved 2009 with the current title; reaffirmed October 2008; originally approved October 2002 titled “Prohibition of Balance Billing.”

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted.


Resolution 38(05) Proper Payment Under Assignment of Benefits adopted.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Substitute Resolution 29(01) Funding of Emergency Care for Foreign Nationals adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted. A report was distributed at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. ACEP’s Task Force on Health Care and the Uninsured developed six principles to be used as a framework for expanding health care coverage to all. In 2000, ACEP hosted the National Congress on Preserving America’s Health Care Safety Net in Washington, DC. This initiative called for a national debate on the issue and for building a national consensus among leaders in business, consumer and advocacy groups, public policy, health care, and medicine to make incremental changes to expand health care access. ACEP also joined six other medical specialties in calling on Members of Congress and presidential candidates to begin a serious debate over the health care funding crisis confronting the nation. Coverage of the uninsured will reduce the financial pressures on EDs of EMTALA compliance.
June 1999 approved the revised policy statement, "Compensation When Services are Mandated."

Amended Resolution 11(92) Payment for Mandated Services adopted.

**Background Information Prepared by:** Adam Krushinskie, MPA
Reimbursement Manager

**Reviewed by:**
- Gary Katz, MD, MBA, FACEP, Speaker
- Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
- Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 26(20)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Addressing Systemic Racism as a Public Health Crisis

PURPOSE: Requests ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism, continue to explore models of health care that would make equitable health care accessible to all, and continue to support ACEP members who seek to dismantle systems of discrimination and advocate for policies promoting social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

FISCAL IMPACT: Budgeted committee and staff and resources.

WHEREAS, ACEP advocates for tolerance and respect for the dignity of each individual and opposes all forms of discrimination against and harassment of patients;¹ and

WHEREAS, Minorities in America disproportionately suffer from income inequality, debt, barriers to housing and home-ownership, discrimination from financial institutions, decreased access to education, barriers to employment, workplace discrimination, barriers to accessing health care, disparities in the quality of health care, over-policing, and many other forms of injustice due to historical and ongoing structural racism; and

WHEREAS, ACEP acknowledges the causal link between these persistent disadvantages (collectively known as the social determinants of health) and poor health outcomes; and

WHEREAS, ACEP’s mission includes the promotion of health equity within the communities we serve;² and therefore be it

RESOLVED, That ACEP reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism; and be it further

RESOLVED, That ACEP continue to explore models of health care that would make equitable health care accessible to all; and be it further

RESOLVED, That ACEP continue to use its voice as an organization and support its members who seek to dismantle systems of discrimination and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Background

The resolution requests ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism, continue to explore models of health care that would make equitable health care accessible to all, and continue to support ACEP members who seek to dismantle systems of discrimination and advocate for policies promoting social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

institutional, local, state, and national level.

Over the last several years, health researchers and medical professionals have focused greater attention on social determinants of health and health disparities that exist for minority communities in the United States, with increasing awareness of the impact of systemic or institutional racism as a social determinant in particular. Recent events, including nationwide protests that occurred in the wake of the deaths of George Floyd and Breonna Taylor, have also brought the issue of structural racism further into the collective American public consciousness.

Systemic or “structural” racism refers to the systems, structures, or institutions that disadvantage minority populations. Though much of the recent attention has centered around structural racism within law enforcement, it also manifests in housing policies, employment and economic opportunities, educational systems, politics, health care, geography, and numerous other factors.

Discrimination also occurs in institutional health care experiences, e.g., disparities that result from a lack of access to the same or comparable high-quality health care options and facilities as those available to white Americans, implicit (or explicit) biases on the part of providers, or provider ignorance of culturally- or racially-sensitive health care needs.

Racism also has a causal link to health outcomes. The American Psychological Association (APA) notes that chronic stress resulting from “…factors such as poverty, family dysfunction, feelings of helplessness and/or traumatic early childhood experience” can disrupt nearly all the body’s physical processes. Chronic stress is linked to greater risk for numerous diseases, such as heart disease, obesity, diabetes, and immune disorders, as well as premature aging that can accelerate or exacerbate many of these diseases. The APA further notes that “[s]tudies examining the role of social and biological stress on health suggests a link between socioeconomic status and ethnic disparities in stress and health (Warnecke et al, 2008). Some ethnic/racial groups are more economically disadvantaged and may be more susceptible to SES-related stress.”

Additionally, there are a number of chronic health issues that disproportionately affect certain racial or ethnic groups, and care and treatment for these populations may be affected. Sickle cell disease (SCD), for example, is the most common genetic blood disorder affecting about 100,000 Americans, predominantly occurring in those of Black or African-American (1 in 365) or Hispanic (1 in 16,300) descent. Patients with SCD often present in the emergency department with severe pain, and due to limited SCD treatment options, opioid treatment is frequently the only effective option (though new evidence-based clinical guidelines have been developed). However, in the wake of the nation’s response to the opioid epidemic and a push to reduce or avoid opioid treatments, patients with SCD have experienced new challenges in treating the pain so often associated with this disease. These difficulties have been aggravated by unintentional outcomes of federal guidelines like the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain. Despite clarifications that the guideline is not intended to deny clinically-appropriate opioid therapy to patients with conditions such as SCD or cancer, emergency physicians have continued to receive reports that patients with SCD are unable to access these appropriate medications.

In March 2018, ACEP, as a recommendation of the Diversity and Inclusion Task Force, ACEP launched the Unconscious Bias in Clinical Practice one-hour, accredited CME course. This course focuses on:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

ACEP’s policy statement “Non-Discrimination and Harassment” advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual’s race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin,

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3 https://www.apa.org/topics/health-disparities/fact-sheet-stress
language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender, identity or expression, sexual orientation, or any other classification protected by local, state, or federal law. ACEP’s goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Discrimination and bias can serve as major drivers of influence on the quality of care provided in the emergency department toward individuals of underrepresented populations.

ACEP’s policy statement “Cultural Awareness and Emergency Care” supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP’s position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. Implicit Bias is recognized by the individual and mitigated through education recalling stereotypical thought processes.

As referenced, ACEP issued a statement on structural racism and public health on May 30, 2020. ACEP’s Social Emergency Medicine has as one of its objectives “to propose, evaluate, and critique health policies that affect the social determinants of health of our communities, especially as they pertain to marginalized and vulnerable populations that frequently present to EDs for their care.”

Demonstrating the ongoing importance of this issue, 14 of ACEP’s committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

**ACEP Strategic Plan Reference**

Goal 1 – Improve the Delivery System for Acute Care  
Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement  
Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

**Fiscal Impact**

Budgeted committee and staff and resources.

**Prior Council Action**

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP’s opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

**Prior Board Action**

April 2020, approved the revised policy statement “Cultural Awareness and Emergency Care;” reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

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

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


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

April 2017, reviewed the information paper “Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management.”

Substitute Resolution 41(05) Non-Discrimination adopted.

**Background Information Prepared by:** Ryan McBride, MPP, Senior Congressional Lobbyist

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
                 Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
                 Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 27(20)

SUBMITTED BY: Emergency Medicine Residents’ Association

SUBJECT: Attributing the Unqualified Term “Resident” to Physicians

PURPOSE: 1) Advocate for the use of the unqualified terms “resident” and “residency” and “fellow” and “fellowship” when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program. 2) Recognize the gold standard for emergency medicine training is, and must remain, the completion of an ABEM or AOBEM accredited physician residency program.

FISCAL IMPACT: Budgeted resources to convey ACEP’s position to federal Executive and Legislative branch officials.

WHEREAS, The term “resident” or “residency” in reference to physician training and accreditation was first introduced over 125 years ago; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) defines the term resident as “an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board”; and

WHEREAS, “EMRA believes that the only pathway to the independent practice of emergency medicine in the 21st century is completion of an Accreditation Council for Graduate Medical Education/American Osteopathic Association (ACGME/AOA) accredited emergency medicine residency training program and board certification by ABEM/AOBEM”; and

WHEREAS, The Society for Emergency Medicine Physician Assistants (SEMPA) guidelines on Emergency Medicine Physician Assistant Postgraduate Training discourages the use of “residencies” to describe postgraduate emergency medicine training programs for physician assistants; and

WHEREAS, A consensus on terminology for emergency medicine physician assistant postgraduate training has not been reached, as evidenced by a cursory search engine inquiry which results both “fellowship” and “residency” in the top ten auto-complete suggestions; and

WHEREAS, Half of patients surveyed by the American Medical Association for the campaign “Truth in Advertising” believed it was difficult to identify who is a physician by reading their title; and

WHEREAS, The same campaign suggested nearly 90% of patients believe “only a medical doctor or doctor of osteopathic medicine should be able to use the title ‘physician’”; and

WHEREAS, The SEMPA standard for postgraduate physician assistant training in emergency medicine is “a minimum of 3,000 hours or 18 months of direct-patient care in an emergency department, preceptored by an experienced emergency physician”; and

WHEREAS, The average board certified emergency physician will complete an average of 14,272 to 18,772 hours of postgraduate training prior to sitting for ABEM/AOBEM board certification exams; and

WHEREAS, There is widely held belief that the terms “resident” and “fellow” connote “physician”; and
WHEREAS, A reasonable patient may be led to draw a conclusion about the clinical experience of their provider that may misrepresent the provider’s clinical expertise based on the use of the terms “resident” or “fellow,” potentially to the patient’s detriment; therefore be it

RESOLVED, That ACEP advocate for the use of the unqualified terms “resident” and “residency” and “fellow” and “fellowship” when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program; and be it further

RESOLVED, That ACEP recognizes the gold standard for emergency medicine training is, and must remain, the completion of an American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine accredited physician residency program.

References:

Background

This resolution requests ACEP to: 1) Advocate for the use of the unqualified terms “resident” and “residency” and “fellow” and “fellowship” when used in the emergency medicine clinical setting to connote a physician with acceptance, enrollment, and participation in an approved allopathic, osteopathic, dentistry, or podiatry residency (or fellowship) program; and 2) Recognize the gold standard for emergency medicine training is, and must remain, the completion of an ABEM or AOBEM accredited physician residency program.

For several years, ACEP has worked with the AMA to promote federal legislation that would require appropriate representation about a clinician’s license and training. The current bill, the “Truth in Healthcare Marketing Act” (H.R. 6663), would make it unlawful for any person to make a deceptive or misleading statement, or engage in a deceptive or misleading act, that misrepresents whether they hold a state health care license or misrepresents their education, training, degree, license, or clinical expertise. It further requires that any person who is advertising health care services disclose the applicable license under which they are authorized to provide those services.

As part of the AMA’s Truth in Advertising campaign, we have also sought a requirement that all health care professionals wear, during patient encounters, a name tag that clearly identifies the type of license they hold. The overall objective of the campaign is to ensure health care providers clearly and honestly state their level of training, education, and licensing. As the materials state: “Patients are confused about the qualifications of different health care professionals. Many non-physicians earn advanced degrees, and many of those degree programs now confer the title ‘doctor.’ As a result, patients often mistakenly believe they are meeting with physicians (medical doctors or doctors of osteopathic medicine) when they are not.” A 2014 study by the AMA found that 35% of the general public believed that NPs with their doctorate of nursing practice were physicians.

According to Physicians for Patient Protection, nurse practitioners (NPs) and physician assistants (PAs) have recently developed programs that training institutions are referring to as “residencies” and “fellowships.” These programs are normally one year and contain multiple “administrative half days.” These programs are not necessarily standardized or accredited and many of these programs claim equivalence with physician training, although they are 1/3 or less of the residency training time for physicians.
ACEP’s policy statement “Use of the Title ‘Doctor’ in the Clinical Setting” states “ACEP strongly opposes the use of the term ‘doctor’ by other professionals in the clinical setting…”

ACEP’s policy statement “The Role of the Legacy Emergency Physician in the 21st Century” emphasizes that “physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by ABEM or AOBE.”

ACEP’s policy statement “Emergency Medicine Training, Competency, and Professional Practice Principles” specifies that it is the “role and responsibility of ABEM and AOBE to set and approve the training standards” for emergency physicians.

Given the standard use of the term “resident” and “fellow” to denote physicians, mid-level providers who introduce themselves as a resident or fellow may be confusing to patients. As noted in the previously referenced study, patients are often perplexed about who is taking care of them, even without the use of confusing terminology.

Some medical organizations have already developed statements in opposition to NP and PA advanced training programs using the terms “residency” and “internship.” In May 2019, the American Academy of Dermatology (AAD) approved the following statement: “Education of physicians and non-physician clinicians is entirely different. Physicians undergo rigorous training programs that have been accredited by various agencies. Historically the terms ‘residency training’ and ‘fellowship training’ have been used to indicate physician training. This lexicon has become standard across the medical profession . . . It is the position of the AAD that the term ‘residency’ in reference to training in dermatology apply only to allopathic and osteopathic physicians (MD’s and DO’s) trained in Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training programs and that the term ‘fellowship’ in reference to clinical or research training in dermatology apply only to MD’s and DO’s so trained.”

In February 2020, the American Academy of Emergency Medicine (AAEM) and AAEM/RSA approved a position statement that additional training programs for PAs and NPs: “Should be clear to the public by avoiding the use of the following terms: doctor, intern, internship, resident, residency program, fellow, fellowship . . . Should be structured, intended or advertised as to prepare its participants to practice only as members of a physician-led team.”

ACEP and eight other emergency medicine organizations released a Joint Statement Regarding Post-Graduate Training of Nurse Practitioners and Physician Assistants on September 3. The statement conveyed unified support of physician-led patient care and training and that the terms “resident,” “residency,” “fellow,” and “fellowship” in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within ACGME accredited training programs.

The American Board of Emergency Medicine released a Statement on Advanced Practice Providers on September 10 affirming that “use of the terms ‘residency’ or ‘fellowship’ in conjunction with an advanced practice provider training program should be avoided as they are not equivalent to the training undertaken in an ACGME-accredited emergency medicine program.”

ACEP’s policy statement “Guidelines Regarding the Role of Physician Asistants and Nurse Practitioners in the Emergency Department” states “the gold standard for care in an ED is that performed or supervised by a board-certified/board eligible emergency physician.”

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
  Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
Fiscal Impact

Budgeted resources to convey ACEP’s position to federal Executive and Legislative branch officials.

Prior Council Action

Substitute Resolution 30(13) Use of the Title “Doctor” in the Clinical Setting adopted. Directed ACEP to affirm that a physician is an individual who has received a “Doctor of Medicine” or “Doctor of Osteopathic Medicine” degree or equivalent degree and that anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Prior Board Action

June 2020, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” with the current title; revised and approved June 2013 titled “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” replacing “Guidelines on the Role of Physician Assistants in Emergency Departments” (2002) and “Guidelines on the Role of Nurse Practitioners in the Emergency Department” (2000).

February 2020, approved the revised policy statement “Use of the Title ‘Doctor’ in the Clinical Setting,” originally approved April 2014.


Substitute Resolution 30(13) Use of the Title “Doctor” in the Clinical Setting adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 28(20)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Young Physicians Section
Florida College of Emergency Physicians

SUBJECT: Banning of Choke Holds

PURPOSE: Endorse a national ban on the use of choke holds, educate members and relevant stakeholders about the hazard of choke holds and the availability of non-lethal alternatives, and promote these alternatives when appropriate.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Choke holds or neck holds that compress the upper airway (trachea, larynx or laryngopharynx) therefore interfering with breathing and leading to asphyxia can lead to death are dangerous and less safe than blood chokes (carotid restraints) \(^1\), \(^2\); and

WHEREAS, Not all choke holds result in death, however, an analysis of 56 episodes of transient cerebral hypoxia on people who completely lost consciousness showed muscle jerks in 90\% of patient generally consisting of multifocal arrhythmic jerks in both proximal and distal muscles, superposition of generalized myoclonus, righting movements (if the patient had slumped in one direction while falling asleep they woke up and immediately corrected), oral automatisms, head turns, visual and auditory hallucinations; \(^3\) and

WHEREAS, Use of choke holds by law enforcement leading to inadvertent upper airway compression can have deadly outcomes especially when performed on a combative person and even when the initial intent is to apply a neck hold the danger exists that the officer’s pressure will slip or move to the front of the neck, constricting the windpipe and thereby stemming the flow of oxygen to the lungs and the brain \(^4\); and

WHEREAS, In a 2013 Justice Department survey, police departments serving more than one million people, 43\% allow a neck restraint of some kind including choke holds \(^5\); and

WHEREAS, Almost half of the people who lost consciousness were injured according to Minneapolis police data in which neck restraints were used at least 237 times since 2015 and of these, 16\% lost consciousness \(^6\); and

WHEREAS, Recognizing the deadly consequences of the choke hold, most large police departments do not allow it including the New York Police Department, Metropolitan Police Department of Washington, DC, the Los Angeles Police Department. and the Chicago Police Department \(^7\); and


Resolution 28(20) Banning of Choke Holds

WHEREAS, A federal appeals court, the Ninth US Circuit Court of Appeals, banned the use of the maneuver when someone is not resisting arrest citing it violates the constitutional ban on unreasonable search and seizure; therefore be it

RESOLVED, That the American College of Emergency Physicians endorse a national ban on the use of choke holds; and be it further

RESOLVED, That ACEP educate its members and relevant stakeholders about the hazard of choke holds and the availability of non-lethal alternatives and promote these alternatives when appropriate.

Background

This resolution proposes that ACEP endorse a national ban on the use of choke holds, that ACEP educate its members and relevant stakeholders about the hazards of choke holds and the availability of non-lethal alternatives, and promote these alternatives when appropriate.

A choke hold is a form of restraint intended to control an individual who may be uncooperative or violent by compressing the upper airway to interfere with breathing or cause asphyxiation. A choke hold is distinguished from another type of neck restraint, a “stranglehold” (also referred to as a blood choke or carotid restraint), that is a form of strangulation restricting the flow of blood to the brain. Both are capable of inflicting significant injuries and death.

The use of choke holds and other uses of force by law enforcement has come under greater scrutiny in recent years, especially after high-profile incidents like the death of Eric Garner, who was killed in 2014 by a police officer who put him in a prohibited choke hold, and more recently, the killing of George Floyd, who was killed by police during an arrest after an officer knelt on his neck for eight minutes with no medical attention rendered. The nationwide protests that began in the wake of George Floyd’s death have brought more widespread attention to the issue of what constitutes appropriate use of force by law enforcement and renewed calls for training that prioritizes de-escalation tactics. Others, like some in law enforcement, maintain that through proper training, choke holds are an important method to control an individual to reduce the potential for greater injury or violence. ACEP issued statement on Structural Racism and Public Health on May 30, 2020 denouncing racism and all senseless acts of violence.

As the resolution notes, several law enforcement agencies already discourage or prohibit the use of choke holds, but some doubt the effectiveness of these policies. In the Eric Garner killing, the New York Police Department (NYPD) had already banned the use of choke holds. In New York City, the Civilian Complaint Review Board found that the use of choke holds appeared to increase though the restraint was prohibited. On June 12, 2020, New York Governor Andrew Cuomo signed into law the “Eric Garner Anti-Chokehold Act,” which allows for any police officer who injures or kills someone by using a choke hold (or similar use of force) to be charged with a class C felony that is punishable by up to 15 years in prison.

On June 16, 2020, President Donald Trump signed an executive order (EO), “Executive Order on Safe Policing for Safe Communities,” which among other provisions, bans the use of most choke holds by making receipt of federal grants by law enforcement agencies contingent on banning the use of choke holds, “except in those situations where the use of deadly force is allowed by law.” The EO also encourages law enforcement agencies to improve training procedures to emphasize de-escalation tactics and to better interact with individuals with mental health needs, substance use disorders, or suffering from homelessness. However, some police reform advocates have suggested this EO does not go far enough to address the issue.

Congress has also recently attempted to address the issue of law enforcement reform, including policies surrounding the use of choke holds. A recent legislative proposal offered by the Democratic Majority in the House of Representatives proposed a complete nationwide ban on the use of choke holds, while a proposal put forward by the Senate Republican Majority would encourage police departments to ban choke holds but would not legally ban their use outright.

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**ACEP Strategic Plan Reference**

**Goal 1 – Improve the Delivery System for Acute Care**
  Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

**Goal 2 – Enhance Membership Value and Member Engagement**
  Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Resolution 34(18) Violence is a Health Issue adopted. Directed ACEP to recognize violence as a health issue addressable through medical and public health interventions, and to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

Resolution 14(15) Body-Worn Cameras for Police not adopted. Directed ACEP to create a policy statement endorsing laws requiring police officers to wear body-worn cameras.

Resolution 22(10) Police Pursuits not adopted. Directed ACEP to strongly encourage use of safer alternatives to police pursuits, support enactment of laws requiring law enforcement agencies to accept responsibility for their actions regarding police pursuits and support mandatory tracking of pursuit-related injury data by NHTSA.

Amended Resolution 21(08) Excited Delirium adopted. Directed ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

**Prior Board Action**

April 2020, approved the revised policy statement “Cultural Awareness and Emergency Care;” reaffirmed April 2014; originally approved April 2008 with the current title, replacing “Cultural Competence and Emergency Care” that was approved October 2001.

April 2019, revised and approved the policy statement “Violence-Free Society;” reaffirmed June 2013; revised and approved January 2007; reaffirmed 2000; originally approved January 1996.

October 2009, approved the “White Paper Report on the Excited Delirium Syndrome” and authorized its distribution to the Council. A workgroup was appointed in August 2020 to update the paper.

Amended Resolution 34(18) Violence is a Health Issue adopted.

Amended Resolution 21(08) Excited Delirium adopted
Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Senior Congressional Lobbyist

**Reviewed by:**
Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 29(20)

SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP

SUBJECT: Billing and Collections Transparency in Emergency Medicine

PURPOSE: 1) Amend two current ACEP policy statements to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. 2) Adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. 3) Petition state or federal legislative and regulatory to require revenue cycle management entities to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. 4) Adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy efforts. Potentially significant reduction in outside funding support.

WHEREAS, It is common knowledge that many ACEP members are denied access to what is billed and collected in their name; and

WHEREAS, A lack of transparency regarding what is billed and collected in a physician’s name breeds distrust and can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing the difficult specialty of emergency medicine; and

WHEREAS, Without transparency regarding what is billed and collected in a physician’s name the efforts to end gender disparity in physician pay will be lacking due to insufficient information; and

WHEREAS, The physician is supposed to see this information to ensure honest billings and can be held individually liable for up coding and fraud; and

WHEREAS, Without this information the physician risks being a party to fee-splitting whereby a physician gives up a portion of their professional fee above fair market value in return for the right to see patients (receive referrals) in the ED; and

WHEREAS, The original Bylaws of ACEP opposed fee-splitting stating that “In the practice of medicine, a physician shall limit the source of his income to medical services actually rendered by him to his patients. He should neither pay nor receive a commission for referral of patients.”; and

WHEREAS, Participation in prohibited fee splitting has long been recognized as a risk to the emergency physician by ACEP as demonstrated in the 1996 book published by ACEP written by Kalifon and Sullivan titled “Before you sign. Contract basics for the emergency physician” and this book states “Medicare, Medicaid and some states’ laws prohibit kickbacks and fee-splitting. The Group and the Contractor (the physician) might violate these laws if the Group retains or, phrased differently, the Contractor pays more than fair market value for the services the Group provides to the Contractor.”; and

WHEREAS, With reports of fee-splitting being up to 20% of the professional fee this is a significant economic issue for the membership of the ACEP, the value of which could run in the millions over a 20- to 30-year career; and
WHEREAS, AMA policy H – 190.971 states that “all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information” (reaffirmed 2017); and

WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are detrimental to its members or the public”; and

WHEREAS, Denial of this information can be detrimental to ACEP members in regard to unwitting participation in fee-splitting and upcoding as well as to the public if they are subject to excessive charges; and

WHEREAS, The billing entity is supposed to be answerable to the individual physician; and

WHEREAS, The reputation of an emergency physician can be affected if inflated bills for services are sent to the patient; therefore be it

RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Contractual Relationships” through deletion and substitution as follows: “The emergency physician should have the right to review what is billed and collected for his or her service on at least a monthly basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law. The emergency physician shall not be asked to waive access to this information.”; and be it further

RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and Responsibilities” through deletion and substitution as follows: “5. Emergency physicians shall be provided periodic detailed itemized reports of billings and collections in their name on at least a monthly basis and have the right to audit such billings, without retribution. The emergency physician shall not be asked to waive access to this information.”; and be it further

RESOLVED, That ACEP adopt as policy that: “No member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide.”; and be it further

RESOLVED, That ACEP petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly provide every emergency physician its bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and be it further

RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on what has been billed and collected in the physician’s name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing companies.”

Background

This resolution directs ACEP to amend two current policy statements, “Emergency Physicians Contractual Relationships” and “Emergency Physician Rights and Responsibilities,” to stipulate a requirement that all members shall automatically receive monthly detailed reports of services billed in their names. The resolution further directs ACEP to adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services. Additionally, the resolution directs ACEP to petition state and federal regulatory bodies to require revenue cycle management entities, regardless of their
ownership structure, to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis. Finally, the resolution directs ACEP to adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP and that these reports should be provided automatically to every member without a requirement to request such reports.

The intent of this resolution is similar to Resolution 30(20) Protection and Transparency, therefore the background for both resolutions is also similar. The scope of Resolution 30(20) is not as comprehensive.

The requested new policy stating that “no member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide” would presumably be enforced through ACEP’s ethics procedures. Non-member entities would not be subject to this process for member violations.

ACEP’s policy statement “Emergency Physician Contractual Relationships” and the associated Policy Resource and Education Paper (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name. Further, the PREP states that “the contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is party and to relate to one another in an ethical manner.”

Although patients are generally billed on behalf of the specific emergency physician who cared for them, the way business is structured in emergency medicine, funds paid by a patient or by a third-party payer on behalf of a patient do not generally go directly to the emergency physician. In most instances, the emergency physician has assigned his or her payments to another entity, generally the entity contracted with the emergency physician. The physician, however, is responsible for the accuracy of the charting and also the accuracy of the coding and billing based upon the physician’s charting. The bottom of the Health Insurance Claim Form 1500 (required by many government payers) reads:

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

Like many professional associations, ACEP provides venues for competitors to communicate with its members such as exhibiting at meetings, sponsoring events, and advertising in publications. While some court decisions allow associations to offer or deny access to these venues on arbitrary grounds, there is also case law holding that a denial of essential means of competition may be made the basis for antitrust challenges against associations. Since ACEP is the oldest and largest association of emergency physicians and its Scientific Assembly is the largest emergency medicine meeting in the world, excluding certain competitors from these venues could have a significant, adverse impact on those competitors’ ability to compete and could result in antitrust litigation filed against ACEP.

ACEP’s “Antitrust” policy statement states: “The College is not organized to and may not play any role in the competitive decisions of its member or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.” The policy further specifies:

- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers…
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.
• There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.

Adoption of a policy that prohibits members from denying other emergency physicians the right to detailed reports of billing and collections for their services would presumably mean that members could face sanctions, including possible expulsion from membership, for failing to abide by the policy. ACEP would be required to report any suspension or expulsion to the National Practitioners Data Bank. Enforcement of self-regulation codes, even if the enforcement is not anti-competitive, must be carried out in a manner that affords the alleged offender due process, which includes proper notice and a fair hearing. The ACEP Bylaws state that “Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.” The College Manual currently describes the process for addressing all disciplinary actions and is the process currently used to adjudicate ethics charges.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide adequate due process to the accused member(s). The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to revoke a member’s membership or deny an entity’s ability to exhibit, sponsor, or advertise with ACEP may create additional potential liability risk for ACEP. Affected members could bring legal action against the College with claims of defamation, limiting professional opportunities, or denial of due process on the part of ACEP. Excluding an entity from being able to sponsor any ACEP activity could subject the College to a claim of restraint of trade. Such challenges can be mitigated by developing and adhering to strict processes.

Currently, approximately 24% of all corporate support in FY 2019-20 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed $1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
   Objective E: Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources for policy development and advocacy efforts. The financial impact would depend on how many entities would not agree to provide monthly detailed itemized reports to all contracted emergency physicians. Physician groups, staffing companies, and hospitals/clinics contributed $1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities in FY 2019-20. Additionally, ACEP’s prescribed procedures for adjudicating accusations of member misconduct is time intensive for the Ethics Committee, Board of Directors, and staff involved in investigation and rendering decisions on ethics complaints.

Prior Council Action

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement “Promotion of College Policies on Contracting and Compensation” and potentially realign it with other ACEP policies or rescind it and report back to the 2003 Council.

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to
disclose their level of compliance with College policies on compensation and contractual relationships.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the “Emergency Physician Rights and Responsibilities” policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Directed ACEP to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations and to explore legal issues surrounding coercive contracting and if appropriate request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians’ rights policies, including: “Emergency Physicians Rights and Responsibilities,” “Emergency Physician Contractual Relationships,” “Agreements Restricting the Practice of Emergency Medicine,” and “Compensation Arrangements for Emergency Physicians”

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that “the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment,” and its accompanying objective that “fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered.”

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians’ rights to fair and equitable treatment.

Prior Board Action

January 2019, reaffirmed the policy statement “Antitrust;” reaffirmed June 2013 and October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title that was approved in April 1994.


October 1984 titled “Contractual Relationships between Emergency Physicians and Hospitals.”


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


Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

June 1997 reviewed the information paper “Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships.”

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

**Background Information Prepared by:** David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 30(20)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Protection and Transparency

PURPOSE: Establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information monthly to the emergency physician for all charges billed and all collections made under the physician’s name, license number, or other identifying information without the physician having to request it. Additionally calls for new policy that would require these same entities to automatically provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or CMG as a result of the physician providing his or her services.

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

WHEREAS, Many emergency physicians work for or are contracted by others to provide their services; and

WHEREAS, The majority of emergency department staffing contracts are owned, controlled, or influenced by contract management groups and not the physicians working in the emergency department; and

WHEREAS, Most of the billing done for the services provided by emergency physicians are not billed by or under the control of the physicians who provided, or are responsible for, the services; and

WHEREAS, The physician remains responsible and liable for any fraud or false claims that might occur in the billing for services provided by them or that they may be responsible for in a supervisory role, regardless of who performs the billing services; and

WHEREAS, The False Claims Act (FCA) provides that any person who knowingly submits false claims to the government is liable for treble the government’s damages plus a penalty ($5,000-$10,000) that is linked to inflation for each false claim”ii; and

WHEREAS, “The False Claims Act makes it a crime for any person or organization to knowingly make a false record”iii and “knowingly includes having actual knowledge that a claim is false or acting with ‘reckless disregard’ as to whether a claim is false”iv; and

WHEREAS, 31 U.S.C. § 3729 (False Claims Act) states that while “the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false”v; and

WHEREAS, The physician may be viewed as “acting with reckless disregard” if he or she is not aware of what is being billed under their name or license number; and

WHEREAS, By providing detailed information to the physician for all charges that are billed and collected under his or her name and allow the physician to review the information would remove this reckless disregard argument and protect the physician; and

WHEREAS, Allowing physicians who have charges billed under their identifying information would serve as an additional tool to protect physicians, help screen for, identify, and possibly prevent healthcare fraud; and
WHEREAS, Contract management groups (CMGs) or employers may not want to share the physician’s billing or collection data with the physician for various reasons; and

WHEREAS, CMGs often receive benefits because of the services the emergency physicians provide that may be separate from traditional billing and collections; and

WHEREAS, CMGs or employers may discourage physicians from requesting their own billing or collection information and may penalize conspicuously or inconspicuously; and

WHEREAS, If this information is only provided when a physician asks for it, physicians who request such information would stand out and could become targets for discriminatory treatment by their employer or CMG; and

WHEREAS, Many emergency physicians do not know exactly how much is being billed to patients and third parties for the services they provided or were the attending physician supervising a non-physician provider who provided the service; and

WHEREAS, Many emergency physicians are unaware how much is taken out of the money they generate for medical malpractice insurance, billing services, management fees, or other expenses; and

WHEREAS, Many emergency physicians are unaware of their true market value as emergency physicians because they are unaware of the exact amount of collections that are generated under their identifying information; therefore be it

RESOLVED, That ACEP establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information on a monthly basis to the emergency physician for all charges billed and all collections made under the physician’s name, license number, or other identifying information without the physician having to request it; and be it further

RESOLVED, That ACEP establish policy that requires all employers, persons or entities who contract for emergency physician services to provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services without any requirement of the physician requesting it.

Background

This resolution directs the College to establish policy that requires all employers, persons, or entities who contract for emergency physician services (whether in-person or via telehealth) to provide itemized billing and collection information on a monthly basis to the emergency physician for all charges billed and all collections made under the
ohysician’s name, license number, or other identifying information without the physician having to request it. The resolution additionally calls for new policy that would requires these same entities to automatically provide information on a monthly basis to physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services.

The intent of this resolution is similar to Resolution 29(20) Billing and Collections Transparency in Emergency Medicine, therefore the background for both resolutions is also similar. The scope of resolution 29(20) is more comprehensive.

ACEP’s policy statement “Emergency Physician Contractual Relationships” and the associated Policy Resource and Education Paper (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name:

Billing Rights:
- The emergency physician should have the right to review what is billed and collected for his or her service regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law.

Further, the PREP states that “the contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is party and to relate to one another in an ethical manner.”

Although patients are generally billed on behalf of the specific emergency physician who cared for them, the way business is structured in emergency medicine, funds paid by a patient or by a third-party payer on behalf of a patient do not generally go directly to the emergency physician. In most instances, the emergency physician has assigned his or her payments to another entity, generally the entity contracted with the emergency physician. The physician, however, is responsible for the accuracy of the charting and also the accuracy of the coding and billing based upon the physician’s charting. The bottom of the Health Insurance Claim Form 1500 (required by many government payers) reads:

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.”

ACEP’s policy statement “Compensation Arrangements for Emergency Physicians,” mentions recognition of various compensation methods and that exploitation of emergency physicians is improper. It further strongly urges members to carefully evaluate any health care delivery system or arrangement that might unfairly profit from the professional services of the emergency physician.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide adequate due process to the accused member(s). ACEP would not have any standing to investigate CMG’s for non-compliance since ACEP’s “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” apply only to members. It is also possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
Objective E: Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources for policy development.

Prior Council Action

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement “Promotion of College Policies on Contracting and Compensation” and potentially realign it with other ACEP policies or rescind it and report back to the 2003 Council.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted. Directed ACEP to endorse the principles outlined in the Emergency Physician Rights and Responsibilities" information paper as a priority for the College.

Resolution 12(01) Coercive Contracting not adopted. Directed ACEP to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations and to explore legal issues surrounding coercive contracting and if appropriate request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that “the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment,” and its accompanying objective that “fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered.”

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians’ rights to fair and equitable treatment.

Prior Board Action


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


Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

June 1997 reviewed the information paper “Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships.”

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

**Background Information Prepared by:** David McKenzie, CAE  
Reimbursement Director

Adam Krushinskie, MPA  
Reimbursement Manager

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker  
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 31(20)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Insurer Accountability/Policy Weakness Disclosure

PURPOSE: Establish policy that advocates for legislation requiring Policy Weakness Disclosures (PWDs) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy and support legislation imposing penalties on insurers who do not provide PWDs to policyholders as required.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement and convey ACEP’s position to federal Executive and Legislative branch officials.

WHEREAS, Many insurance companies sell many different forms of health insurance policies; and

WHEREAS, People often choose policies based on the costs\(^1\), and

WHEREAS, Many people do not understand the policies that they are being sold or what their financial responsibilities will be should they need medical attention or incur medical costs\(^{ii}\) and

WHEREAS, In many cases the physician, hospital, staffing company and/or their staff are the ones that often must explain the insurance policy to patients and not the insurance company that sold the policy; and

WHEREAS, Many insured have complained about “surprise bills” (balance billing) and ACEP and EDPMA representatives have stated that often turns out to be a “surprise coverage problem”\(^iii\); and

WHEREAS, There has been a lot of national attention regarding surprise billing and will likely result in legislation that could significantly impact reimbursement and patient care that ACEP has been addressing through conversations with legislators, i.e., meetings, Day on the Hill, lobbying efforts, etc.; and

WHEREAS, Because the average or typical family has about $400-$700 in emergency funds, insurance companies are shifting more of the financial responsibility to patients, and after one applies in or out of network status, deductibles, and co-pays, the financial responsibility of the patient often outstrips the emergency funds of the family\(^iv\); and

WHEREAS, Approximately one in five people in the United States have medical debt in collections\(^v\) and according to the Commonwealth Fund, two in five working Americans (72 million) are paying off medical debt or have medical bill problems\(^vi\); and

WHEREAS, Physicians explain risks and benefits of procedures to patients and often are required to obtain written informed consent before they proceed with procedures to document the patient’s understanding of the risks and benefits, including the unlikely but most serious risks such as loss of limb, brain damage, permanent disability, vegetative state, or death, etc., it is reasonable that insurers also be required to explain to patients (their customers) what they are selling them; and

WHEREAS, In an ACEP Fair Coverage Fact Sheet, it was stated “9 out of 10 emergency physicians polled say health insurance companies mislead patients…”\(^vii\); therefore be it
RESOLVED, ACEP establish policy that advocates for legislation requiring Policy Weakness Disclosures *(PWD)* be provided by health insurers to potential customers before and at the time of sale of any healthcare policy that specifically explains the policy that they are selling with specific examples of “worse case scenarios” (including hypothetical emergency department visits resulting in $10,000 outpatient visit and $200,000 hospitalization with out-of-network emergency physicians, anesthesiologists, radiologists, telehealth physician and non-physician providers, excluded services, co-pays, deductibles, etc., to help the public understand the potential risks of buying a particular insurance policy that actually can and do occur; and be it further

RESOLVED, That ACEP support legislation imposing penalties on insurers who do not provide Policy Weakness Disclosures to policyholders as required, i.e., before they purchase the policy that include requiring the insurer to cover 100% of all charges without deductible, co-pay, exclusions, etc.

*PWD-Policy Weakness Disclosure. A written disclosure that insurance companies would be required to provide to customers before they could receive any benefit (sell) that explains the policy and lists numerous examples of the short fall or worse case scenarios where customers would be financially responsible (insurance would not cover) for large amounts of money based on what actually occurs, i.e., emergency department visits (testing, imaging, out-of-network emergency physicians, radiologists, anesthesiologists, pathologists, etc.).

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1 Shaheen, Etch. (2020). *How the healthcare system keeps you... IN THE DARK.* Knowledge is Power Publishing.

**Background**

This resolution directs ACEP to establish policy that advocates for legislation requiring Policy Weakness Disclosures (PWDs) be provided by health insurers to potential customers before and at the time of sale of any healthcare policy and support legislation imposing penalties on insurers who do not provide PWDs to policyholders as required.

A 2016 survey conducted by PolicyGenius in partnership with Radius Global Research of 2,000 American health insurance consumers found that 96% of Americans overestimate their understanding of four key health insurance concepts – deductible, co-insurance, co-pay, and out-of-pocket maximum. There was a significant difference between the respondents’ confidence (68%) that they “definitely understood” these terms and their overall comprehension (42%) of these terms. Only 4% could actually define all four terms.

In 2019, PolicyGenius used Google Consumer Surveys to poll a nationally representative sample of 1,500 people and found more than one in four people said uncertainty over their coverage led them to avoid treatment. It also found few people understand what health insurance plans must cover by law. They have also conducted surveys about health insurance literacy for the past three years and found people are increasingly confused about the Affordable Care Act (ACA) and what coverage is required. In 2018 and 2019, the surveys asked about the same six (of 10) essential health benefits (EHBs). While 28% thought health insurance plans were not required to cover any of the six EHBs in 2018, 44% held this incorrect belief in 2019.

With the reinstatement in 2017 of short-term (up to one year) health insurance plans by the Trump Administration, there is further confusion amongst consumers about their health insurance coverage. A 2019 report from Kleimann Communication Group, which was commissioned by a group of consumer representatives to the National Association of Insurance Commissioners (NAIC), found most consumers struggled to understand the marketing materials for a popular short-term plan and many misunderstood the basic concept of that type of insurance plan because they expect
their health insurance to reflect the Affordable Care Act’s consumer protections.

Kleimann also asked about the federally mandated disclosure and whether consumers thought it adequately conveyed the limitations of the policy. The federally mandated disclosure requires short-term plans to state, on application materials and the contract, that the plan does not have to comply with the ACA and may have coverage limitations and annual or lifetime dollar limits. However, the disclosure went largely unnoticed and was ineffective at reducing consumer confusion. Few participants looked at the disclosure language included on the cover page of the short-term plan brochure. Participants in the study did not notice the disclosure because it was de-emphasized through its placement on the cover in very small font. When the disclaimer was pointed out to them, participants thought it was important, but few noticed it on their own and it did not eliminate or reduce the confusion about coverage and cost-implications.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
  Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement and convey ACEP’s position to federal Executive and Legislative branch officials.

Prior Council Action

Substitute Resolution 10(03) Changing Payer Market adopted. It directed ACEP to: 1) study the effect of changes in the private payer market (caused by health care insurers’ changes in coverage and payment policies) to access to emergency medical services, including increases in premiums, co-payments, and deductibles incurred by insured individuals, as well as discounted fees to health care providers; and 2) develop a strategy targeting the business community and insurers to address adverse effects of changes in the private payer market. A report was developed and distributed to the 2004 Council. The report focuses on the lack of evidence supporting a relationship between payer policies and ED access.

Prior Board Action

None

Background Information Prepared by: Brad Gruehn
  Congressional Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
  Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
  Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 32(20)

SUBMITTED BY: Harrison Alter, MD, FACEP  
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SUBJECT: Loss of Health Insurance Due to COVID-19

PURPOSE: Support adoption of Medicare-for-All as an alternative to employment-based insurance (with conditions) and explore opportunities to partner with other like-minded organizations favoring a Medicare-for-All approach.

FISCAL IMPACT: Budgeted staff and committee time and resources.

WHEREAS, The COVID-19 pandemic has caused almost 27 million Americans to lose health care coverage as a result of becoming involuntarily unemployed; and

WHEREAS, Tying insurance to employment creates an undue burden on both employees and businesses alike; and

WHEREAS, The 2010 Affordable Care Act (ACA) created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead, and even prior to COVID-19 left 28 million Americans uninsured and another 44 million underinsured, causing them to receive care at an advanced stage of disease or to forego care altogether; and

WHEREAS, Medicare-for-All is an alternative to employment-based insurance, with financing streamlined through a single-payer system; adds simplicity to billing and medical care administration resulting in lower overhead; and has the potential to help American businesses compete globally by reducing their financial obligations for their employees’ health care; and

WHEREAS, Recent polls demonstrate majority support for Medicare-for-All or single-payer by the general public and among clinicians; and

WHEREAS, There is no truth to the memes that Medicare-for-All is “socialized medicine”; that it is “government-controlled health care”; that it represents a massive pay cut for physicians; or that it will block health care competition, diminish quality, forestall medical innovation, or inhibit patient choice of provider; and

WHEREAS, In 1999, the ACEP Council adopted Resolution 15(99) Promotion of Health Care Insurance stipulating that ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured, a stipulation that has yet to be consummated; and

WHEREAS, ACEP’s Health Care Financing Task Force, created in 2017 to study alternative financing models that foster competition and preserve patient choice, did not provide any actionable conclusions; and

WHEREAS, ACEP’s Acute Unscheduled Care Model (AUCM), created by the Alternative Payment Model...
Task Force, focused on physician reimbursement rather than overall health care financing; therefore, be it

RESOLVED, That ACEP support adoption of Medicare-for-All as an alternative to employment-based insurance – but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine; and be it further

RESOLVED. That ACEP explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach to providing universal health care to all Americans.

2 Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, February 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
3 KFF Health Tracking Poll. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage (slide file; published May 27, 2020), at: http://files.kff.org/attachment/SP_5.21.20
4 Poll: 69 percent of voters support Medicare for All. The Hill. Published April 24, 2020, at: https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all
5 Murad Y. As coronavirus surges, ‘Medicare for All’ support hits 9-month high. Morning Consult/Politico poll (February 21-23, 2020 and March 27-29, 2020; published April 1, 2020), at: https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/

Background

The resolution calls for ACEP to support the adoption of Medicare-for-all as an alternative to employment-based insurance, but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine. Additionally, it calls for ACEP to explore opportunities to partner with other like-minded organizations that favor the Medicare-for-all approach to providing universal health care to all Americans.

The resolution notes the economic impact of the COVID-19 pandemic that resulted in dramatic job losses in the U.S., especially during the first several months of the response. While some of these losses were temporary and the economy has recovered a large portion of the initial drop, as of mid-August, weekly unemployment claims numbered nearly one million. Since President Trump declared a state of emergency on March 14, 2020, more than 56 million Americans have applied for unemployment benefits in a 21-week period. The resolution further notes that because of the predominance of the employer-sponsored model of health insurance in the U.S., unemployment is directly linked to a loss of insurance, which in turn affects individual and public health in addition to its financial impacts on the health care system.

The resolution references the Health Care Financing Task Force (HCFTF) established in response to Amended Resolution 19(16) to study alternative health care financing models, including single payer. The task force submitted its report to the Board of Directors in fall 2018 and the report served as the foundation for the 2018 Council Town Hall Meeting. The report notes:

Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the ‘9 Principles’ outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied single-payer models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system –
could be espoused over another. The HCFTF concluded “ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer.”

It is important to recognize that single-payer is not equivalent to universal health care. Universal health care refers to a system in which all citizens have access to health care services, although payment for these services could derive from either a single source or multiple sources. Single-payer, on the other hand, is a health care financing system where all reimbursements derive from one entity.

Further, while the resolution states “Single-payer health insurance, often known as ‘Medicare-for-All’…”, it should be noted that “single-payer” and “Medicare-for-All” are also considered distinct proposals, even by many proponents. For example, a 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, “there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a “Medicare for all” program could be single-payer but does not necessarily have to be.”

Recently, there appears to be growing public support for Medicare-for-All proposals, driven by the COVID-19 pandemic. The resolution cites an April 2020 Morning Consult/Politic survey of registered voters showing an approximately 40 percent increase in support for both the Affordable Care Act and for universal health care proposals. It is unclear if this trend has continued in the ensuing weeks. It also found that support for Medicare-for-All was supported by 55 percent of registered voters, a one percent increase since June 2019.

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP or military health care (TRICARE or VA/CHAMPVA). For those who are privately insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs and in the private marketplace. Government programs insured 95 million Americans while private insurance covered 196 million of those who had health insurance in 2010.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources. For example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the Journal of the American Medical Association in 2003), all residents of the U.S. would be enrolled and all medically necessary care would be covered. Obviously, the question of what is considered medically necessary could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums. Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294
billion annually on administrative costs, which represents 31% of health expenditures in this country. However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification. Furthermore, these savings would only be generated one time.

Regarding cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government’s ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: “restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers.” Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
   Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

   Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff time and resources. Potential additional costs associated with working with like-minded partners or coalitions.

Prior Council Action

Resolution 37(19) Single-Payer Health Insurance not adopted.

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.


Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.
Resolution 32(20) Loss of Health Insurance Due to COVID-19

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Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a taskforce to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Resolution 11(00) Funding the Mandate referred to the Board.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted. Directed the College to develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting. This resolution was linked to Resolution 12(99). A health policy report, “Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured” was developed and included in the published proceedings of ACEP’s educational conference “National Congress for Preserving America’s Healthcare Safety Net.” The report included several principles developed by the task force, including the urgent need to expand health insurance coverage.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.
Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

**Prior Board Action**

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.


Substitute Resolution 31(14) Single Payer Health Insurance adopted.


Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP’s primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the “Principles of Reform of the U.S. Health Care System” developed by eleven physicians’ organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.


Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.
Resolution 32(20) Loss of Health Insurance Due to COVID-19
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Background Information Prepared by: Ryan McBride, MPP
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Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
   Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
   Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 33(20)

SUBMITTED BY: Aimee Moulin, MD, FACEP
John Rogers, MD, FACEP

SUBJECT: Metrics, Measures, and Pay-for-Performance Programs

PURPOSE: Seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay for performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of up to 15 ACEP staff.

WHEREAS, Scientific management by metrics, first described by Frederick Taylor, has been widely adopted and implemented in emergency medicine; and

WHEREAS, Metrics are often the basis for reimbursement through pay-for-performance programs; and

WHEREAS, Metrics often become goals, therefore violating Goodhart’s law and no longer serve as useful measures; and

WHEREAS, Pay-for-performance programs often lead to perverse behaviors and gaming; and

WHEREAS, Don Berwick, a previous CMS Director, and others, have called for the end of pay-for-performance programs; and

WHEREAS, Many measures, such as the sepsis quality measures, are often at odds with current science; and

WHEREAS, The American Medical Informatics Association has called for the discontinuation of using clinical documentation for billing and administrative purposes; and

WHEREAS, Many emergency physicians cite these programs and expectations as oppressive and rob them of the joy of practicing emergency medicine; therefore be it

RESOLVED, That the College seek the decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements; and be it further

RESOLVED, That the College seek the end of pay-for-performance programs in emergency medicine; and be it further

RESOLVED, That the College encourage the Emergency Medicine Foundation Board of Trustees to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.
Resolution 33(20) Metrics, Measures, & Pay-for-Performance
Page 2

Background

This resolution requests ACEP to seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians. The intent of the resolution is to address programs that have become too complex, burdensome, potentially detrimental, and unjustly used to punish physicians and expresses concern that the metrics have become the goals and thereby are no longer useful measures.

The American Medical Informatics Association (AMIA)\(^1\) proposes to substitute clinical documentation by creating an authoritative body from professional and specialty societies to: (1) assess clinical documentation requirements; (2) evaluate technological capabilities available today to extract then report data; and (3) define a financial mechanism to remunerate clinicians, hospitals, and healthcare systems for their work.

Decoupling clinical documentation from the functions of billing, regulatory, and compliance functions is a revolutionary idea. There is long precedent that the medical record is the best source of data to determine the level of service provided, support that service using diagnosis and management options considered, and justify the medical necessity of those choices to the payer community for payment and review under audit. A viable alternative would need to be provided in place of the medical record for this to occur. The clinical medical record is currently the most reliable vehicle for the physician themselves to document what care was provided and why to inform the selection of codes reported for payment, to provide a record of the medical care for future interactions and to justify the services provided under audit for internal review, productivity based compensations, and external payer compliance audits.

Such a move could hurt ACEP’s advocacy efforts in the American Medical Association CPT Editorial Panel to define clinical services and the Relative Value Update Committee (AMA RUC) process to accurately value ED-related services.

Eliminating pay for performance programs for emergency medicine would require a change to the 2015 MACRA law that was passed with high bi-partisan support. The resolution invokes former CMS Director Don Berwick and the book *The Tyranny of Metrics* describing how pay-for-performance programs have been detrimental to other industries. Additionally, the resolution warns that although quality measures as a basis for improving performance is admirable, using them for payment purposes may be misguided.

A large percentage of ACEP’s Clinical Emergency Data Registry (CEDR) participant groups have scored very well in their Merit-based Incentive Payment System (MIPS) scores to qualify for the “exceptional” bonus. In 2018, 40% of CEDR participants received the exceptional bonus. In 2019, the percentage is likely to be much higher. Exceptional bonus provides a significant return on investment for CEDR participation and a good pay-for-performance bonus on Medicare Part-B reimbursement. For a perfect score of 100 the bonus is 1.79 percent on all Medicare payments for the year under review. If the pay-for-performance program was eliminated, this bonus will likely end. Currently, 70-80% of the participants in CEDR join for the pay-for-performance bonus opportunity. If this program is ended; CEDR will not be sustainable as a data registry. ACEP may have to bring additional funding for it to remain self-sustaining as a tool for quality improvement and gaining data insights. Eliminating CEDR altogether would cause a revenue loss of $3.6 million with a net profit of $335,526. The larger loss would be non-financial to the membership/success of emergency medicine and staff. ACEP would lose its data leadership, quality measures would become non-operational, and the industry would lose methods for emergency physician performance/quality measurement. Additionally, approximately 15 ACEP staff positions would be eliminated if CEDR is not sustainable.

The Emergency Medicine Foundation (EMF) is an independent organization and does consider directed research funds for targeted research.

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ACEP Strategic Plan Reference

Goal 1: Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Objective D: Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay-for-performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of approximately 15 ACEP staff members.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted. Directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment.

Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards referred to the Board. Called for ACEP to collaborate and build coalitions with non-medical organizations involved in developing quality standards and engage with regulatory entities such as CMS, Joint Commission, and the National Quality Forum.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care and effective ED information sharing systems to incentivize EDs to perform intensive case management for high utilizers.

Amended Resolution 17(10) CMS payment Model Pilot Projects adopted. Directed ACEP to continue to develop models for appropriate payment for patient care services provided by emergency physicians and when appropriate, engage CMS.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted. Directed ACEP to closely monitor Medicare contractor behavior regarding interpretation of guidelines and addressing inconsistent and unreasonable policy.

Prior Board Action

June 2017, approved the Quality & Patient Safety Committee’s recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Reviewed and approved an information paper “The Role and Value of Emergency Medicine in Accountable Care Organizations” in November 2015 which discussed metrics and quality measures for emergency medicine.

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.
Amended Resolution 17(10) CMS payment Model Pilot Projects adopted.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted.

**Background Information Prepared by:**  David McKenzie, CAE
Reimbursement Director

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Reimbursement Manager

**Reviewed by:**  Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 34(20)

SUBMITTED BY: New York Chapter

SUBJECT: Public/School Bleeding Control Kit Access and Training

PURPOSE: Support access to bleeding control kits in all schools and public venues nationwide and support the expansion of bleeding control training in schools and communities to support educated use of these kits.

FISCAL IMPACT: Budgeted expenses for the Until Help Arrives program.

WHEREAS, The average person is not prepared to be a first responder in the event of a crisis; and

WHEREAS, There are programs available from the American College of Emergency Physicians (Until Help Arrives) and the American College of Surgeons (Stop the Bleed) to increase confidence and teach lifesaving skills; and

WHEREAS, Every minute that passes in a hemorrhage situation waiting for emergency care to arrive increases morbidity and mortality; and

WHEREAS, Multiple states have already passed laws funding or requiring bleeding control kits and training in public schools; and

WHEREAS, Public sites and schools are already required to have public access automated external defibrillators (AEDs) accessible; therefore be it

RESOLVED, That ACEP support access to bleeding control kits in all schools and public venues nationwide akin to the automated external defibrillators (AED) access programs; and be it further

RESOLVED, That ACEP support the expansion of bleeding control training in schools and communities to support educated use of these kits in the event of an emergency until help arrives.

Background

This resolution calls for ACEP to support access and training for bleeding control kits in all schools and public venues.

ACEP was a key stakeholder of the “Stop the Bleed” campaign when it was initiated by the White House and the National Security Council in October of 2015. The White House campaign was headed by ACEP member Richard Hunt, MD, FACEP, who was assigned as the Director for Medical Preparedness Policy at the National Security Council.

The initial decision was for ACEP to support the objectives of the “Stop the Bleed” campaign, which included public access to bleeding control kits and public training on their use. This was accomplished by promoting the campaign through the Prehospital-EMS Care Section, other related ACEP Sections, and ACEP’s National EMS Week Campaign. The American College of Surgeons – Committee on Trauma (ACS-COT) had a public focused bleeding control course already developed and ACEP was invited to partner on promotion of this course.

ACEP staff were tasked in the spring of 2018 to develop a new public-focused in-person course to include bleeding
control and lay-person CPR and present it in a course length of 60 minutes or less. Around the same time period, ACEP was approached by staff at the U.S. Dept of Health and Human Services (HSS)/Office of the Assistant Secretary for Preparedness and Response (ASPR) to support and help promote a new online bleeding control course they had developed. After reviewing the ASPR course, ACEP staff pursued integrating the bleeding control content into the new course in development by ACEP. ASPR agreed to allow use of their bleeding control content as well as the course name, Until Help Arrives.

ACEP partnered with an existing vendor, Simulab, to develop resources for the course including several different bleeding control kits and a training kit designed specifically for the ACEP course. ACEP released the new Until Help Arrives course, which includes bleeding control and compression-only CPR, during ACEP19 in Denver, CO. Plans were in place to market and promote the course aggressively during the spring/summer 2020 but has been delayed because of the impact of COVID-19. Staff are exploring options for an on-line version of the course should in-person public training be delayed long term.

The authors of this resolution are aware of the Until Help Arrives campaign and fully support it but believe emphasis on supporting access to the necessary equipment in schools and public venues is still needed.

**ACEP Strategic Plan Reference**

Goal 1 – Improve the Delivery System for Acute Care

Objective H – Position ACEP as a leader in emergency preparedness and response. This objective has a specific tactic to promote “Until Help Arrives” with a special emphasis on pilot projects involving chapters, outside partners, businesses, and civic groups.

**Fiscal Impact**

Budgeted expense for the Until Help Arrives program.

**Prior Council Action**

None

**Prior Board Action**

June 2019, approved funding for the Until Help Arrives campaign.

**Background Information Prepared by:** Rick Murray, EMT-P

Director, EMS & Disaster Preparedness

**Reviewed by:**

Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 35(20)

SUBMITTED BY: Sara Brown, MD FACEP  
Alaska Chapter  
Angela Cornelius, MD FACEP  
Georgia College of Emergency Physicians  
John McManus, MD FACEP  
Government Services Chapter  
Gina Piazza, DO FACEP  
Indiana Chapter  
Allen Yee, MD FACEP  
Kansas Chapter  
Air Medical Transport Section  
Maryland Chapter  
EMS-Prehospital Care Section  
Texas College of Emergency Physicians

SUBJECT: Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care

PURPOSE: Take a leadership role to ensure inclusion of prehospital care as a seamless component of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport; advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed prehospital care into a seamless patient-centered system of health care delivery.

FISCAL IMPACT: Budgeted staff resources to convey ACEP’s position to federal Executive and Legislative branch officials.

WHEREAS, In 2016, The National Academy of Sciences published “A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury” Recommendation 10: Congress, in consultation with the U.S. Department of Health and Human Services, should identify, evaluate, and implement mechanisms that ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and

WHEREAS, EMS operates at the intersection of healthcare, public health, and public safety and integration across the continuum of care delivery is essential to optimizing patient outcomes and to managing costs effectively; and

WHEREAS, Through an estimated nearly 26 million transport calls annually, prehospital EMS care is delivered directly to patients, in the locations where help is needed, providing a measurable effect on mortality to certain life-threatening medical emergencies; and

WHEREAS, EMS agencies are forced to limit services because of poor reimbursement, which leads to extended delays for interfacility transports particularly in rural areas; and

WHEREAS, The groundbreaking work of innovative EMS clinicians to deliver healthcare as Mobile Integrated Health or Community Paramedicine programs has demonstrated the benefit of these mobile providers of healthcare to improve health and decrease cost of more conventional healthcare delivery models; and

WHEREAS, Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year trial payment model, in which the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and clinicians to: 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations; 2) transport to an alternative destination partner; or 3) provide treatment in place with a qualified health care partner, either on the scene or connected using telehealth, and as a result, the ET3 model aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports; and
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WHEREAS, EMS has demonstrated during the COVID-19 pandemic their ability to respond in new and
innovative ways to deliver medical care to include telehealth platforms, assisting with disease screening and testing, treat
and non-transport protocols, and providing immunizations; and

WHEREAS, EMS has stood with our emergency department partners on the front lines to provide care in this
pandemic and countless other disasters and EMS should be reimbursed for these services both within and outside of
pandemic response; and

WHEREAS, The Department of Transportation National Highway Traffic Safety Administration (NHTSA)
Office of EMS (and its precursor entities) has been the only federal agency to provide continuous support to the national
EMS systems development since the publication of the paper, “Accidental Death and Disability: the Neglected Disease of
Modern Society” by the National Academies of Sciences in 1966; and

WHEREAS, The NHTSA Office of EMS has led the development and maintenance of the National EMS
Information System (NEMSIS), the standardized repository for all EMS clinical care records; and

WHEREAS, The evolution of the healthcare system in the United States, to include the integration of prehospital
care as an outcomes-driven, appropriately remunerated, patient-centered element, will require the shared efforts of all
relevant stakeholders, including professional organizations (ACEP, NAEMSP, ACS-COT, NAEMT, AAA, NASEMSO,
etc.) and governmental agencies (NHTSA, DHS, DHHS, DOD, FCC, CMS, HRSA, etc.); and

WHEREAS, Emergency physicians are leaders in prehospital care, serving as medical directors, systems
directors, educators, and as care providers and they should play an integral role in evolution of the healthcare system as it
seeks to integrate prehospital care as a seamless component; and therefore be it

RESOLVED, That ACEP take a leadership role to ensure the inclusion of prehospital care (e.g., emergency
medical services) as a seamless component of health care delivery rather than merely a transport mechanism; and be it
further

RESOLVED, That ACEP advocate for bidirectional data integration between hospitals and EMS; and be it
further

RESOLVED, That ACEP advocate for appropriate payment of EMS services to include all clinical services
separate from transport; and be it further

RESOLVED, That ACEP advocate for the development of a payment structure for EMS medical direction and
oversight including physician field response; and be it further

RESOLVED, That ACEP advocate for additional support to the National Highway Traffic Safety Administration
Office of EMS to allow for further federal leadership of EMS systems development and evolution and expansion of the
National EMS Information System; and be it further

RESOLVED, That ACEP collaborate with other stakeholder organizations to promote legislation that will allow
for the integration of reimbursed prehospital care into a seamless patient-centered system of healthcare delivery.

Background

This resolution directs ACEP to take a leadership role to ensure inclusion of prehospital care as a seamless component
of health care delivery, rather than a transport mechanism; advocate for bidirectional data integration between hospital
and EMS; advocate for appropriate payment of EMS services to include clinical services separate from transport;
advocate for payment structure for EMS medical direction and oversight; advocate for support to NHTSA Office of
EMS; and collaborate with other stakeholders to promote legislation that will allow for the integration of reimbursed
prehospital care into a seamless patient-centered system of health care delivery.
The essence of this resolution revolves around the role ACEP should play in the development and support of the Mobile Integrated Healthcare/Community Paramedicine (MIH/CP) model of patient care. ACEP’s legislative and regulatory priorities currently include working to promote appropriate guidelines and procedures for community paramedicine.

In June 2016, the ACEP MIH/PC Task Force developed an information paper on these issues. As stated in the primer: “Mobile integrated healthcare and community paramedicine (MIH/CP) is a term applied to a new model of community-based health care service delivery that often primarily uses emergency medical services (EMS) personnel and systems to provide acute medical care, coordination of services, healthcare maintenance, post-acute care, and prevention services to patients outside of routine EMS transport service to hospital destination care.” While each community may have unique needs that may benefit from various aspects of this health care delivery model, there are several core services this model is designed to address – chronic disease management and injury prevention, reduced 911 requests and transports for non-urgent patients, and the ability to provide appropriate follow-up care for high-risk patients without hospital readmission. Since EMS services in the United States are essentially reimbursed only when an appropriate transport to a hospital, skilled nursing facility (SNF), or for renal dialysis treatments are provided, the MIH/PC model also seeks to derive reimbursement for these alternative services.

Proponents of the MIH/PC model suggest patients’ health would be improved by helping them manage their chronic diseases, such as diabetes, high blood pressure, and high cholesterol, as well as reducing common injuries. This would be achieved through home visits/wellness checks to verify compliance with prescription medications and simple home improvements to prevent accidents. The MIH/PC model would also decrease “down time” between EMS calls and improve access to primary care services, especially in rural communities where many patients lack access to primary care and use 911 and EMS to receive health care services in non-emergency situations. Additional benefits of an MIH/PC model would be improved patient satisfaction with their overall health care experience and improved access to timely early warning signs of worsening conditions. Finally, by reducing non-emergency transports, it is argued that the system is keeping those resources available for true emergencies.

The Center for Medicare and Medicaid Innovation (CMMI) within the HHS’ Center for Medicare & Medicaid Services (CMS) has established a demonstration program, the “Emergency Triage, Treat, and Transport (ET3) Model,” to test the MIH/PC system and its potential benefits to Medicare beneficiaries and the Medicare program overall. ET3 is a voluntary, five-year payment model designed to “provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call.” Under this model, CMS will reimburse Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers to either: (1) transport the patient to a hospital ED or other covered destination (see above), (2) transport to an alternative destination partner (primary care/urgent care), or (3) provide treatment in place with a qualified health care partner (either on the scene or connected using telehealth). These determinations would be made by establishing a medical triage line for low-acuity calls within an existing 911 dispatch operation.

As a result, the ET3 model “aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.” Any individual who calls 911 and is connected to a dispatch system that has incorporated a medical triage line under the model would be screened for eligibility for medical triage services prior to ambulance initiation. Upon arriving on scene, participating ambulance suppliers and providers may triage Medicare FFS beneficiaries to one of the model’s interventions upon ambulance dispatch following a 911 call.

During the development of ET3, ACEP submitted comments to CMMI about important patient safeguards that should be incorporated into the model. Specifically, ACEP stated “all triage, treatment, transport, and destination decisions should be through direct oversight with EMS medical director physicians.” While acknowledging the health care providers delivering these services should be credentialed by their participating EMS system’s clinical oversight body, ACEP urged the model to “require the highest level of consult available, ideally with the EMS physician who is substantively familiar with resources available to the EMS system in the area it serves.” ACEP further urged CMMI to require all EMS system applicants “to attest in their application that they will commit, attain, and maintain contemporaneous direct medical oversight by physicians board-certified in EMS Medicine.” Finally, understanding that aspects of the demonstration project will likely change over time, ACEP highlighted one essential aspect that must remain – “proper safeguards for patient safety and responsible triage, treatment, transportation, and destination decisions obtained with continuous EMS medical director physician oversight.”
The ET3 model was supposed to begin on May 1, 2020 but has been delayed until the fall because of COVID-19.

ACEP has long acknowledged the critical role EMS, and EMS physician medical directors, play as an integral component in the continuum of acute medical care. According to ACEP’s “Emergency Medical Services Interfaces with Health Care Systems” policy statement: “EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare, providing acute medical assessment and interventional care contemporaneous with the navigation of patients. Patients, particularly those with time-critical conditions, are best served in geographically appropriate health care facilities having the specialized capabilities and services, either on site or via appropriate communications modalities, required for their evidence-based, optimal clinical outcomes. Appropriate funding of coordinated continuum of care systems (e.g., trauma systems) is essential to promoting the availability of regionalization of healthcare. EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of healthcare to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients. EMS destination protocols must be constructed with the substantive leadership of the EMS system’s physician medical director(s), always based primarily upon evidence-based clinical rationale, factoring geographical operational realities.”

While appropriate physician oversight/supervision remains a core concept for ACEP, other factors that may be relevant for consideration by the ACEP Council regarding the long-term viability of these programs are financing, liability, the Prudent Layperson Standard (PLS), and the Emergency Medical Treatment and Labor Act (EMTALA).

Generally, where MIH/PC models currently exist, they are funded by grants or subsidized by hospital or other health care entities as cost saving vehicles, particularly in response to bundled payments and formation of Accountable Care Organizations (ACOs). As mentioned previously, CMS/CMMI is about to undertake the ET3 demonstration and while the administration of the program will be funded through normal federal appropriations, reimbursement for the services provided for either alternate transportation or on-site treatment will come from the Medicare Trust Fund. There is no current long-term model for financing these programs and no standardized reimbursement for MIH/PC activities at the federal level.

Since paramedics and EMTs provide health care services under the EMS physician medical director’s license, the expanded practice roles for EMS physician medical directors involved with MIH/PC likely will require different malpractice coverage. The expanded services addressing wellness, prevention, care for the chronically ill, post-discharge care, social support networks, and increasing compliance for a local population. In addition to the potential added liability these services may create, the actual role of providing medical direction for an MIH/PC program may not be covered under the EMS medical director’s traditional insurance plan.

Regarding PLS and EMTALA, ACEP has stressed that patient safety must always be the primary defining element when considering alternatives to ambulance response, ambulance transportation, and/or non-emergency department destinations. Per ACEP’s “Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs” policy statement: “Patients utilizing a prudent layperson standard of a medical emergency accessing emergency care via 911 (or equivalent) public safety answering points with acute, unscheduled, and undifferentiated medical conditions should be transported to an emergency department with clinical capabilities consistent with emergency care needs. Similar patients, but with stable, differentiated medical conditions that may be suitable for transportation to a destination other than an emergency department (e.g., mental health facility, sobering center, physician’s clinical office) must be afforded at that alternative destination a medical screening exam (MSE) and stabilizing treatment by a qualified medical professional in accordance with [EMTALA].”

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
Resolution 35(20) Supporting Development of a Seamless Healthcare Delivery System to Include Prehospital Care

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Fiscal Impact

Budgeted staff resources to convey ACEP’s position to federal Executive and Legislative branch officials.

Prior Council Action

Resolution 34(13) Community Paramedicine adopted. Directed ACEP to develop a policy statements on the definition of community paramedicine and the role of the pre-hospital provider in community paramedicine; develop guidelines and standards and a clinical model.

Prior Board Action

June 2018, approved the policy statement “Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs;” replacing the following rescinded/sunsetted policy statements: Alternate Ambulance Transportation and Destination (2001-2018); Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018); and Refusal of Medical Aid (2000-2018).

June 2018, approved the policy statement “Relationship Between Clinical Capabilities and Medical Equipment in the Practice of Emergency Medical Services Medicine.”


June 2016, reviewed the information paper “Mobile Integrated Healthcare/Community Paramedicine (MIH/CP) Primer.”

Resolution 34(13) Community Paramedicine adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 36(20)

SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter

SUBJECT: Telehealth Free Choice

PURPOSE: Support legislation that would: 1) make the CMS telehealth waivers that are allowed during the COVID-19 public health emergency permanent; 2) require insurers to allow enrollees to pick any physician and allow physicians to provide telehealth services for acute unscheduled care to any or all their insured patients; 3) require insurers to pay physicians and non-physician health providers for telehealth services at the same rate that the equivalent services are paid at when delivered in-person; 4) support penalties for insurers for any intentional actions that prevent access to necessary acute unscheduled care.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Telehealth can provide effective and well needed care to patients from a remote location; and

WHEREAS, Telehealth increase access to patients who may otherwise be unable to receive medical attention; and

WHEREAS, Telehealth is often an equivalent, sometimes superior, alternative to in-person care; and

WHEREAS, Telehealth has been used at numerous emergency departments for years and is received by patients and practitioners; and

WHEREAS, Allowing patients to choose a physician or non-physician provider to provide healthcare services to them is fair and would be well received; and

WHEREAS, CMS allows and does not limit the number of licensed physicians to provide services to CMS patients; and

WHEREAS, CMS has realized the potential benefits offered to patients using telehealth; and

WHEREAS, During the SARS-CoV-2/COVID-19 pandemic, CMS waived many restrictions on telehealth, including cost-sharing requirements, requiring the patient to be located at certain locations, and not reimbursing at parity, or reimbursing at all, for telehealth services; and

WHEREAS, Some third-party payers restrict access by providing telehealth services but only to employed non-physician providers or other employed health care workers; therefore be it

RESOLVED, That ACEP support legislation to make the CMS waivers that were allowed during the COVID-19-declared emergency related to telehealth permanent, i.e., allow patient to be at any location, allow provider to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; and be it further

RESOLVED, That ACEP support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer’s network, or outside of insurer’s network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; and be it further
Resolution 36(20) Telehealth Free Choice
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RESOLVED, That ACEP support legislation requiring all payers to pay parity to physician and non-physician
health providers for telehealth services as would be paid for in-person services for appropriate or equivalent care; and
be it further

RESOLVED, That ACEP support penalties to insurers for intentional actions, rules or policy that limit,
restrict, delay, deny or prevent access to necessary acute unscheduled care or services from the physician or non-
physician provider of the patient’s choice in an appropriate time period as determined by physicians in that region, or
national determined standard or in the payment to the practitioner for the care or services provided.

Background

This resolution calls on ACEP to support legislation that would: 1) make the CMS telehealth waivers that are allowed
during the COVID-19 public health emergency permanent; 2) require insurers to allow their enrollees to pick any
physician they choose and allow physicians to provide telehealth services for acute unscheduled care to any or all
their insured patients; 3) require insurers to pay physicians and non-physician health providers for telehealth services
at the same rate that the equivalent services are paid at when delivered in-person; and 4) support penalties for insurers
for any intentional actions that prevent access to necessary acute unscheduled care.

In accordance with ACEP’s policy statement “Emergency Medicine Telehealth,” which was revised and approved in
February 2020, ACEP has supported the delivery of emergency telehealth services by board-certified emergency
physicians. Before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for
Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED)
evaluation and management (E/M) codes to the list of approved Medicare services. During the PHE, CMS took
numerous steps to expand the use of telehealth under Medicare. Specifically, CMS temporarily added many codes,
including all five ED E/M codes, to the list of approved telehealth services. That means that these codes are
reimbursable under Medicare when delivered remotely via telehealth at the same rate as they are when the services are
delivered in-person. Further, CMS used its unique “1135” waiver authority that only exists during a national
emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement
(which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and
not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only
rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of
where they or their patient are located, in both urban and rural areas.

Over the spring and summer, administration officials, including the CMS Administrator, Seema Verma, have been
vocal in their support of making some of the telehealth flexibilities available during the PHE permanent. However,
CMS does not have the legal authority to permanently waive the originating site and geographic restrictions.
Eliminating these telehealth restrictions requires legislation from Congress. ACEP sent a letter calling on Congress to
take action immediately. Specifically, ACEP called on Congress to enact S.2741, the Creating Opportunities Now for
Necessary and Effective Care Technologies (CONNECT) for Health Act. This vital legislation sets the stage for
permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve
patient outcomes. In the letter to Congress and in a separate opinion article, ACEP also called on state Medicaid
programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth
policies with Medicare’s to ensure consistent regulation, licensure, billing, and coding for emergency telehealth
services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative
challenges that hinder the sustainability of these new and vital telehealth programs.

ACEP’s policy statement “Emergency Medicine Telehealth” addresses two other key themes of this resolution – free
choice of physicians and payment parity for telehealth services. With respect to patient choice of physicians providing
telehealth services, ACEP “supports patient choices in the selection of a telemedicine provider, but with the
understanding that by the nature of emergencies and hospital credentialing practices, a choice may not be available, as
is also true of in-person staffing in emergency departments.” Further, with respect to reimbursement for telehealth
services, ACEP believes that “telehealth services, like other health care services, should be reimbursed at a fair market
value for the services rendered.” ACEP also “supports current efforts by the American Medical Association and other
stakeholders in advocating for appropriate billing and fair payment for services rendered by emergency physicians providing telehealth services.” The language in the statement builds off of Amended Resolution 28(14) Fair Payment for Telemedicine Services that directed ACEP to work with appropriate parties at the federal and state levels to advocate or legislation and regulation that will provide fair payment by all payers for appropriate services provided by telemedicine.

Finally, related to the last resolve, ACEP has historically pushed back against attempts from insurers to restrict access to care by narrowing their networks or limiting their benefit packages and has also supported penalties on insurers that have violated certain regulatory requirements. For example, ACEP believes that all insurance plans should cover all ten essential health benefits (EHBs), one of which is emergency services. Without such guaranteed coverage, consumers can be left with a narrow set of benefits that do not ensure access to the items and services they need to manage their health conditions. Further, in 2018, ACEP endorsed a CMS policy to impose civil monetary penalties and take other enforcement actions on Medicare Advantage Organizations (MAOs) that do not comply with provider directory requirements. Maintaining adequate networks is essential to ensuring that patients have access to the care they need. Finally, ACEP wrote a letter to CMS calling on the agency to add emergency physicians and other safety net providers in the list of specialty types that are subject to CMS network adequacy standards for Medicare Advantage plans. Currently, emergency medicine is not one of the specialty types that is subject to CMS’ standards. In that same letter, ACEP urged CMS to reward MA plans that choose to contract with telehealth providers who specialize in emergency medicine.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
   Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.
Resolution 36(20) Telehealth Free Choice
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Prior Board Action

May 2020, reviewed the information paper “COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.”

February 2020, approved the revised policy statement “Emergency Medicine Telehealth;” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

June 2016, approved the policy statement “Ethical Use of Telemedicine in Emergency Care.”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.


Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.


Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 37(20)

SUBMITTED BY: Government Services Chapter
Illinois College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians Ohio Chapter
Pennsylvania College of Emergency Physicians
Emergency Telehealth Section

SUBJECT: Telehealth Implementation, Reimbursement, and Coverage

PURPOSE: 1) advance the responsible implementation of telehealth practices that are consistent with established policies and guidelines; 2) advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity telehealth visits; and 3) oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, There is a shortage of primary care and specialty physicians relative to need in large portions of the United States; and

WHEREAS, Limited access to primary, emergency, and specialty healthcare leads to delays in care with significant associated negative impact on health outcomes; and

WHEREAS, Transportation limitations and geographical location of healthcare practitioners pose barriers to seeing a healthcare provider for millions of Americans; and

WHEREAS, Coordinating occupational, social, and family obligations with scheduling in-person healthcare visits places significant burden on many Americans, particularly on individuals with elevated baseline risks related to diminished socioeconomic status and social determinants of health; and

WHEREAS, Patients in rural areas have greater difficulty accessing care, elevated mortality rates from common diseases, and higher percentages of unintentional drug overdose deaths; and

WHEREAS, In 2018, 21% of individuals with substance use disorders who perceived a need for treatment did not know where to go to get treatment; and

WHEREAS, Limitations in the availability of primary and specialty care including post-acute care leads to costly utilization of acute care and hospital-based services; and

WHEREAS, The COVID-19 pandemic has prompted rapid expansion of telehealth services to ensure ongoing delivery of care and maintenance of physician practices while limiting in-person healthcare visits for the protection of patients and healthcare facility staff; and

WHEREAS, Published evidence of telehealth outcomes has been encouraging in relation to improved access to care, patient satisfaction, and outcomes; but, ongoing investigation of benefits and potential risks to guide definitive recommendations of best practice is needed; and
WHEREAS, The American Medical Association (AMA), American College of Emergency Physicians (ACEP), and other specialty organizations have developed guidelines regarding the ethical and responsible implementation of telehealth practice, confidentiality, and patient safety standards; and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) have expanded reimbursement for telehealth services including live video telemedicine visits, store and forward technology, remote patient monitoring, email/phone/fax communication, and eConsults; and

WHEREAS, Forty-two states and the District of Columbia have passed private payer reimbursement regulation or legislation including mandated parity for telehealth and in person medical visits in 5 states, but there remains significant variability in state legislation guiding the reimbursement of telehealth; and

WHEREAS, Proposed telehealth legislation in some states has sought to apply restrictions to the care delivered via telemedicine for reasons other than patient safety; therefore, be it

RESOLVED, That ACEP advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; and be it further

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and be it further

RESOLVED, That ACEP oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

References

Background

This resolution calls on ACEP to: 1) advance the responsible implementation of telehealth practices that are consistent with established policies and guidelines; 2) advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity telehealth visits; and 3) oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

ACEP is actively engaged in advocacy efforts aimed at advancing the use of telehealth in emergency medicine.
In accordance with ACEP’s policy statement “Emergency Medicine Telehealth,” which was revised and approved in February 2020, ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians. From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. Before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED) evaluation and management (E/M) codes to the list of approved Medicare services. During the PHE, CMS took numerous steps to expand the use of telehealth under Medicare, all of which were endorsed by ACEP. Specifically, CMS temporarily added many codes, including all five ED E/M codes, to the list of approved telehealth services and allowed emergency physicians to perform medical screening exams – a component of the Emergency Medical Treatment and Labor Act (EMTALA) – via telehealth.

Further, CMS used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas. ACEP has submitted a letter to Congress calling for the permanent removal of these two restrictions. ACEP supports S.2741, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, which sets the stage for permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve patient outcomes. In the letter to Congress and in a separate opinion article, ACEP also called on state Medicaid programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare’s to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

The “Emergency Medicine Telehealth” policy statement previously mentioned discusses ACEP’s position on reimbursement for emergency telehealth services. ACEP believes that “telehealth services, like other health care services, should be reimbursed at a fair market value for the services rendered.” In addition, ACEP “supports current efforts by the American Medical Association and other stakeholders in advocating for appropriate billing and fair payment for services rendered by emergency physicians providing telehealth services.” The language in the policy statement builds off of Amended Resolution 28(14) Fair Payment for Telemedicine Services that directed ACEP to work with appropriate parties at the federal and state levels to advocate or legislation and regulation that will provide fair payment by all payers for appropriate services provided by telemedicine.

Finally, related to the last resolved calling on ACEP to “oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections,” it is important to highlight CMS’ telehealth proposals in the Calendar Year (CY) 2021 Physician Fee Schedule and Quality Payment Program proposed rule. In the proposed rule, CMS examines which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 PHE should remain on the list permanently. Codes on this list are reimbursable under Medicare when delivered remotely via telehealth at the same rate as they are when the services are delivered in-person. CMS proposes to keep ED E/M code levels 1-3 (CPT codes 99281-99283) on the approved telehealth list for the remainder of the year after the PHE expires (i.e., if the PHE ends in January 2021, the codes would remain on the list until December 31, 2021). However, CMS did not propose to include ED E/M levels 4 and 5 (CPT codes 99284 and 99285) on the list of approved Medicare services past the duration of the PHE. CMS believes that ED E/M code levels 4 and 5 cannot truly be conducted via two-way, audio/video telecommunications technology, because of the characteristics of patients who receive the services, the clinical complexity involved, the urgency for care, and the need for complex decision-making. Given CMS’ stance on the appropriateness of delivering telehealth in certain circumstances, the Council should consider which restrictions, if any, it believes should be in place regarding the use of telehealth services.
Resolution 37(20) Telehealth Implementation, Reimbursement, & Coverage

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ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

May 2020, reviewed the information paper “COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.”

February 2020, approved the revised policy statement “Emergency Medicine Telehealth;” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

June 2016, approved the policy statement “Ethical Use of Telemedicine in Emergency Care.”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.


Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 38(20)

SUBMITTED BY
Government Services Chapter
Illinois College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians
Ohio Chapter

Pennsylvania College of Emergency Physicians
Diversity, Inclusion, & Health Equity Section
Emergency Telehealth Section
Rural Emergency Medicine Section

SUBJECT: Universal Access to Telehealth Care

PURPOSE: Advocate for universal access to telehealth in all rural and underserved areas of the United States and to support innovative strategies to improve individual access to broadband and cellular technology.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Access to primary, emergency, and specialty healthcare is limited for many Americans leading to delays in care with significant associated negative impact on health outcomes; and

WHEREAS, The pandemic has demonstrated a growing place for telehealth in emergency care; and

WHEREAS, Transportation limitations and geographical location of healthcare practitioners pose barriers to seeing a healthcare provider for millions of Americans; and

WHEREAS, The COVID-19 pandemic highlights that without high-quality broadband communication services telehealth usage is drastically limited; and

WHEREAS, Access to broadband is a social determinant of health and therefore important to health equity; and

WHEREAS, Structural inequalities in availability of healthcare services disproportionately disenfranchise the poor, racial minorities, and other vulnerable communities; and

WHEREAS, According to a Pew Research Center survey conducted in 2019, 18% of low-income American adults do not use the internet; and

WHEREAS, A Pew Research Center survey from 2019 indicates that low-income Americans have substantially limited access to technology capable of connecting to telehealth care since only 71% have a smartphone, 54% have access to a home desktop or laptop computer, 36% own a tablet, and 56% have home broadband access; and

WHEREAS, Patients in rural areas have greater difficulty accessing care, elevated mortality rates from common diseases, and higher percentages of unintentional drug overdose deaths; and

WHEREAS, According to a Pew Research Center survey conducted in 2019, only 63 percent of rural Americans say they have a broadband internet connection at home and are 12% less likely to have a smartphone, limiting patients’ access to telehealth in these communities; and

WHEREAS, The pandemic has made more evident disparities in telehealth capacity among low-income populations, with inadequate broadband services a barrier particularly in rural communities; and
Resolution 38(20) Universal Access to Telehealth

WHEREAS, As a result of the COVID-19 pandemic, the FCC has bolstered funding of its Telehealth Program, the Centers for Medicare and Medicaid Services has expanded its telehealth policy, and there is bipartisan Congressional support to strengthen broadband infrastructure, indicating interest by policymakers to expand broadband infrastructure in rural and underserved communities; and

WHEREAS, Initiatives such as the Department of Housing and Urban Development’s ConnectHome pilot and ConnectHomeUSA Expansion programs have capitalized on public-private partnerships to expand access to broadband services, internet-capable devices, as well as digital education for low-income Americans; therefore, be it

RESOLVED, That ACEP, in collaboration with other medical organizations, advocate for universal access to telehealth care through expanded broadband infrastructure and wireless connectivity to all rural and underserved areas of the United States as well as supporting innovative strategies to improve individual access to broadband and cellular technology.

References:
3. Pew Research Center, April 22, 2019. “10% of Americans Don’t Use the Internet. Who Are They?”

Background

This resolution calls on ACEP to advocate for universal access to telehealth in all rural and underserved areas of the United States and to support innovative strategies to improve individual access to broadband and cellular technology. ACEP is actively engaged in advocacy efforts aimed at advancing the use of telehealth in emergency medicine. The resolution cites recent analyses showing that many low-income Americans as well as individuals in rural areas do not have access to smart phones or broadband internet, thereby limiting their ability to receive vital telehealth services. Further, ACEP’s information paper “Delivery of Emergency Care in Rural Settings” specifically discusses the barriers that broadband and equipment availability / interoperability present in rural areas. The paper states that “although the costs of obtaining the hardware for telehealth assessments have been rapidly decreasing and may be minimal, some areas may lack sufficient capital or knowledge to establish a telehealth site or may be geographically located in areas without internet or broadband access. Another barrier relates to not having compatible interfaces among different healthcare providers. The information should flow seamlessly across the system. The implementation group of the telehealth program needs to consider both the electronic and spoken language challenges in the planning process.” The paper concludes by stating that telehealth dramatically improves “the access of health care across rural and underserved areas across the nation and the world. This system enables rural providers to maintain their knowledge base and skills and improves the rural populations’ access to needed, but difficult-to-recruit, specialists which can be lifesaving in the rare/high-risk scenarios when the full-time recruitment of a particular specialist for an area would be cost prohibitive. Telehealth use in the rural ED helps to bring a vast array of specialty expertise to the bedside in environments that are otherwise unable to provide these services.”

In accordance with ACEP’s policy statement “Emergency Medicine Telehealth” (most recently revised in February 2020), ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians.
From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. The Medicare statute currently restricts reimbursement for telehealth to services performed in rural areas. During the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive this restriction, as well as another restriction called the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home). ACEP has supported legislation that would permanently eliminate these restrictions, thereby allowing low-income Medicare beneficiaries in urban, underserved communities to also receive telehealth services from any location, including their home.

With respect to funding for broadband infrastructure, as referenced in the resolution, the Federal Communications Commission (FCC) has implemented initiatives to support health care providers who want to stand up telehealth programs in rural and underserved communities. First, the FCC established a $200 million telehealth program for healthcare providers responding to the COVID-19 PHE. Congress appropriated the funds as part of the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act. Through the COVID-19 Telehealth Program, the FCC helped healthcare providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. The FCC has closed applications for this program.

The FCC also has finalized regulations implementing a Connected Care Pilot Program. This separate three-year Pilot Program will provide up to $100 million of support to help defray health care providers’ costs of providing connected care services. ACEP supported this program and offered comments to the FCC when it was first proposed. The FCC has not yet begun accepting applications for this program.

Finally, on September 1, the U.S. Department of Health and Human Services (HHS), the FCC, and U.S. Department of Agriculture announced that they have signed a Memorandum of Understanding to work together on a Rural Telehealth Initiative. Through this new initiative, these departments will collaborate and share information that will address health disparities, resolve service provider challenges, and promote broadband services and technology to rural areas.

**ACEP Strategic Plan Reference**

**Goal 1 – Improve the Delivery System for Acute Care**

**Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.**

**Fiscal Impact**

Budgeted staff resources.

**Prior Council Action**

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.
Resolution 38(20) Universal Access to Telehealth

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

May 2020, reviewed the information paper “COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage.”

February 2020, approved the revised policy statement “Emergency Medicine Telehealth;” originally approved June 2016.

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs.

August 2017, reviewed the information paper “Delivery of Emergency Care in Rural Settings.”

June 2017, approved policy statement “Definition of Rural Emergency Medicine.”

June 2016, approved the policy statement “Ethical Use of Telemedicine in Emergency Care.”

Amended Resolution 45(15) Telemedicine Appropriate Support and Control.


Amended Resolution 28(14) Fair Payment for Telemedicine Services.


Background Information Prepared by: Jeffrey Davis
Director of Regulatory Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 39(20)

SUBMITTED BY: Marisa Dowling, MD
James Maloy, MD

SUBJECT: Urging the Prohibition of Law Enforcement Use of Rubber Bullets and Tear Gas for Crowd Control

PURPOSE: Join the American Academy of Ophthalmology in condemning the use of rubber bullets (and similar projectiles) and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP advocates for tolerance and respect for the dignity of all persons and supports the goal of a society free from violence; and

WHEREAS, All Americans have the rights of freedom of speech and public assembly; and

WHEREAS, ACEP, while recognizing the role of law enforcement in our society, notes that certain police methods of crowd control have the potential to threaten the health of citizens; and

WHEREAS, ACEP acknowledges that law enforcement use of rubber bullets and tear gas, though non-lethal, can cause life-altering eye injuries, up to and including blindness; therefore be it

RESOLVED, That ACEP join the American Academy of Ophthalmology in condemning the use of rubber bullets (and similar projectiles) and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

Background

The resolution calls for ACEP to join the American Academy of Ophthalmology (AAO) in condemning the use of rubber bullets and similar projectiles and tear gas to control or disperse crowds and calling on all law enforcement officials to permanently and immediately end these practices.

On June 3, the AAO issued a release condemning the use of rubber bullets, other projectiles such as paintballs used to mark protestors, or tear gas to disperse protestors, and on June 4, the AAO issued an official statement on the use of rubber bullets for crowd dispersion. The statement reads:

“In the past week, Americans engaged in peaceful protests have been blinded by the use of rubber bullets fired at the face.”

3. 1st Amendment, United States Constitution
While classified as non-lethal, they are not non-blinding. These life-altering injuries are a common result of urban warfare, rioting and crowd dispersion. We have seen it around the world, and we now see it in the United States.

Following numerous serious injuries in the past two weeks, the American Academy of Ophthalmology calls on domestic law enforcement officials to immediately end the use of rubber bullets to control or disperse crowds of protesters. The Academy asks physicians, public health officials and the public to condemn this practice.

Americans have the right to speak and congregate publicly and should be able to exercise that right without the fear of blindness. You shouldn’t have to choose between your vision and your voice.”

The AAO’s statement was endorsed by a number of other organizations, including the American Academy of Allergy, Asthma and Immunology, the American Academy of Family Physicians, the American College of Surgeons, the American Geriatrics Society, the American Society of Nephrology, the Council of Medical Specialty Societies, the Sociedad Chilena de Oftalmologia (Chilean Society of Ophthalmology), and the Society of Interventional Radiology.

Rubber bullets, projectiles such as pepper balls or paintballs, pepper spray, and tear gas, are “less-lethal” alternatives used by law enforcement to control riots or disperse protestors. While described as “less-lethal,” these can often still result in serious injuries or death. In the U.S., recent nationwide protests against the use of force and violence by law enforcement have seen these tools employed against peaceful protestors, including injuries to members of the media and other innocent bystanders.

Rubber bullets and other kinetic impact projectiles (KIPs) can cause a number of serious injuries such as blindness, permanent disabilities, nerve damage, fractures, and even death. A 2017 study in the British Medical Journal examined data on injuries and death from the use of KIPs:

“…these projectiles have caused significant morbidity and mortality during the past 27 years, much of it from penetrative injuries and head, neck and torso trauma. Given their inherent inaccuracy, potential for misuse and associated health consequences of severe injury, disability and death, KIPs do not appear to be appropriate weapons for use in crowd-control settings.”

Regarding the use of tear gas, pepper spray, or other chemical irritants, as AAO notes, tear gas does not typically cause irreversible injury to the eye but can still cause severe eye injuries. Nevertheless, tear gas or pepper spray can cause other serious injuries, especially for those with underlying health conditions such as asthma or chronic obstructive pulmonary disease (COPD), potentially resulting in respiratory failure or death.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
   Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement
   Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 34(18) Violence is a Health Issue adopted. Directed ACEP to recognize violence as a health issue addressable through medical and public health interventions, and to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.
Resolution 39(20) Urging the Prohibition of Law Enforcement Use of Rubber Bullets & Tear Gas for Crowd Control

Page 3

Resolution 14(15) Body-Worn Cameras for Police not adopted. Directed ACEP to create a policy statement endorsing laws requiring police officers to wear body-worn cameras.

Resolution 22(10) Police Pursuits not adopted. Directed ACEP to strongly encourage use of safer alternatives to police pursuits, support enactment of laws requiring law enforcement agencies to accept responsibility for their actions regarding police pursuits and support mandatory tracking of pursuit-related injury data by NHTSA.

Amended Resolution 21(08) Excited Delirium adopted. Directed ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP’s opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

April 2019, revised and approved the policy statement “Violence-Free Society;” reaffirmed June 2013; revised and approved January 2007; reaffirmed 2000; originally approved January 1996.

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

Amended Resolution 34(18) Violence is a Health Issue adopted.

Substitute Resolution 41(05) Non-Discrimination adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
2020 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 40-52

Hilary Fairbrother, MD, FACEP (TX) Chair
Shamie Das, MD, FACEP (GA)
Heather M. Heaton, MD, FACEP (MN)
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Alison Smith, MD, MPH, (UT)
Nicole A. Veitinger, DO, FACEP (OH)

Margaret Montgomery, RN, MSN
Paul Krawietz
Mandi Mims, MLS
RESOLUTION:  40(20)

SUBMITTED BY:  Pennsylvania College of Emergency Physicians

SUBJECT:  Addressing Critical Need for PPE by Emergency Physicians During a Pandemic

PURPOSE: 1) Develop a stockpile of airborne and contact level PPE to include five N95 respirators, five surgical masks, five gowns and one face shield that would be available to members on request during a pandemic to mitigate delays from normal supply chains. 2) ACEP partner with hospitals and other organizations to donate or sell PPE stockpiled for members when their expiration dates near and replenish the stockpile to maintain adequate volumes for members.

FISCAL IMPACT: Based on prices as of August, the estimated costs for purchasing the PPE stockpile for 40,000 members is $1,345,600. If prices returned to pre-COVID levels, total purchase costs would be approximately $156,000. The expense would be repeated prior to the expiration date of each type of PPE, which could be partially offset if buyers could be found sometime prior to the expiration date. Additional unknown expense to store the stockpiled PPE and mailing/shipping costs. Additional staffing may also be required.

WHEREAS, The recent coronavirus disease of 2019 (COVID-19) pandemic has resulted in critical supply shortages of personal protective equipment (PPE) for healthcare workers (HCW); and

WHEREAS, appropriate use of PPE by HCWs can protect them from contracting COVID-19 and other infections; and

WHEREAS, COVID-19 guidelines recommend HCWs wear gloves, eye protection, gown and at least a simple mask for routine care or an N95 respirator for care during aerosol generating procedures; and

WHEREAS, Despite efforts to reuse, reclaim, repurpose and create PPE, the shortage remains and the demand during the COVID-19 pandemic has created cost mark ups as high as 1,500% for simple masks, 1,513% for N95 respirators and 2000% for gowns; and

WHEREAS, The Strategic National Stockpile was inadequately maintained and has been unable to meet the demand for PPE by HCWs; and

WHEREAS, ACEP dues stand at $615 per year and this would be an ACEP benefit available for members; therefore be it

RESOLVED, That ACEP develop a stockpile of airborne and contact level personal protection equipment that would include five N95 respirators, five surgical masks, five gowns, and one face shield available to members on request during a pandemic to mitigate delays from normal supply chains; and be it further

RESOLVED, That ACEP partner with hospitals or other organizations to donate or sell personal protection equipment stockpiled for members when the expiration dates are near to prevent waste and automatically replenish the stockpile to maintain adequate volumes for our membership.

References:
3. Offeddu V, Yung CF, Low MSF, Tam CC. Effectiveness of Masks and Respirators Against Respiratory Infections in
Resolution 40(20) Addressing Critical Need for PPE by Emergency Physicians During a Pandemic

Page 2


Background

The resolution calls for ACEP to develop a stockpile of airborne and contact level personal protection equipment to include five N95 respirators, five surgical masks, five gowns and one face shield that would be available to members on request during a pandemic to mitigate delays from normal supply chains. Additionally, the resolution requests that ACEP partner with hospitals and other organizations to donate or sell PPE stockpiled for members when their expiration dates near and replenish the stockpile to maintain adequate volumes for members.

From the early appearance of COVID-19 in the United States and across much of the world, and continuing to a large degree to this day, one of the most significant obstacles to providing appropriate care to patients and protecting the emergency medical personnel responding to the pandemic has been the widespread critical shortage of N95 respirators and other PPE. Inadequate initial stockpiles followed by demand that quickly overwhelmed normal supply chains put emergency physicians and other health care workers at immediate significant risk as they were forced to reuse PPE far beyond safety limitations or work with substandard or even homemade materials in desperate efforts to provide a minimal level of protection while taking care of their patients.

ACEP worked to address the catastrophic impacts of the PPE shortages on multiple fronts. In March 2020, ACEP issued the policy statement COVID-19: Personal Protective Equipment (PPE) During the Pandemic. The policy included a statement that “close contact during procedures or processes (including a physical examination) that generate potentially infectious aerosols requires a higher level of PPE that includes an N95 respirator.” In April 2020, the College issued an additional statement COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment (PPE), which stated in part that “Processes and procedures that create higher risk, such as close contact and aerosolizing procedures, require full PPE, including N95s. Because the inadequate PPE supply increases the risk to our physicians, they have taken to buying their own PPE or utilizing donations from other industries. ACEP urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.”

In March, ACEP partnered with GetUsPPE.org to help get PPE to the frontlines of the COVID-19 pandemic, by coordinating donations of PPE to hospitals in need. ACEP reached out to 28 trade associations as a part of this collaborative campaign to drive more PPE donations to local emergency departments. ACEP also partnered with Project N95, the National Critical Equipment Clearinghouse for PPE and critical equipment, to vet suppliers claiming to have large quantities of quality PPE for sale and connect legitimate suppliers with hospitals, health systems and local and state governments looking to make bulk purchases.

ACEP launched a campaign to engage its membership to send their members of Congress an email urging them to ensure PPE is prioritized for frontline personnel. As of August 23, there were 34,917 individuals who have already taken action.

Early in March, ACEP sent every member of Congress and other policymakers a series of key policy changes necessary to mitigate the impact and spread of the virus in the U.S. and support emergency physicians and other frontline responders to the pandemic.
Outraged by the growing reports of employers retaliating against frontline health workers who are trying to ensure workplace safety during this pandemic, ACEP partnered with leading health care organizations to issue a joint statement on March 30: Urgent Call for Federal Action to Address Medical Equipment Shortages. The statement called for an increase in the PPE supply and deployment to the areas in most critical need.

ACEP has worked with key decisionmakers within the Trump Administration and Congress to address many issues facing emergency physicians, especially those related to PPE. For example, the College has had weekly conversations with the Centers for Disease Control and Prevention (CDC) to discuss best clinical practices, share experiences from the ground, and hear more about current or upcoming guidance that could impact emergency physicians and their patients. ACEP has shared the insights it has gleaned from the CDC on ACEP’s COVID-19 website and the COVID-19 communications hub. ACEP has also shared personal (anonymized) stories of its members about ongoing struggles obtaining PPE or being able to use their own PPE without fear of reprisal with the Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), and the American Hospital Association. In the last week of March 2020, ACEP had a call with TJC to convey the College’s concerns that hospitals were punishing or forbidding staff from wearing their self-purchased or donated PPE. On March 31, TJC issued a statement supporting emergency physicians’ right to bring their own standard face masks or respirators to wear at work when their healthcare organizations cannot provide access to PPE routinely that is commensurate with their risk of exposure. TJC also posted an FAQ about this statement.

On April 28, ACEP hosted its Virtual Hill Day during which nearly 500 ACEP members representing 45 states conducted 306 online meetings with legislators to discuss COVID-19 concerns: PPE, hazard pay, liability relief, and more. Nearly 50% of the meetings were with legislators or senior staff, and ACEP members were able to share their personal perspectives from the front lines.

On June 26, ACEP submitted its response to the Senate Health, Education, Labor, and Pensions (HELP) Committee regarding its “Preparing for the Next Pandemic” white paper, focused on five areas where Congress should work with federal departments and agencies, states, and the private sector. In the letter, ACEP raised significant concerns about the inappropriate allocation and re-use of PPE.

On July 2, the House Select Subcommittee on the Coronavirus Crisis held a hearing, “The Administration’s Efforts to Procure, Stockpile, and Distribute Critical Supplies,” to examine efforts to acquire PPE, COVID-19 testing supplies, and other critical supplies needed to respond to the coronavirus pandemic. ACEP submitted a letter for the record to highlight ongoing shortages of these supplies and how they affect emergency physicians’ ability to effectively treat patients during the pandemic.

As some PPE became sporadically available for individual purchase, ACEP worked to provide members ways to take advantage of those opportunities. On June 16, ACEP announced its partnership with Amazon. The partnership allowed members priority access to cleaning supplies, PPE, and more. In August, ACEP partnered with Project N95 and more than a dozen other national specialty societies to provide members of the participating societies a one-week window to purchase N-95 masks and other PPE at volume prices.

The volume pricing available through the Project N95 offer included:

- N95 Respirators: $4.56/mask – $5.11/mask
- Isolation Gowns (AAMI Level 1): $1.41/gown
- Face Shields: $0.84/shield
- Surgical Masks were not included in the offering but were available through Project N95 at $0.29 – $0.58.

While the amounts charged through the special offering represented a substantial discount from what could be purchased individually in August, they were significantly higher than the costs of PPE prior to the pandemic. According to a report by the Society for Healthcare Organization Procurement Professionals (SHOPP), prices that skilled nursing facilities and assisted living centers paid pre-COVID were:
Resolution 40(20) Addressing Critical Need for PPE by Emergency Physicians During a Pandemic

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- N95 Respirators: $0.38/mask
- Isolation Gowns: $1.41/gown
- Face Shields: $0.50/shield
- 3-Ply Surgical Masks: $0.05

ACEP currently has more than 40,000 members and it is unknown how many members would request PPE from the stockpile. Based on 40,000 members, ACEP would need to purchase and stockpile:

- 200,000 N95 respirators: $4.75/mask = $950,000
- 200,000 isolation gowns: $0.25/gown = $282,000
- 200,000 surgical masks: $0.40/mask = $80,000
- 40,000 face shields: $0.84/shield = $33,600

The total estimated expenditure is $1,345,600. If prices return to pre-COVID levels as measured by the SHOPP report, the costs of providing all members with these same supplies would be $76,000 for N95 respirators; $50,000 for gowns; $10,000 for surgical masks; and $20,000 for face shields for a total expenditure of $156,000. ACEP would incur additional costs for offsite storage to contain the stockpiled PPE, additional costs for mailing/shipping the PPE to members, and potentially additional staffing to manage the supply, demand, and monitoring of expiration dates, and reselling if possible prior to the expiration date.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
   Objective H - Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement
   Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Based on prices as of August, the estimated costs for purchasing the PPE stockpile for 40,000 is $1,345,600. If prices returned to pre-COVID levels, the total purchase costs would be approximately $156,000. This expense would be repeated prior to the expiration date of each type of PPE, which could be partially offset if buyers could be found sometime prior to the expiration date. Additional unknown expense to store the stockpiled PPE and mailing/shipping costs. Additional staffing may also be required.

Prior Council Action

None

Prior Board Action

March 2020, approved the policy statement “COVID-19: Personal Protective Equipment (PPE) During the Pandemic.”

March 2020, approved the policy statement “COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment.”

June 2016, approved the revised policy statement “Personal Protective Equipment Guidelines for Health Care Facility Staff;” reaffirmed October 2009; originally approved August 2003.

April 2014, approved the revised policy statement “Emergency Department Planning and Resource Guidelines;” revised and approved October 2007, June 2004 and June 2001 with the current title; reaffirmed September 1996;
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originally approved December 1985 with the title “Emergency Care Guidelines.” The policy statement includes a list of suggested equipment and supplies for emergency departments which includes “personal protective equipment—gloves, eye goggles, face mask, gowns, head and foot covers.”

**Background Information Prepared by:** Craig Price, CAE
Senior Director, Policy

**Reviewed by:**
Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 41(20)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Personal Protection Equipment

PURPOSE: Establish new policy statements that hospitals maintain adequate supply of personal protection equipment, employer or staffing company supply appropriate and adequate supply of personal protection equipment, and emergency physicians and other emergency workers be permitted to provide their own personal protection equipment.

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

WHEREAS, Personal protection equipment (PPE) is intended to protect healthcare and other workers from various potentially harmful “things” including but not limited to viruses, bacteria, fungi, and other infectious organisms, radioactive material, various vapors, heat, caustic substances and materials, acids, irritants, etc.; and

WHEREAS, PPE can include gloves, masks, respirators, eye protection, face shields, self-contained breathing apparatus, impermeable gowns, a combination of these or many other items; and

WHEREAS, It is typically the host hospital’s duty to provide necessary equipment for workers at the facility to protect themselves and/or others; and

WHEREAS, Many hospitals do not maintain adequate PPE supplies to protect the healthcare workers during a disaster or pandemic as became obvious during the SARS-CoV-2/COVID-19 pandemic in 2020 in the United States; and

WHEREAS, During the recent SARS-CoV-2/COVID-19 pandemic, many emergency physicians expressed concerns that hospitals did not have sufficient supplies of PPE for healthcare workers to adequately protect themselves as recommended by manufacturers of the PPE and medical personnel; and

WHEREAS, In April 2020, the ACEP statement on PPE in COVID-19: Personal protective equipment (PPE) during the pandemic indicated: “that health care personnel (HCP) in the emergency department (ED) and emergency medical services (EMS) should consider wearing a face mask or surgical mask during their entire shift if they are providing patient care, unless the mask becomes soiled and needs replacement,” but did not address its recommendations when this recommendation conflicted with the recommended use of such PPE by the PPE manufacturers; and

WHEREAS, A stronger worded recommendation or guidance statement from ACEP would help emergency physicians in helping to protect themselves, their co-workers, and patients; and

WHEREAS, Some physicians and other health care workers obtained their own PPE to use at work to protect themselves; and

WHEREAS, Some hospitals have policies that prohibit self-provided PPE to be used in their hospitals creating concern from emergency physicians of being penalized for simply trying to protect themselves in the workplace; therefore be it

RESOLVED, That ACEP establish a new policy that hospitals must maintain adequate supply of personal
Resolution 41(20) Personal Protection Equipment
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...protection equipment to supply all emergency and other workers that may be necessary during an infectious, radioactive, chemical, or biologic disaster for at least a 60-day minimum when used as directed by the manufacturer; and be it further

RESOLVED, That ACEP establish a new policy that in the event any hospital fails to provide adequate personal protection equipment in terms of quantity, particular type, and quality, to its emergency workers the employer or staffing company is responsible and will immediately supply appropriate and adequate personal protection equipment for the physicians and non-physicians staffing the emergency department and other sites; and be it further

RESOLVED, That ACEP establish a new policy supporting emergency physicians and other emergency workers providing their own personal protection equipment without any penalty of any kind if the hospital or other “employer” (staffing company) fails to provide adequate and sufficient personal protection equipment to be used as intended by the manufacturer of the personal protection equipment.


Background

This resolution calls for the College to establish new policy statements that hospitals maintain adequate supply of personal protection equipment, employer or staffing company supply appropriate and adequate supply of personal protection equipment, and emergency physicians and other emergency workers be permitted to provide their own personal protection equipment.

In March and April 2020, ACEP issued two statements that emphasized the role of the emergency care team as the front line in the recent SARS-CoV-2/COVID-19 pandemic and the importance of appropriate personal protective equipment.

The policy statement “COVID-19: Personal Protective Equipment (PPE) During the Pandemic,” firmly emphasizes that “health care personnel (HCP) in the emergency department (ED) and emergency medical services (EMS) should consider wearing a face mask or surgical mask during their entire shift if they are providing patient care, unless the mask becomes soiled and needs replacement.”

The policy statement “COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment (PPE)” clearly states that “ACEP has and will continue to support the use of surgical masks with proper eyewear and other protective equipment for physicians and other individuals caring for patients, regardless of their complaint.” The College also advocated for hospitals to permit emergency physicians and other emergency workers to provide their own personal protection equipment by adding that “Because the inadequate PPE supply increases the risk to our physicians, they have taken to buying their own PPE or utilizing donations from other industries. ACEP urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.”

The College noted that emergency physicians and health systems around the country were facing severe shortages of PPE, such as N95 masks, that left many health professionals insufficiently protected in the midst of the SARS-CoV-2/COVID-19 pandemic. In March, ACEP partnered with GetUsPPE.org to help get PPE to the frontlines of the COVID-19 pandemic, by coordinating donations of PPE to hospitals in need. ACEP reached out to 28 trade associations as a part of this collaborative campaign to drive more PPE donations to local emergency departments. ACEP also partnered with Project N95, the National Critical Equipment Clearinghouse for PPE and critical equipment, to vet suppliers claiming to have large quantities of quality PPE for sale and connect legitimate suppliers with hospitals, health systems and local and state governments looking to make bulk purchases.

ACEP received reports of workarounds that many of our physicians had to resort to that compromised the protection that appropriate PPE is designed to provide. Because of these reports and shortages, ACEP launched a campaign to
engage the ACEP membership to send their members of Congress an email urging them to ensure PPE is prioritized for frontline personnel. As of August 23, there were 34,917 individuals who have already taken action.

Additionally, early in March, ACEP sent every member of Congress and other policymakers a series of key policy changes necessary to mitigate the impact and spread of the virus in the U.S. and support emergency physicians and other frontline responders to the epidemic.

Outraged by the growing reports of employers retaliating against frontline health workers who are trying to ensure workplace safety during this pandemic, ACEP partnered with leading health care organizations to issue a joint statement on March 30: Urgent Call for Federal Action to Address Medical Equipment Shortages. The statement called for an increase in the PPE supply and deployment to the areas in most critical need.

ACEP has worked with key decisionmakers within the Trump Administration and Congress to address many issues facing emergency physicians, especially those related to PPE. For example, the College has had weekly conversations with the Centers for Disease Control and Prevention (CDC) to discuss best clinical practices, share experiences from the ground, and hear more about current or upcoming guidance that could impact emergency physicians and their patients. ACEP has shared the insights it has gleaned from the CDC on ACEP’s COVID-19 website and the COVID-19 communications hub. ACEP has also shared personal (anonymized) stories of its members about ongoing struggles obtaining PPE or being able to use their own PPE without fear of reprisal with the Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), and the American Hospital Association. In the last week of March 2020, ACEP had a call with TJC to convey the College’s concerns that hospitals were punishing or forbidding staff from wearing their self-purchased or donated PPE. On March 31, TJC issued a statement supporting emergency physicians’ right to bring their own standard face masks or respirators to wear at work when their healthcare organizations cannot provide access to PPE routinely that is commensurate with their risk of exposure. TJC also posted an FAQ about this statement.

On April 28, ACEP hosted its Virtual Hill Day during which nearly 500 ACEP members representing 45 states conducted 306 online meetings with legislators to discuss COVID-19 concerns: PPE, hazard pay, liability relief, and more. Nearly 50% of the meetings were with legislators or senior staff, and ACEP members were able to share their personal perspectives from the front lines.

On May 21, the recently-established House Select Subcommittee on the Coronavirus Crisis held a virtual briefing featuring essential and frontline workers, including a prominent ACEP member. The panelists noted the personal risks exacerbated by a lack of adequate PPE, as well as the emotional and mental health toll the pandemic has taken on frontline workers. The panelists also discussed the lack of access to rapid testing, fair pay and compensation such as hazard pay, and paid leave protections. In response to a question from Rep. Andy Kim (D-CA) as to whether the U.S. is prepared for a potential second wave of infection, the panelists warned that we are not yet prepared given the lack of testing, PPE, scientific progress on fighting the virus, and inconsistent public health guidance.

On June 16, ACEP announced its partnership with Amazon. The partnership allowed members access to cleaning supplies, PPE, and more. ACEP’s new central business account allowed members to purchase important supplies to keep their homes safe or supplement items they may need on shift before the general public.

On June 26, ACEP submitted its response to the Senate Health, Education, Labor, and Pensions (HELP) Committee regarding its “Preparing for the Next Pandemic” white paper, focused on five areas where Congress should work with federal departments and agencies, states, and the private sector. In the letter, ACEP raised significant concerns about the inappropriate allocation and re-use of PPE.

On July 2, the House Select Subcommittee on the Coronavirus Crisis held a hearing, “The Administration’s Efforts to Procure, Stockpile, and Distribute Critical Supplies,” to examine efforts to acquire PPE, COVID-19 testing supplies, and other critical supplies needed to respond to the coronavirus pandemic. ACEP submitted a letter for the record to highlight ongoing shortages of these supplies and how they affect emergency physicians’ ability to effectively treat patients during the pandemic.
On July 16, ACEP President, William Jaquis, MD, FACEP, and ACEP staff met with officials from the Occupational Safety and Health Administration (OSHA). During the meeting, ACEP shared de-identified stories from emergency physicians who have been penalized by their hospitals for wearing their own PPE or for speaking out publicly about PPE shortages or other issues. The College strongly urged OSHA to revise their standards and guidance to better protect emergency physicians and re-enforce their right to wear PPE that they believe keeps them safe. ACEP also asked OSHA to respond as quickly as possible to formal complaints filed by emergency physicians.

In August, ACEP partnered with Project N95 and more than a dozen other national specialty societies to provide members a one-week opportunity to purchase N-95 masks and other PPE at volume prices.

**ACEP Strategic Plan Reference**

Goal 1 – Improve the Delivery System for Acute Care
   Objective H - Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement
   Objective A – Improve the practice environment and member well-being.

**Fiscal Impact**

Budgeted committee and staff resources for development of policy statements.

**Prior Council Action**

None

**Prior Board Action**

March 2020, approved the policy statement “COVID-19: [Personal Protective Equipment (PPE) During the Pandemic](#).”

March 2020, approved the policy statement “COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment.”

June 2016, approved the revised policy statement “[Personal Protective Equipment Guidelines for Health Care Facility Staff](#);” reaffirmed October 2009; originally approved August 2003.

April 2014, approved the revised policy statement “[Emergency Department Planning and Resource Guidelines](#);” revised and approved October 2007, June 2004 and June 2001 with the current title; reaffirmed September 1996; originally approved December 1985 with the title “Emergency Care Guidelines.” The policy statement includes a list of suggested equipment and supplies for emergency departments which includes “personal protective equipment—gloves, eye goggles, face mask, gowns, head and foot covers.”

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
   Practice Management Manager

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
   Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
   Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 42(20)

SUBMITTED BY: Florida College of Emergency Physicians
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians

PURPOSE: Develop policy statements addressing ethical, safety, and financial challenges faced by emergency physicians during the COVID-19 pandemic and in future medical crises.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, COVID-19 is a global pandemic caused by a virus with easy respiratory droplet transmission and significant morbidity and mortality; and

WHEREAS, Emergency physicians are on the frontline of responding to the pandemic; and

WHEREAS, There have been many reports of inadequate personal protective equipment (PPE) for emergency physicians and other emergency department and emergency medical services personnel; and

WHEREAS, There have been emergency physicians and other emergency department and emergency medical services personnel who have suffered from COVID-19, some of whom have been critically ill or died as a result; and

WHEREAS, Emergency physicians and other emergency department and emergency medical services personnel are at risk of transmitting COVID-19 to family members and others in close proximity to where they live or work; and

WHEREAS, Some emergency physicians have had inadequate resources, specifically as relates to critical care, relative to the patients they encountered during the pandemic; and

WHEREAS, There have been multiple reports of hospitals and other practice entities making disproportionate and potentially permanent reductions in compensation or benefits beyond the demands of the current emergency and recovery of the institution; and

WHEREAS, ACEP has put forward policy statements on personal protective equipment as relates to the COVID-19 pandemic, but has not to date considered whether related policies more broadly applicable in future pandemics or related events are needed; and

WHEREAS, Future pandemics may cause similar ethical concerns; therefore be it

RESOLVED, That ACEP develop policy statements to address:

1) the implications for emergency physicians of inadequate personal protective equipment;
2) conflicts with hospitals and practice organizations on the use of self-purchased personal protective equipment;
3) crisis treatment standards; and
4) the proportionality of responses by hospitals and practice organizations toward emergency physicians’ compensation or benefits during times of pandemic illness or other similar events.
Background

This resolution calls for the College to develop policy statements addressing ethical, safety and financial challenges faced by emergency physicians during the COVID-19 pandemic and in future medical crises.

The novel coronavirus disease (COVID-19) is a global pandemic and continues to spread nationally and internationally. In carrying out their duty to provide medical treatment to patients affected by this dangerous virus, emergency physicians and other emergency medicine personnel have struggled to obtain adequate personal protective equipment (PPE) and other needed resources, specifically as they relate to patient critical care. These inadequate resources have endangered the lives of ACEP members and other medical professionals, their families and the community at large.

Further, as a result of reduced revenue caused by the cancellation of elective procedures in many states and a nationwide decline in emergency department visits, among other factors, hospitals and other practice management groups have reduced pay and benefits for many emergency physicians. CBS News April 2020

The Board of Directors approved several new policy statements related to the COVID-19 pandemic. ACEP also developed a number of resources; including topic discussions, webinars, press releases, social media content, and a highly informative resource page to assist emergency physicians with patient care:

- “Stop the Spread: A Patient Guide to the Novel Coronavirus (COVID-19)”
- Recognizing the importance of hospitals in defining roles and determining the level of resources needed to reduce the impact of the virus, the “National Strategic Plan for Emergency Department Management of Outbreaks of COVID-19” was developed and informs health care personnel, public health, and government officials at all levels about the necessary requirements for successful emergency department management.
- ACEP’s “Field Guide to COVID-19 Care in the ED” (Field Guide) was created to assist in the pandemic crisis. The Field Guide is a living document that will be updated as new information, guidance, and best practices evolve.
- During this COVID-19 public health crisis, concern of the critical shortage or lack of personal protective equipment (PPE) and other essential medical equipment continued to increase, as it had already endangered the lives of many, including the risk to health care providers. ACEP’s new policy statement “COVID-19 Personal Protective Equipment (PPE) During the Pandemic” addresses the CDC’s recommendation that healthcare personnel in the emergency department (ED) and emergency medical services (EMS) should consider wearing a face mask or surgical mask during an entire shift.
- It is imperative that health care providers receive the necessary resources and equipment critically needed to protect themselves, the health and welfare of their families, and the patients to whom they are providing lifesaving care. ACEP’s policy statement “COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment (PPE)” urges hospitals and other health care facilities to allow physicians to use their donated or self-purchased PPE.
- A joint policy statement “Care of Patients with Behavioral Health Emergencies and Suspected of Confirmed COVID-19” for care of the behavioral health patient with suspected or confirmed COVID-19 was developed by the American Association for Emergency Psychiatry, ACEP, American Psychiatric Association, Coalition on Psychiatric Emergencies, Crisis Residential Association, and the Emergency Nurses Association.
- To stand up for the emergency physicians and healthcare professionals serving on the frontlines of the COVID-19 pandemic having their livelihoods threatened, ACEP issued a statement “Now is Not the Time to Reduce Support for Health Care Heroes.”

In 2014, ACEP created and distributed materials addressing the Ebola virus disease (EVD); however, COVID-19 and potential future pandemics will create similar ethical and medical practice concerns requiring policies with a more expansive application.

The Ethics Committee will work on two specific objectives for the 2020-21 committee year regarding COVID-19:
Resolution 42(20) Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians

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- Identify and develop educational opportunities and materials on ethics issues, including at least three articles for ACEP publications including:
  - Ethical review of the US healthcare system’s response to the COVID-19 pandemic and ethical considerations for future pandemics.
- Develop a policy statement on the ethics of national pandemic disaster response.

Fifteen other ACEP committees also have objectives for the 2020-21 committee year to address COVID-19 and future pandemics.

**ACEP Strategic Plan Reference**

**Goal 1 – Improve the Delivery System for Acute Care**

  - Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  - Objective H – Position ACEP as a leader in emergency preparedness and response.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

None

**Prior Board Action**

April 2020, approved the policy statement “Care of Patients with Behavioral Health Emergencies and Suspected or Confirmed COVID-19.”

April 2020, approved the policy statement “Staffing Models and the Role of the Emergency Department Medical Director.”

March 2020, approved the policy statement “COVID-19 Personal Protective Equipment (PPE) During the Pandemic.”

March 2020, approved the policy statement “COVID-19: Use of Donated or Self-Purchased Personal Protective Equipment (PPE).”


June 2017, approved the revised policy statement “Emergency Physician Shift Work;” revised June 2010 and September 2003; reaffirmed October 1998; originally approved September 1994. As an adjunct to this policy
Resolution 42(20) Addressing Ethical Challenges of the COVID-19 Pandemic for Emergency Physicians

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statement, ACEP has prepared a policy resource education paper (PREP) titled, “Circadian Rhythms and Shift Work.”

June 2016, approved the revised policy statement “Personal Protective Equipment Guidelines for Health Care Facility Staff;” reaffirmed October 2009; originally approved August 2003.

April 2016 approved the revised policy statement “Fair Payment for Emergency Department Services;” originally approved April 2009.


Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 43(20)

SUBMITTED BY: District of Columbia Chapter
Maryland Chapter
Diversity, Inclusion. & Health Equity Section

SUBJECT: Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions

PURPOSE: Promote transparency in institutional data for identification of disparities and biases in medical care; continue to encourage compliance with training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination in EDs and institutions at all levels.

FISCAL IMPACT: Budgeted section and staff resources. Potential unbudgeted costs for convening a task force and accrediting enduring CME course(s). Actual cost depends on the scope of the work, potential honorarium, and whether meetings will occur virtually or in person. Minimum cost for accrediting CME is $12,000 per course offering.

WHEREAS, ACEP advocates for tolerance and respect for the dignity of all persons and opposes all forms of discrimination within healthcare¹; and

WHEREAS, Multiple studies have provided evidence for unconscious bias impacting the quality of care certain patients receive²; and

WHEREAS, ACEP has recognized the importance of unconscious bias in clinical practice and has developed an online course to assist all individuals in recognizing their own biases to curb their effects³; and

WHEREAS, ACEP recognizes that fostering a broad and inclusive healthcare environment and mitigating clinicians’ unconscious bias enhances patients’ experience and health outcomes; therefore be it

RESOLVED, That ACEP promote transparency in institutional data to better identify disparities and biases in medical care; and be it further

RESOLVED, That ACEP continue to encourage compliance with training to combat discrimination for all clinicians; and be it further

RESOLVED, That ACEP continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Background

This resolution calls for the College to promote transparency in institutional data for identification of disparities and biases in medical care; continue to encourage compliance with training to combat discrimination for all clinicians; and

²https://store.aamc.org/downloadable/download/sample/sample_id/168/
continue to explore frameworks for integrating anti-discrimination in EDs and institutions at all levels.

In March 2018, ACEP, as a recommendation of the Diversity and Inclusion Task Force, launched the Unconscious Bias in Clinical Practice one-hour, accredited CME course. This course focuses on:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

Amended Resolution 14(19) Implicit Bias Awareness and Training was adopted by the Council and the Board of Directors. The resolution directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias. The Academic Affairs Committee was assigned to develop the policy statement, which will be completed in the 2020-21 committee year. The Diversity, Inclusion, & Health Equity Section continues to promote the Unconscious Bias in Clinical Practice course.

The Diversity, Inclusion, & Health Equity Section has several objectives that relate to this resolution:

- Develop strategies to create a true culture of promoting diversity and inclusion and of addressing issues of health equity within the emergency medical community.
- Promote practical and realistic solutions in efforts to address diversity, inclusion, and health equity within the emergency medicine community.
- Develop and present educational programs on the many facets of cultural competency, diversity, inclusion, unconscious bias, and health equity within emergency medicine.
- Generate awareness of and promote pathways to address unconscious bias in emergency medicine.
- Identify the impact of a diverse workforce on health equities and patient outcomes and workforce in Emergency Medicine.
- Develop and make available to members of the College a Diversity and Inclusion Toolkit.

ACEP’s policy statement “Non-Discrimination and Harassment” advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual’s race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender, identity or expression, sexual orientation, or any other classification protected by local, state, or federal law. ACEP’s goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Discrimination and bias can serve as major drivers of influence on the quality of care provided in the emergency department toward individuals of underrepresented populations.

The information paper “Disparities in Emergency Care” includes three recommendations that directly supports the need for continued education related to cultural competence, clinical decision-making, and knowledge gaps among physicians that lack post-graduate education in emergency medicine.

1. Promote the evidence-based teaching of cultural competency.
2. Emphasize the use of clinical decision tools that standardize the approach to risk stratification and potentially reduce subjective bias.
3. Explore initiatives that address the “knowledge disparity” between rural and urban providers of emergency services, including providers who do not have post-graduate training in emergency medicine

ACEP’s policy statement “Workforce Diversity in Health Care Settings” reinforces that hospitals and emergency physicians should work together to promote diversity in staffing of emergency departments.
Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs and Healthcare Institutions

ACEP’s policy statement “Cultural Awareness and Emergency Care” supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP’s position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias as cultural awareness helps combat negative assumptions and discrimination. Implicit bias is recognized by the individual and mitigated through education recalling stereotypical thought processes. The recognition of bias can help prevent an individual from acting upon bias, which occurs in the form of discrimination.

Demonstrating the ongoing importance of this issue, 14 of ACEP’s committees will work on objectives during the 2020-21 committee year to address health care disparities and health equity.

One approach to address the third resolved of this resolution to explore frameworks for integrating anti-discrimination into emergency departments is to convene a task force. Additional implicit bias training courses could also be developed.

ACEP Strategic Plan Reference

Goal 2: Enhance Membership Value and Member Engagement

Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted section and staff resources. Potential unbudgeted costs for convening a task force and accrediting enduring CME course(s). Actual cost depends on the scope of the work, potential honorarium, and whether meetings will occur virtually or in person. Minimum cost for accrediting CME is $12,000 per course offering.

Prior Council Action

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP’s opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

April 2020, approved the revised policy statement “Cultural Awareness and Emergency Care;” reaffirmed April 2014; revised and approved April 2008; originally approved October 2001.

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

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


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

April 2017, reviewed the information paper “Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management.”
Substitute Resolution 41(05) Non-Discrimination adopted.

**Background Information Prepared by:**  Riane Gay, MPA  
Senior Manager, Development & Special Projects

**Reviewed by:**  Gary Katz, MD, MBA, FACEP, Speaker  
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 44(20)

SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP

SUBJECT: Due Process in Emergency Medicine

<table>
<thead>
<tr>
<th>PURPOSE: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right; 2) revise the policy statement “Emergency Physician Rights and Responsibilities;” 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.</th>
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<tbody>
<tr>
<td>FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy efforts. Potentially significant reduction in outside funding support.</td>
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WHEREAS, It is common knowledge that, despite an ACEP policy in favor of due process, many ACEP members are denied due process as it regards to their ability to see patients in the emergency department; and

WHEREAS, This denial is often achieved by requiring a physician to automatically give up their rights to a fair hearing outlined in the Medical Staff Bylaws when terminated by the entity holding the exclusive contract for emergency services; and

WHEREAS, Hospital administrators can request or pressure the entity holding the exclusive contract for emergency services to terminate an emergency physician thus avoiding the existing Joint Commission prohibition on such administrative interference with the Medical Staff Bylaws and responsibilities, and

WHEREAS, Due process is considered a fundamental right that is essential to allow the physician to act in the best interest of the patient; and

WHEREAS, The literature and recent examples during the pandemic confirm that emergency physicians can be terminated for speaking up regarding the quality of care and patient safety; and

WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are detrimental to its members or the public”; and

WHEREAS, The denial of due process is detrimental to ACEP members and the public; therefore, be it

RESOLVED, That ACEP adopt this policy; “No member of ACEP will, directly or indirectly, deny another emergency physician the right to due process regarding their medical staff privileges and ability to see patients in an emergency department. No member of ACEP will hold a management position with any entity that denies an emergency physician of this right.”; and be it further

RESOLVED, That ACEP modify the existing policy statement “Emergency Physician Rights and Responsibilities” through deletion and substitution as follows: “6. Emergency physicians **shall** be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges **shall** not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law. 7. Emergency physicians who practice pursuant to an
exclusive contract arrangement should shall not be required to waive their individual medical staff due process rights as a condition of practice opportunity or privileges.”; and be it further

RESOLVED, That ACEP adopt this policy: “Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with the ACEP will as of January 1, 2021 shall remove all restrictions on due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but is not limited to physician groups, hospitals, and staffing companies.”

References:
Seattle Times article on Dr. Ming Lin https://www.seattletimes.com/seattle-news/health/er-doctor-who-criticized-bellingham-hospitals-coronavirus-protections-has-been-fired/

Background
This resolution directs the College to adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right. The resolution further calls for wording changes in the policy statement “Emergency Physician Rights and Responsibilities” and the adoption of a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

ACEP’s policy statement “Emergency Physician Contractual Relationships” includes the following provisions:

- ACEP supports the emergency physician receiving early notice of a problem with his or her performance and an opportunity to correct any perceived deficiency before disciplinary action or termination is contemplated.
- All entities contracting with or employing emergency physicians to provide clinical services, either indirectly or directly, should ensure an adequate and fair discovery process prior to deciding whether or not to terminate or restrict an emergency physician’s contract or employment to provide clinical services.
- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor’s contract with the hospital concerning termination of a physician’s ability to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.
- Emergency physician contracts should explicitly state the conditions and terms under which the physician’s contract can be reassigned to another contracting vendor or hospital with the express consent of the individual contracting physician.
- The emergency physician should have the right to review the parts of the contracting entities’ contract with the hospital that deal with the term and termination of the emergency physician contract.

The policy statement has an accompanying Policy Resource and Education Paper (PREP), which states in part: “The core issue behind language in emergency medicine contracts having to do with termination of the physician's ability to practice is that of due process. Due process refers to the right to have a fair hearing, including input from the affected physician, prior to any decision being made about termination of the ability to practice (specifically the loss of hospital medical staff privileges). The concept of due process is felt to support the independence of a physician in advocating for patients without undue influence from extrinsic forces and preserves the sanctity of the physician-patient relationship. These forces may include non-medical concerns, such as financial, marketing, or political interests.”
The Joint Commission requires hospital medical staffs to provide due process for physicians. Section 10.01.01 of its Medical Staff Standards dictates that “There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions regarding reappointment, denial, reduction, suspension or revocation of privileges that may relate to quality of care, treatment, and services issues.” Additionally, the Health Care Quality Improvement Act of 1986 includes a provision that members of a professional review body are not shielded from liability for their professional review actions if they do not ensure due process for the physician facing that action.

Despite these efforts to ensure physicians are accorded due process related to actions that may negatively impact their medical staff privileges, physicians aren’t always assured due process in actual practice. The aforementioned PREP notes that “frequently emergency physicians have been forced to waive due process rights.” Hospitals may ask physicians to waive their due process rights as part of the employment agreement or award staffing contracts only to groups that require their physicians to waive their rights to due process.

ACEP’s policy statement “Emergency Physician Rights and Responsibilities” addresses the due process issue, stating in part:

7. Emergency physicians should be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law.

8. Emergency physicians who practice pursuant to an exclusive contract arrangement should not be required to waive their individual medical staff due process rights as a condition of practice opportunity or privileges.”

In 2018, ACEP and seven other emergency medicine organizations signed a letter to CMS Administrator Seema Verma. The letter noted that “Whether employed by hospitals or contracted groups, emergency physicians are often deprived of their due process rights via inclusion of a ‘waiver of due process rights’ clause in employment contracts. The letter requested CMS to guarantee physician due process rights by making them unwaivable and irrevocable. Also in 2018, ACEP and the other emergency medicine organizations supported the introduction of legislation that would prohibit the mandatory waiver of due process rights which many emergency physicians are forced to comply with as a condition of employment. An ACEP press release issued after introduction of the legislation quoted then president Dr. Paul Kivela who stated “This is an important safeguard that will ensure all emergency physicians have access to a fair due process procedure.”

The bill was introduced again with the new Congress in 2020 as H.R. 6910, the “ER Hero and Patient Safety Act.” In April, a letter from ACEP President Dr. William Jaquis was sent to the bi-partisan cosponsors of the new bill, Congressmen Raul Ruiz and Roger Marshall, reaffirming ACEP’s support for legislation to ensure every emergency physician has due process rights. The letter notes, “The threat of termination or the actual termination of physicians without the right of a fair hearing prevents emergency physicians from fully advocating for their patients for fear of retribution. For these reasons, ACEP believes that all emergency physician contracts should include a due process clause regardless of whether those physicians are directly employed by a hospital or they provide emergency medical services at a hospital through a group or individual contract.” ACEP continues to encourage members to ask their representatives to cosponsor the bill through a call to action, which has resulted in more than 1,000 contacts with members of Congress in support of the bill.

During the pandemic, emergency physicians have faced new threats to their employment. A Washington State emergency physician sued his hospital and group employer after losing his position at the hospital following his social media postings that claimed insufficient hospital efforts to protect staff from contracting the virus. There were also numerous reports of emergency physicians being threatened with termination for bringing their own PPE to work to better protect themselves. In a statement issued by ACEP, Dr. Jaquis stated, “Emergency physicians are prepared to handle virtually anything thrown at us as we seek to treat and heal our patients, however, we should not be forced to put our own lives at risk and have our jobs threatened simply for wearing our own supplied protective equipment.”
There is not one universally accepted standard for what constitutes due process. If the resolution is adopted, a detailed definition will need to be developed and advertised to fully inform the membership and stakeholder organizations about the new obligations, and ultimately to determine compliance.

Adoption of a policy that prohibits members from denying other emergency physicians the right to due process regarding their medical staff privileges and prohibit members from holding management positions at entities that deny emergency physicians this right would presumably entail sanctions, including possible expulsion from membership, for members failing to abide by the policy. ACEP would be required to report any suspension or expulsion to the National Practitioners Data Bank. Enforcement of self-regulation codes, even if the enforcement is not anti-competitive, must be carried out in a manner that affords the alleged offender due process, which includes proper notice and a fair hearing. The ACEP Bylaws state that “Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.” The College Manual currently describes one process for addressing all disciplinary actions; the process currently used to adjudicate ethics charges.

Should the resolution be adopted, the College would be required to create and implement a means of investigating alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings in order to provide adequate due process to the accused member. The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges and the conduct of this process could be used as a tool by competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to revoke a member’s membership or deny an entity’s ability to exhibit, sponsor or advertise with ACEP may create additional potential liability risk for ACEP. Affected members could bring legal action against the College with claims of defamation, limiting professional opportunities, or denial of due process on the part of ACEP. Excluding an entity from being able to sponsor any ACEP activity could subject the College to a claim of restraint of trade. Such challenges can be mitigated by developing and adhering to strict processes.

As referenced in the Whereas statement, in 2004, ACEP sought and received an Advisory Opinion from the Federal Trade Commission (FTC) regarding issues raised in two Council resolutions referred to the Board in 2003. The resolutions were 17(03) Certificate of Compliance and 18(03) Intention to Bid for a Group Contract. Resolution 17(03) desired to require emergency medicine staffing groups to sign a certificate and comply with its terms as a prerequisite for their participation as an exhibitor or sponsor of any College activity. One of the terms included was that groups must confirm that “with the provision period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.” Other provisions of the certificate included certification that groups provide their physicians a predefined and reasonable pathway to full partnership, that they do not impose post-contractual restrictive covenants, and that the group is wholly owned by practicing physicians. While the FTC Advisory Opinion noted that ACEP could respond to “behavior of market participants that it believes are detrimental to its members or the public,” it raised a number of potential antitrust concerns about actions contemplated by both resolutions. Regarding Resolution 17(03), the Advisory Opinion stated that “an agreement among ACEP members to affiliate only with entities that adopted all of the business practices listed in the proposed Resolution would be highly suspect.” It also stated that “agreements among ACEP members not to do business except on the terms contained in the Resolution, or a direct ACEP prohibition of its members’ accepting employment on non-conforming terms, would raise serious antitrust concerns.” The Advisory Opinion also stated that “ACEP may not unreasonably restrict competition among its members in order to force all contractual relationships between emergency physicians and holders of contracts to provide emergency services to hospitals into its preferred model.”

**ACEP Strategic Plan Reference**

**Goal 2 – Enhance Membership Value and Member Engagement**

Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.
Fiscal Impact

Budgeted committee and staff resources for policy development. Potentially significant reduction in outside funding support. The financial impact would depend on how many employing entities would stop sponsoring ACEP activities because of the requirement to remove all restrictions on due process for emergency physicians and how many entities and individual members would be accused of violating the policy and be subject to an ACEP investigation. Physician groups, staffing companies, and hospitals/clinics contributed $1,055,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities in 2019-20, representing about 24% of all corporate financial support for these activities. Additionally, ACEP’s prescribed procedures for adjudicating accusations of member misconduct is time intensive for the Ethics Committee, Board of Directors, and staff involved in investigation and rendering decisions on ethics complaints.

Prior Council Action

Resolution 45(13) Revision of “AMA Principles for Physician Employment” referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician’s right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Directed ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement, patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Resolution 29(11) Due Process for Emergency Physicians adopted. Directed ACEP to review and update the policy statement “Emergency Physician Contractual Relationships” regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

Resolution 18(03) Intention to Bid for Group Contracts referred to the Board of Directors. The resolution called for ACEP to require member to abide by a policy regarding “Duty to Inform Other ACEP Members of Intention to Bid for Their ED Group Contract.”

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including “With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.”

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to disclose their level of compliance with College policies on compensation and contractual relationships.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the “Emergency Physician Rights and Responsibilities” policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.
Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians’ rights policies, including: “Emergency Physicians Rights and Responsibilities,” “Emergency Physician Contractual Relationships,” “Agreements Restricting the Practice of Emergency Medicine,” and “Compensation Arrangements for Emergency Physicians.”

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans, and contract groups.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for the College to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process. The amended resolution directed the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts.

Resolution 38(90) Due Process Rights of Hospital Based Physicians not adopted. The resolution called for ACEP to work with The Joint Commission on the Accreditation of Hospital Organizations (now The Joint Commission) to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action


September 2018, approved the policy statement “Due Process for Physician Medical Directors of Emergency Medical Services.”


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


Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

September 2003, approved the submission of the request for an FTC Advisory Opinion

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.
Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

Amended Resolution 54(94) Due Process adopted.

**Background Information Prepared by:** Craig Price, CAE
Senior Director, Policy

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 45(20)

SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter

SUBJECT: Emergency Licensing and Protection in Disasters

PURPOSE: 1) Create new or reaffirm policy supporting that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official if the emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services, and practices within his/her area of knowledge and expertise. 2) Create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity if the emergency physician(s) practices within his/their area of knowledge or expertise.

FISCAL IMPACT: Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts and developing a policy statement.

WHEREAS, Natural and/or man-made disasters can and do occur within various parts of the United States and globally; and

WHEREAS, Government is exempt from certain types of civil and criminal prosecution under the protection of sovereign immunity; and

WHEREAS, Medical attention and treatment is often needed in such situations but can be unavailable or in short supply; and

WHEREAS, Emergency physicians along with other healthcare personnel/professionals often respond to such disasters; and

WHEREAS, Many other emergency physicians and other healthcare providers/professionals would like to or be willing to respond to such disasters; and

WHEREAS, “The American College of Emergency Physicians (ACEP) and the National Association of Emergency Medical Services Physicians (NAEMSP) believe an organized approach is needed for the utilization of unsolicited medical personnel who volunteer to respond to disaster scenes or mass casualty incidents”; and

WHEREAS, Despite the encouragement of the ACEP and NAEMSP for members to become affiliated with pre-established disaster response organization, many needed physicians in a disaster are not pre-established with such organizations thus resulting in less physicians being able to help in disasters who are willing to; and

WHEREAS, The emergency system, maintained by the U.S. Department of Health and Human Services, is aimed at recruiting medical professionals who are willing to volunteer in times of disasters and verifying their medical credentials ahead of time; and

WHEREAS, The reality is that this is not well advertised, or promoted and many physicians and other health care workers, who can provide valuable services to disaster victims, do not sign up or register in advance; and

WHEREAS, The response of enough qualified physicians during disasters is critical, if instead there could be
a simple method for confirming licensure in good standing in any US state or territory without requiring pre-
registration, instead by having a simple means to check if physicians are licensed in good standing in any US state or
territory, this would drastically increase the number of available and qualified emergency physicians who could assist
in disasters; and

WHEREAS, Most/all states have state licensing requirements and while many states allow care to be
provided without a medical license within the state under disaster or emergency situations, not all do; and

WHEREAS, The Federal Emergency Management Administration (FEMA), Department of Health and
Human Services (HHS), Department of Defense (DOD), Department of Homeland Security (DHS), or other federal,
state, or governmental agency could contact the Federation of State Medical Boards (FSMB) or maintain a national
registry from state medical licensing boards or licensing departments that does not require the physician to actively
register beforehand that shows all physicians who hold a medical license in good standing or without any reason not
to allow that physician to practice medicine in a disaster situation; and

WHEREAS, Convergent volunteerism is a reality whether planners plan for it or not; and

WHEREAS, FEMA acknowledges that everyone has the potential to contribute strength and resources in
times of emergency, that there are valuable and appropriate roles for unaffiliated spontaneous volunteers (sometimes
called “unsolicited volunteers”), that “the spontaneous nature of individual volunteering is inevitable; therefore, it
must be anticipated, planned for and manage,” and recommends: “emergency management experts and volunteer
organizations active in disasters (VOAD) partners are encouraged to identify and utilize all existing capacity for
integrating unaffiliated volunteers”iii; and

WHEREAS, While currently pacts may exist between some states that allow physicians licensed in one state
to become licensed and to practice in other states, these pacts have been slow to develop, becoming licensed in
multiple states can be labor and time intensive, do not include all 50 states and thus do not allow for maximum
availability to victims of disasters when the need arises; and

WHEREAS, State licensing requirements can be rather complex, difficult and time prohibitive especially
when trying to include all 50 states; and

WHEREAS, By allowing easing of licensing requirements during federal or state declared disasters, the
availability of qualified emergency physicians who are willing to provide care and treatment for victims of disasters
could be increased without affecting licensing requirements of states outside of declared disaster periods; and

WHEREAS, The current litigation environment varies between the 50 states and can be particularly severe in
some states, and can be a strong disincentive to provide much needed quality care particularly during times of
declared disasters; and

WHEREAS, It is important, fair, and the right thing to do to ensure liability protection to emergency
physicians and other healthcare workers who provide services within their expertise and at no charge during times of
state or federally declared man-made and natural disasters; and

WHEREAS, ACEP’s “Good Samaritan Protection” policy statement supports legislation to reduce liability
exposure and supports extension of existing good samaritan legislation to provide protection from liability for
emergency physicians who respond to emergencies outside the emergency department, including but not limited to in-
hospital and out of hospital emergencies, mass casualty incidents, and other disasters but does not specifically
mention this protection to emergency physicians who provide their services not-in-person, or remotely, as is the case
with Telehealth, electronically, via drones, etc.; and

WHEREAS, ACEP already supports sovereign immunity for emergency physicians in certain settings as
reflected by ACEP’s “Reform of Tort Law” policy statement that immunity should be given to emergency physicians
for emergency medical treatment and labor act (EMTALA) required services; therefore be it
RESOLVED, That ACEP create new or reaffirm policy that supports that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official and afterwards until services related to the disaster are no longer needed, so long as emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services and practices within his/her area of knowledge and expertise; and be it further

RESOLVED, That ACEP create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity and holding them harmless for any services, that they provide to patients during disasters and aftermath so long as the emergency physician(s) practices within his/their area of knowledge or expertise.

*Immunity: an order whereby a physician cannot commit a legal wrong and is immune to civil suit or criminal prosecution.


Background

This resolution requests ACEP to: 1) Create new or reaffirm policy supporting that all states and U.S. territories waive standard licensing requirements including fees for emergency physicians to provide their services, whether in person or not, in any state or territory once a disaster has been declared by a state or federal entity, agency or official if the emergency physician holds a license in good standing in any U.S. state or territory, does not charge for his/her services, and practices within his/her area of knowledge and expertise; and 2) Create new policy that supports legislation protecting any/all emergency physicians who provide their services, in person or otherwise, at no charge during disasters and their aftermath, and granting these emergency physicians immunity if the emergency physician(s) practices within his/their area of knowledge or expertise.

ACEP has multiple policy statements that address this resolution as described below. One of the key points in the resolution that is difficult to address is “waive standard licensing requirements including fees.” While ACEP could develop a policy statement, or revise an existing policy statement, it is unlikely that licensing requirements and fees would be suspended.

Despite the willingness of many physicians to provide support in a disaster situation, and who do not register in advance to provide such support, it can create a dangerous situation for physicians that are not trained in disaster response and entering into unstable environments.

ACEP’s policy statement “Support for National Disaster Medical System and Other Response Teams” supports the National Disaster Medical System (NDMS) and encourages further development and funding of the program. ACEP also supports its members who participate in the Disaster Medical Assistance Teams (DMAT), Urban Search and Rescue (USAR teams), or other federal or state-sponsored medical teams.

ACEP’s policy statement “Disaster Medical Response” supports a national credentialing mechanism and up-to-date database of available physicians and medical volunteers who could be deployed as needed in the face of a national emergency. A policy and program must be in place to provide these responders with workers’ compensation and medical liability protection when deploying to a disaster at the request of the federal or state government.

ACEP’s policy statement “Good Samaritan Protection” supports good samaritan protection legislation designed to reduce liability exposure. ACEP also supports the extension of existing good samaritan legislation to provide
protection from liability for emergency physicians who respond to emergencies outside the emergency department, including but not limited to in-hospital and out-of-hospital emergencies, mass casualty incidents, and other disasters.

ACEP’s policy statement “Health Care System Surge Capacity Recognition, Preparedness, and Response” includes the following excerpt: Legislation should be enacted where necessary to mitigate provider liability issues during crisis situations.

ACEP’s policy statement “Hospital Disaster Physician Privileging” includes language that The Joint Commission (TJC) has put forth standards (TJC Standard EM.02.02.13) to address Hospital Disaster Physician Privileging. During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners (LIP).

ACEP’s policy statement “Unsolicited Medical Personnel Volunteering at Disaster Scenes” is a joint statement with the National Association of EMS Physicians that encourages “members to become affiliated with pre-established disaster response organizations. This includes becoming pre-registered as disaster response personnel through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), which is present in every state and provides for license verification, personnel notification, and rostering of response teams.” This is contrary to the information in the sixth Whereas statement, beginning in line 16, indicating that ACEP and NAEMSP “believe an organized approach is needed for the utilization of unsolicited medical personnel who volunteer to respond to disaster scenes or mass casualty incidents.”

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
  Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.
  Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement
  Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts and developing a policy statement.

Prior Council Action

Resolution 58(05) Disaster Medical Response referred to the Board. Requested ACEP to recommend to the Federal Emergency Management Agency (FEMA) that they establish a national credentialing mechanism for the deployment of physicians in a national emergency.

Substitute Resolution 41(94) Disaster Response Program adopted. Endorsed the concept of volunteer medical disaster programs at the local level and that, ideally, the volunteer response or emergency physicians and their integration into existing state and federal disaster plans and resources should be coordinated by chapters.

Substitute Resolution 19(91) Disaster Medical Care adopted. Supported the position that every community needs a comprehensive backup system for immediate emergency medical care and directed ACEP to develop guidelines for the development of such systems.

Resolution 38(89) Mitigation of the Effects of Natural Disasters adopted. Supported the concept of global disaster mitigation and planning and that ACEP supports members activity in disaster planning, leadership, health care, educational activities, and networking with other disaster care organizations.
Amended Resolution 31(88) National Disaster Medical System (NDMS) adopted. Directed ACEP to make members aware of the Disaster Medical Assistance Team (DMAT) within the framework of the NDMS and encourage leadership roles within NDMS by specifically seeking a seat on the panel of health and medical preparedness.

Substitute Resolution 37(86) Disaster Plan adopted. Directed ACEP to assume a leadership role in mass casualty incident education and management and provide access for information to interested physicians and suppliers to aid in relief efforts.

Resolution 56(85) National Disaster Medical System adopted. Directed ACEP to continue to support the National Disaster Medical System.

Prior Board Action

June 2019, approved the revised policy statement “Support for National Disaster Medical System and Other Response Teams;” revised and approved June 2013 with the current title; revised and approved October 2006; originally approved March 1999 replacing Resolution 56(85) National Disaster Medical System and Substitute Resolution 19(91) Disaster Medical Care.

June 2019, reaffirmed the policy statement “Disaster Medical Response;” revised and approved June 2013; originally June 2006

February 2018, approved the revised policy statement “Good Samaritan Protection;” revised and approved June 2012; reaffirmed September 2005; originally approved September 1999.

October 2017, reaffirmed the policy statement “Health Care System Surge Capacity Recognition, Preparedness, and Response;” revised and approved October 2011; originally approved August 2004.

October 2017, approved the revised policy statement “Hospital Disaster Physician Privileging;” revised and approved January 2010 with current title; originally approved February 2003 titled “Hospital Disaster Privileging.”

October 2017, approved the revised policy statement “Unsolicited Medical Personnel Volunteering at Disaster Scenes;” reaffirmed October 2008; originally approved June 2002.

Substitute Resolution 41(94) Disaster Response Program adopted.

Substitute Resolution 19(91) Disaster Medical Care adopted.

Resolution 38(89) Mitigation of the Effects of Natural Disasters adopted.

Amended Resolution 31(88) National Disaster Medical System (NDMS) overruled. Substitute Resolution 37(86) Disaster Plan overruled.

Resolution 56(85) National Disaster Medical System adopted.

Background Information Prepared by: Patrick Elmes, EMT-P
EMS & Disaster Preparedness Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 46(20)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Employment Information

PURPOSE: Establish a database that would allow physicians to review employers and contract management groups (CMGs) in a confidential online environment and create policies opposing employers from discouraging or disciplining physicians choosing to post such reviews.

FISCAL IMPACT: Unbudgeted costs for design and development of the job database platform is estimated at $91,800 for the initial release. Cost for future enhancements and maintenance of the platform, for at least the three years following the release, is estimated at 20% of the initial platform cost or $18,360 per year. Additional costs would need to be allocated for a Product Owner role, outside of Technology Services. Additional staff time may be required in the roles of stakeholders and subject matter experts.

WHEREAS, Many emergency physicians work for or are contracted by others to provide their professional services; and

WHEREAS, Knowing what is a safe or an appropriate staffing model can be difficult unless one understands the specifics of an emergency department or medical facility; and

WHEREAS, It is difficult to be able to get enough information from asking questions on the phone or in an interview; and

WHEREAS, Employers or contract management groups may create, or influence, staffing models and work environments that emergency physicians believe to be unsafe for patient care and for the safe and enjoyable practice of emergency medicine; and

WHEREAS, The opinions of other emergency physicians who have worked in a work environment or with a particular employer, or contract management group, that one is considering to work in, or with, would be valuable to that emergency physician before having to make a decision as to whether to pursue or accept a job at a particular facility with a particular employer or contract management group; and

WHEREAS, A database that contains the opinions, or ratings, of other emergency physicians on various employers, contract management groups or facilities, would be useful and valuable to emergency physicians looking for employment or a new position; and

WHEREAS, Such a database would only contain information from emergency physicians who work for employers or contract management group and would not be influenced by employers or contract management groups; therefore be it

RESOLVED, That ACEP create new policy to establish a confidential “Job Database” or direct such a database to be created and controlled by an emergency physician controlled entity with the top priority of what is best for emergency physicians, that allows emergency physicians to provide their ratings, and/or opinions regarding employers and contract management groups (CMGs) for only those employers and CMGs that they have worked for or been contracted in an anonymous manner that is not accessible by or can be influenced by employers or contract management groups that is only accessible by other emergency physicians; and be it further
RESOLVED, That ACEP establish new policy that opposes employers or contract management groups from discouraging, obstructing, preventing or otherwise preventing any emergency physician from providing information or obtaining information from a confidential Job Database developed by ACEP; and be it further

RESOLVED, That ACEP establish new policy opposing penalty or punishment of any kind, actual or the withholding of benefit, to any emergency physician who provides information to, or receives information from, a confidential Job Database developed by ACEP.

Background

This resolution asks the College to establish a database that would allow physicians to review employers and contract management groups (CMGs) in a confidential online environment and create policies opposing employers from discouraging or disciplining physicians choosing to post such reviews.

Employer review websites, such as Glassdoor.com and Indeed.com are frequently used by potential employees to research the opinions of a company’s current and former employees regarding organizational policies and work conditions. Such sites may contain valuable information for physicians researching an employer or CMG; however, there is a risk that postings may contain false or misleading information from disgruntled employees. It is possible employers may file suit against the publisher or author of negative reviews for claims of defamation or breach of confidentiality agreements. Such risks could be mitigated by creating and maintaining strict user terms and conditions.

The publisher of an employer review website is required to carefully screen all postings and take precautions to protect the identity of users while prohibiting employers from accessing the site. Should ACEP act as publisher of the reviews, it would require ACEP to assign an employee to monitor, review, and possibly research users and postings to ensure the confidentiality of users is protected and that suspected false posts are deleted.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Unbudgeted costs for design and development of the job database platform is estimated at $91,800 for the initial release. Cost for future enhancements and maintenance of the platform, for at least the three years following the release, is estimated at 20% of the initial platform cost or $18,360 per year. Additional costs should be allocated for a Product Owner role, outside of Technology Services. Additional staff time may be required in the roles of stakeholders and subject matter experts

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Leslie Patterson Moore, JD
General Counsel and Chief Legal Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 47(20)

SUBMITTED BY: Emergency Medicine Residents’ Association
Pennsylvania College of Emergency Physicians

SUBJECT: Honoring Employment Contracts for Graduating Emergency Medicine Residents

PURPOSE: Partner with EMRA to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

FISCAL IMPACT: Budgeted committee and staff resources to assist with communication efforts or additional policy development related to encouraging employers to honor their employment contracts with graduating residents.

WHEREAS, Many emergency medicine residency graduates have had their first employment contracts cancelled or amended during the COVID-19 pandemic; and

WHEREAS, The median educational debt for medical school graduates was $192,000 in 2017 with three-quarters of all graduates having some level of debt; and

WHEREAS, Debt has significantly altered career and life decisions for current and recently graduated emergency medicine residents; and

WHEREAS, ACEP believes that physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM), and

WHEREAS, Only 61.1% of practicing emergency medicine clinicians in the United States are emergency medicine physicians with 14.3% being non-emergent physicians and 24.5% being advanced practice providers; and

WHEREAS, 27.1% of counties have no emergency medicine clinicians and 41.4% of counties have no emergency physicians reimbursed by Medicare fee-for-service Part B; and

WHEREAS, Residency trained emergency physicians have been shown to significantly improve mortality, particularly among patients with the highest severity of illness, while bringing down admission rates; and

WHEREAS, Graduating emergency medicine physicians comprise the future of the specialty; therefore be it

RESOLVED, That ACEP partner with the Emergency Medicine Residents’ Association to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

References:
5. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2753679
Background

This resolution calls for ACEP to partner with EMRA to encourage all employers to honor their employment contracts with graduating emergency medicine resident physicians.

Since the outbreak of the COVID-19 pandemic, many hospitals, emergency medicine groups, and emergency physicians have reported significant reductions in patient volumes as people with other conditions of varying acuity avoided going to the emergency department due to fears of contracting the coronavirus.

A report by the Medical Group Management Association states that, as early as April, medical group practices of all sizes and specialties have experienced significant financial hardship from the pandemic, noting that “97 percent of practices have experienced a negative financial impact directly or indirectly related to COVID-19.” The report also states that “on average, practices report a 55% decrease in revenue and 60% decrease in patient volume since the beginning of the COVID-19 crisis.”

A report by physician search firm Merritt Hawkins demonstrated the dramatic drop in recruitment efforts for physicians since the start of the pandemic. It reported that physician search engagements, which had increased for the 12 months ending March 31, declined by more than 30 percent in the next 60 days.

Hospitals and groups were forced to respond to the dramatic decline in revenue. Many did so through a reduction in physician hours and shifts, as well as furloughs of physicians and other staff.

Another significant ramification from the cost-cutting measures imposed as a result of the impact of COVID-19 has involved new residency graduates having their first employment contracts cancelled or amended. EMRA reports numerous incidents of residents having their contracts pulled back after they were signed by both parties. An EMRA Board member experienced a 15% reduction in hours, 10% cut in pay, and elimination of a bonus payment. Other residents have reported being sent to staff different facilities than what was initially promised. EMRA leadership reports these trends appear to be worsening.

A statement released by EMRA on April 27 states: “Rescinding emergency medicine physician employment contracts in the middle of a global pandemic, exactly when we need to remain vigilant, will hurt our health care system’s readiness. Now is not the time to cripple the front lines and devastate our newest emergency medicine attendings.” The statement added that EMRA “strongly encourages employers to honor their commitments to graduating emergency medicine residents and fellows. While we acknowledge the COVID-19 pandemic has changed the health care landscape, we ask employers to explore every option to fulfill the employment contracts already offered to graduating emergency medicine residents. We urge health care administrators to care for their frontline workers in the same way those emergency medicine physicians are caring for patients: with an eye to the common good rather than the bottom line.”

In considering ways that ACEP might partner with EMRA to encourage employers to honor their employment contracts with graduating residents, EMRA leadership suggested potential approaches that could include efforts to:

- Encourage groups to restructure their contracts so that promises can be upheld, and residents can still join the intended group, understanding they may not get the same contract/hours.
- Have employers provide reassurance to residents that terms of the contract will be met should volumes return in the future.
- Reward and recognize employers willing to hire graduating residents in the current climate.
- Advocate for removal of “all cause” termination language in contracts for new graduates, which allow contracts to be dissolved for any reason within a certain number of days’ notice.

ACEP issued a press release on April 7 under the title “Now is Not the Time to Reduce Support for Health Care Heroes.” The press release included a quote from ACEP President Dr. William Jaquis, stating “Cutting benefits or reducing shifts in today’s environment is akin to signing a ‘Do Not Resuscitate’ order for many emergency departments and the physicians that care for the patients, especially those in rural or underserved areas.”
Resolution 47(20) Honoring Employment Contracts for Graduating Emergency Medicine Residents
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ACEP’s policy statement “Emergency Physician Contractual Relationships” includes a provision that states “The contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is a party and to relate to one another in an ethical manner.” The Policy Resource & Education Paper (PREP) “Emergency Physician Contractual Relationships” is an adjunct to the policy statement.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted committee and staff resources to assist with communication efforts or additional policy development related to encouraging employers to honor their employment contracts with graduating residents.

Prior Council Action

None

Prior Board Action


Background Information Prepared by: Craig Price, CAE
   Senior Director, Policy

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
   Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
   Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 48(20)

SUBMITTED BY: New York Chapter

SUBJECT: Residency Program Expansion

PURPOSE: Engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

FISCAL IMPACT: Budgeted task force and staff funds.

WHEREAS, Emergency medicine residency is the only pathway to emergency medicine board certification; and

WHEREAS, In 2011, there were 150 residencies approved by the Accreditation Council for Graduate Medical Education (ACGME) with 1,607 emergency medicine PGY-1 positions offered, while 2018 saw a rise to 220 ACGME-approved residencies with 2,278 PGY-1 positions offered; and

WHEREAS, The change in overall numbers comes both from previously approved American Osteopathic Association residencies along with the proliferation of newly accredited ACGME residencies; and

WHEREAS, There has not been objective criteria in place for the determination of need for approval of new residencies by the ACGME specifically in terms of an assessment of emergency medicine workforce needs; and

WHEREAS, Contract management groups and other private entities have begun to build, control, and take over ACGME-accredited residencies without demonstrable commitment to educational needs or emergency medicine workforce stewardship; therefore be it

RESOLVED, That ACEP engage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

Background

This resolution calls for ACEP to engage the ACGME and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

ACEP has a long history of supporting the development, expansion, and funding of emergency medicine residency programs as well as studying current and future needs of the emergency medicine workforce.

In November 1987, the Board of Directors adopted the position that there was a shortage of board-certified emergency physicians and the projection for physician supply through the year 2010 would drop by 1.6%. An ACEP task force charged with studying the issue at the time reported that while supply would drop, there would be an increase in demand because of increasing population, need for access to care, an increasingly aging population, and increasing...
demand for full time faculty. In 1987 there were 73 emergency medicine residency programs producing approximately 430 graduates a year. The task force recommended that the College explore ways to increase the number of residency training slots within existing programs as well as through the creation of new residency training programs. The task force recommended that the College encourage private and public sources of funding for residencies to address the projected shortage.

The 1998 ACEP workforce study, A Study of the Workforce in Emergency Medicine, found that less than 50% of the necessary emergency medicine physician workforce was able to fully staff U.S. EDs and that the current number of emergency medicine residency programs was not projected to provide a significant increase in the available emergency medicine workforce. A follow-up study, A Study of the Workforce in Emergency Medicine: 1999, was published in Annals of Emergency Medicine. In 2001, the Board was asked to accept a report from the Staffing Task Force looking at current use of paramedics and EMTs and their future roles and to, “provide a special analysis of the ability for emergency medicine residency programs being able to meet the educational requirements for residency training while at the same time meeting the training requirements for paraprofessionals who will work in the ED.” The task force surveyed emergency medicine residency directors and residents in June 1999 and found that 66% of residents and 45% of residency director respondents believed that there would be some competition for career positions with non-physician providers.

A 2008 workforce study, published in Annals of Emergency Medicine, found that while younger physicians were more likely to be emergency medicine trained or emergency medicine board certified, many non-emergency medicine trained/emergency medicine board-certified physicians still provided coverage in EDs and that demand for rural emergency medicine care would likely continue with shortages likely to increase in rural areas.

In July 2009, a Future of Emergency Medicine Summit was convened. The consensus from summit attendees was that there would not be enough emergency medicine residency trained board-certified emergency physicians to meet the needs of all emergency patients in the U.S. for at least the next 20 years. It was noted that midlevel providers would provide some of the care in EDs, particularly where physician shortages exist. Summit participants recommended increasing the number of emergency medicine trainees with a corollary increase in GME funding, improving the geographic distribution of residency trained board certified emergency physician incentives for rural practice, increasing the number and size of emergency medicine programs, including loan forgiveness programs and targeting rural hospitals to host emergency medicine programs. In 2011, representatives from the 2009 meeting reconvened following the enactment of the Patient Protection and Affordable Care Act. The group published an update to their 2009 report. Regarding physician shortages in emergency medicine, the group recommended that policies to secure funding for additional training positions should be developed and residency training programs should provide increased exposure to rural practice.

In 2018, a workgroup of the ACEP Board of Directors was appointed to discuss trends in emergency medicine, such as future workforce needs, the role of physician assistants and nurse practitioners, consolidation of the employment market, and other concerns. It was determined that two task forces would be appointed: Emergency PA/NP Utilization Task Force and Emergency Medicine Workforce Task Force. The Emergency PA/NP Task Force included representation from all stakeholders in the provision of care of emergency patients. Their primary objective was to recommend the scope of practice for physician assistants (PAs) and nurse practitioners (NPs) in the ED, considering such factors as membership growth, education, training and experience, patient acuity, employment models, and the utilization of adjunctors such as telemedicine and other forms of oversight. Their final report was provided to the Board of Directors in April 2020. The primary objective of the multi-organizational Emergency Medicine Workforce Task Force is to assess the current and future emergency medicine workforce with assistance from an outside expert to review the literature and existing data on current and projected emergency medicine workforce needs. The task force launched in November of 2018. A final report is expected from the outside consultant in December 2020. The task force will then continue its work incorporating the consultant’s report and recent publications. Their final report is expected in June 2021.

A recent 2020 study in Annals of Emergency Medicine examined changes in the current U.S. emergency medicine workforce compared to 2008. While the study found an overall increase in physicians since 2008 (up by 9,774), of the 48,835 clinically active emergency physicians, 19% were neither emergency medicine trained nor emergency medicine board certified. Those 19% non-emergency medicine trained, or emergency medicine board-certified
physicians were more likely to be men and international medical graduates. They were also older and more likely to be in rural areas. While the density of emergency physicians has increased overall since 2008 (14.9 per 100,000 U.S. population), the increase is not reflected evenly between urban, large rural, and small rural (1.4, -0.4, -3.7 respectively). The study noted the continued need for effective delivery of care in rural and underserved areas. The study suggests that it is likely that as this group of physicians retire, and as urban areas continue to see increases in newly trained emergency medicine physicians, rural areas are likely to experience further shortages.

According to the ACGME, in 2018-19 there were a total of 7,940 emergency medicine residents in a total of 247 programs (63 of which had initial accreditation). Since the single-accreditation system, emergency medicine is one of the top four specialties with the highest 5-year increase in total number of programs. From 2014-15 to 2018-19, emergency medicine saw a 47.9% increase in programs. The number of active residents from 2014-15 to 2018-19 has increased by 33.6% from 5,941 to 7,940. Across specialties, approximately half of sponsoring institutions with ACGME-accredited programs are General/Teaching Hospitals (47.7%) and the next largest group is Academic Medical Centers/Medical Schools (15%). Academic Medical Centers/Medical Schools account for 9.7% more programs than general/teaching hospitals and have almost the same number of residents (ACGME Databook). It should be noted that the Residency Review Committee of the ACGME is obligated to accredit any residency that meets its criteria and will not be influenced by concern about an excess or deficit of physicians in that specialty.

GME funding for training programs is complex. GME funds are comprised of federal, state, and private monies. The federal government remains the largest funder of GME, covering approximately 86% of training costs. In 2018, the Congressional Budget Office estimated that approximately $15 billion in Medicare and Medicaid was spent on GME. Private funds are difficult to quantify but as the Institute of Medicine noted in their 2014 report, “may be significant.” The report also notes that while nationally, private funding might represent a small fraction of overall GME funding, for some programs it might be a significant support. The ACGME published a position paper in 2011, Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME, (an update to their 2002 guidance) outlining principles for sponsoring institutions and programs using industry GME funds. Some have cited changes in accreditation regulations over the years (reduced work hours for residents, increased supervision requirements, etc.) as driving up the cost of training. With increased costs and capped funding from federal sources, some institutions have turned to private funding, through industry or philanthropy, to cover the costs of training. Other institutions have embraced training programs as a way to recoup some operating costs, solve physician shortages, and increase productivity. In the case of one study, they found that eliminating GME programs would have a negative impact on their hospital’s bottom line. In the case of Hahnemann University Hospital, owned at the time by a private equity firm, while in bankruptcy proceedings attempted to auction off its residency positions even though this move was seen as illegal by CMS. ACEP sent a letter to the ACGME on November 18, 2019, informing them of ACEP’s opposition to the sale of Hahnemann’s GME slots and any further commoditization of GME slots.

Residency training programs and graduates are frequently faced with a changing funding landscape, evolving accreditation standards, shifting patient population needs, and challenges with the distribution of its workforce.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted funds for task force study on workforce issues and staff time.

Prior Council Action

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted. Directed ACEP to support CMS in opposing the sale of GME slots and oppose any sale or other commoditization of GME slots.
Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Directed ACEP to address workforce shortages and lobby for the removal of barriers to increasing the number of residency slots available in emergency medicine. Also directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to work with other emergency medicine organizations to use existing workforce data to identify current and future needs for board certified emergency physicians, recommend strategies based on the projected need to ensure appropriate numbers of emergency medicine residency graduates meet the need, and advocate to eliminate barriers to creating adequate numbers of emergency medicine residency positions and achieving optimal funding for those positions.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted. Directed ACEP to work with appropriate organizations and agencies to develop strategies to implement protections for resident physicians to complete their training in the event of residency program closures.

Resolution 31(96) Cooperative Training Programs in Emergency Medicine and Family Medicine not adopted. Called for ACEP to study the Canadian model of family physicians and generalists in emergency medicine and consider the implications for emergency care in the US. Additionally, work with other organizations to facilitate the development of combined residency training programs in family medicine and emergency medicine as well as a joint specialty certification by ABEM and ABFP.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Resolution 28(92) Emergency Medicine Residency Training Pilot Program not adopted. The resolution called on ACEP to facilitate, develop, and pilot a model training program in emergency medicine designed to allow practicing emergency physicians who completed training in other specialties to meet the requirements of the RRC-EM and become eligible for the ABEM exam. The pilot programs would be completed in a timely manner, through part-time and independent work, while in practice.

Amended Substitute Resolution 45(91) Emergency Medicine Residencies adopted. Directed the College to work with all appropriate organizations and agencies to obtain increased funding for emergency medicine residency programs.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted. Directed ACEP to work with other organizations to continue to provide support, guidance, information, and other appropriate materials for individuals and institutions interested in developing emergency medicine residency programs.
Resolution 48(20) Residency Program Expansion
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Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted. Directed ACEP to encourage development of new models for funding graduate medical education.

**Prior Board Action**

June 2020, filed the report of the Emergency PA/NP Utilization Task Force.

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted.

September 2018, approved appointing the Emergency PA/NP Utilization Task Force to consider the evolution of the role and scope of practice of physician assistants and nurse practitioners in the emergency department.

June 2018, approved the revised policy statement “Resident Training for Practice in Non-Urban/Underserved Areas;” reaffirmed April 2012 and October 2006; originally approved in June 2000.


June 2018, approved the revised policy statement “Financing of Graduate Medical Education in Emergency Medicine;” revised and approved October 2005; originally approved September 1999.

February 2018, reaffirmed the policy statement “Emergency Medicine Workforce;” reaffirmed April 2012 and June 2006; revised and approved September 1999 with the current title; originally approved November 1987 titled “Manpower.”


Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.


Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 45(91) Emergency Medicine Residencies adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs. The Board amended the substitute resolution adopted by the Council. The amended substitute resolution adopted by the Board directed ACEP to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted.

November 1987, adopted the position that, based on current and projected numbers of graduates from emergency medicine residency training programs, there will be a significant shortage of appropriately trained and certified emergency physicians. Additionally directed that a task force be appointed to develop strategies to meet the shortage.
Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 49(20)

SUBMITTED BY: Forensic Medicine Section
William Green, MD, FACEP
Sally Henin, MD, FACEP
Ralph Riviello, MD, FACEP
Heather Rozzi, MD, FACEP
William Smock, MD
Michael L. Weaver, MD, FACEP

SUBJECT: Strangulation Policy Statement and Educational Resources

PURPOSE: 1) Create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement. 2) Work with specialty and stakeholder organizations to develop an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Intimate partner violence (IPV) and sexual assault (SA) are serious public health problems; and

WHEREAS, Many IPV and SA victims seek treatment in the emergency department; and

WHEREAS, Non-fatal strangulation is a form of asphyxia characterized by external pressure on the neck closing the blood vessels or airway; and

WHEREAS, Studies indicate that 23 to 68% of female IPV victims and up to 25% of SA victims will experience strangulation; and

WHEREAS, Strangulation is an indicator of the escalation of violence and associated with increased risk of serious injury and even death in cases of IPV; and

WHEREAS, Strangulation has been identified as one of the most lethal forms of IPV and SA; and is used to exert power over a victim by taking from them control of their own body; and

WHEREAS, When strangled, unconsciousness and anoxic brain injury may occur within seconds and death within minutes; and

WHEREAS, Oftentimes, even in fatal cases, there is no external evidence of injury from strangulation, yet because of underlying brain damage due to hypoxia or vascular injuries during the strangulation assault, victims may have serious internal injuries or consequences, including death, even days, or weeks later; and

WHEREAS, There has been increased awareness of the use of chokeholds/carotid restraint by law enforcement as a potentially dangerous and truly represents lethal force; and in addition, there are several reports of serious injury, including embolic strokes, to individuals when training on these techniques by performing them on each other; and

WHEREAS, Many emergency medicine providers lack specialized training and knowledge to identify the signs and symptoms of strangulation, they mistakenly focus only on the presence of visible or airway injuries when imaging should have also been considered to rule out internal injury, and this lack of training has led to the
minimization of this type of violence, exposing victims to potential serious, short- and long-term health consequences, permanent brain damage, and increased likelihood of death; and

WHEREAS, There are no specific guidelines or recommendations regarding the emergency department management of the non-fatal strangulation victim, including history taking, physical examination, radiographic imaging, treatment, disposition, and documentation; therefore be it

RESOLVED, That ACEP create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement; and be it further

RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders to create an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

Background

This resolution requests that ACEP create a policy statement acknowledging the seriousness of strangulation in intimate partner and sexual violence and denouncing the use of choke hold/carotid restraint by law enforcement, and that ACEP work with specialty and stakeholder organizations to develop an information paper on the emergency department evaluation, treatment, and management of strangulation and available resources.

The “2019 Model of the Clinical Practice of Emergency Medicine,” developed by seven emergency medicine organizations, lists core patient conditions that present to emergency departments. In Item 18.1.9.4 Neck trauma, strangulation is listed as a disorder for which patient acuity could be critical, emergent, or lower acuity. Patient acuity level is fundamental to determining the priority and sequence of tasks to manage the patient.

Clinical signs and symptoms of non-fatal strangulation vary from patient to patient and may not appear for 24 to 36 hours, while the absence of external neck injuries does not exclude strangulation, all of which can make it difficult to identify this injury.

As an adjunct to the ACEP policy statement, “Management of the Patient with the Complaint of Sexual Assault,” ACEP’s Forensic Medicine Section prepared the ebook, “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” that is available on the ACEP Web site. Chapter 16 of the ebook is titled “Strangulation.” This chapter addresses the challenges, physiology, mechanisms, definitions, pathophysiology, clinical symptoms and caveats, clinical findings, clinical evaluation, management, and documentation related to strangulation. There are also examples of a documentation chart for non-fatal strangulation cases, medical release form and questions to ask the victim.

The International Association of Forensic Nurses has developed a position statement on non-fatal strangulation and a documentation toolkit, both available online on their website. The Emergency Nurses Association has a Topic Brief, “An Overview of Strangulation Injuries and Nursing Implications,” available on their website.

The Training Institute on Strangulation Prevention has various resources (e.g., brochures, training DVD, webinars) on the topic, available at no charge on their Web site: https://www.strangulationtraininginstitute.com. The goals of the Institute are to: enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled; improve policy and practice among the legal, medical, and advocacy communities; maximize capacity and expertise; increase offender accountability; and ultimately enhance victim safety.

The 2017 Council referred Resolution 48(17) Non-Fatal Strangulation to the Board of Directors. The resolution
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The 2017 Council referred Resolution 48(17) Non-Fatal Strangulation to the Board of Directors. The resolution directed ACEP to work with other organizations to develop educational resources and programs related to the evaluation and management of non-fatal strangulation, and for ACEP to develop a policy statement on the seriousness of non-fatal strangulation and a clinical practice guideline for the evaluation and treatment of non-fatal strangulation in the emergency department. The Board assigned the referred resolution to the Clinical Policies Committee with the directive to review and provide a recommendation regarding further action. Members of the Clinical Policies Committee performed a literature search and reviewed the resources and materials available on the topic. The committee concluded there was not enough evidence to develop a clinical policy, that a policy statement was not the ideal means of disseminating educational content, and that there were multiple sources of educational content available on non-fatal strangulation. In September 2018, the Clinical Policies Committee recommended to the Board of Directors that a clinical policy or policy statement on non-fatal strangulation not be developed but that existing educational materials on the topic be further disseminated. It was suggested that the Forensic Medicine Section provide links to additional resources on their ACEP microsite and submit a course proposal for an ACEP meeting on this topic.

It is not known at this time whether additional research on this topic has been published without performing another literature search.

**ACEP Strategic Plan Reference**

Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Provide robust communications and educational offerings, including novel delivery methods.

**Fiscal Impact**

Budgeted committee/task force and staff resources.

**Prior Council Action**

Resolution 48(17) Non-Fatal Strangulation was referred to the Board. This resolution directed ACEP to work with other organizations to develop educational resources and programs related to evaluation and management of non-fatal strangulation, develop a policy statement on its seriousness, and develop a clinical practice guideline.

**Prior Board Action**

September 2018, adopted the recommendation of the Clinical Policies Committee to take no further action on Referred Resolution 48(17) Non-Fatal Strangulation.

**Background Information Prepared by:** Travis Schulz, MLS, AHIP
Clinical Practice Manager

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 50(20)

SUBMITTED BY: Alan Heins, MD, FACEP
Rachel Solnick, MD
American Association of Women Emergency Physicians Section
Observation Medicine Section
Vermont Chapter

SUBJECT: Support for Expedited Partner Therapy

PURPOSE: 1) Develop a clinical policy supporting the use of expedited partner therapy. 2) Develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy. 3) Work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Sexually transmitted infections (STIs) in America are at all-time highs and increasing; and
WHEREAS, From 2014 to 2018, gonorrhea cases increased by 63% to over 583,000 cases and chlamydia increased by 19% to 1.8 million cases – the most ever reported to the Centers for Disease Control (CDC); and
WHEREAS, The rate of ED patients with STIs has risen more quickly than the general increase of ED patients and from 2009-2013 there was a 39% increase in ED visits that included an STI diagnosis; and
WHEREAS, Patients at highest risk for STIs are more likely to have poor access to healthcare and thus rely on the ED for their care; and
WHEREAS, STIs are a matter of health disparities and ED patients treated for STI are more likely to be non-white, younger, and lower-income; and
WHEREAS, Untreated STIs can increase susceptibility to HIV and has especially harmful effects for women by causing pelvic inflammatory disease, which the CDC estimates causes infertility in 24,000 women in the U.S. each year; and
WHEREAS, STIs are a preventable drain on the healthcare system economy carrying an estimated lifetime cost of $678 million attributed to gonorrhea and chlamydia; and
WHEREAS, Traditional methods of partner notification (informing partners of patients with STIs of their exposure) have yielded poor results and in areas of highest infection rates partner notification rates were as low as 12% and 17% for chlamydia and gonorrhea, respectively; and
WHEREAS, Expedited partner therapy (EPT) is the practice of treating sex partners of persons with a laboratory-confirmed STI without medical evaluation of the partners to treat and prevent ongoing transmission of STIs; and
WHEREAS, EPT is recommended for heterosexual partners who are unlikely to access timely evaluation and treatment and EPT provides source patient counseling, written instructions for the partner on treatment and prevention, and uses drugs with a low risk of anaphylaxis and medications are dispensed with instructions about adverse effects; and
WHEREAS, Partners receiving EPT are encouraged to seek additional medical evaluation as soon as possible to discuss screening for other STIs, including HIV infection; and

WHEREAS, In randomized controlled trials, EPT has shown to be more effective compared to unassisted referrals at decreasing rates of source patient reinfection or persistent infection compared to standard partner referral and in a systematic review of trials of over 12,000 patients there were no drug-related adverse effects or allergic reactions reported; and

WHEREAS, California established a hotline to record any adverse events from EPT prescriptions and received no calls for the full 10 years it was running and similarly, according to the Centers for Disease Control and Prevention (CDC), there have been no cases of malpractice associated with the practice of EPT; and

WHEREAS, EPT is recommended by the CDC, American College of Obstetrics and Gynecology, American Academy of Family Physicians, American Osteopathic Association, Society of Adolescent Medicine, American Academy of Pediatrics, and the American Bar Association; and

WHEREAS, EPT has gained legal acceptance in many states over the past decade because of state-specific pharmacy or medical board decisions and the passage of state laws or regulations allowing the practice; and

WHEREAS, EPT is currently permissible in 44 states, potentially allowable in 5 states (Alabama, Kansas, New Jersey, Oklahoma, South Dakota, Puerto Rico), and only prohibited in South Carolina; therefore be it

RESOLVED, That ACEP develop a clinical policy supporting the use of expedited partner therapy; and be it further

RESOLVED, That ACEP develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and be it further

RESOLVED, That ACEP work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

References
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Background

This resolution calls for ACEP to: 1) develop a clinical policy supporting the use of expedited partner therapy; 2) develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and 3) work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

Expedited partner therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. The CDC reports that cases of STIs have steadily increased since 2014. Limited resources mean that many partners are unable to receive standard treatment. The CDC has also concluded that, although ongoing evaluation is necessary, EPT is a useful option to facilitate partner management.

Currently, 45 states allow EPT (instead of 44 as reflected in the Whereas statement). It is potentially allowed in four states (instead of five as reflected in the Whereas statement), and prohibited in South Carolina. Some states have created programs specifically geared towards EPT. In 2014, the Illinois Department of Public Health used EPT along with other education to improve treatment outcomes in gonorrhea and chlamydia. The Minnesota Department of Health has created online guidance for using EPT for Chlamydia trachomatis and Neisseria gonorrhoeae. Both states found that more education on EPT was needed both for the public and practitioners.

While ACEP has a clinical policy on Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy (2016), there is not a clinical policy specifically on EPT or STI transmission. The American Osteopathic Association (AOA) has a statement advocating for the use of EPT. The American Academy of Family Physicians (AAFP) also has a statement in support of EPT.

There is research that supports EPT as an effective option to facilitate partner management. A clinical trial published in 2010 found that EPT was superior to standard partner referral across a wide spectrum of sociodemographic and behaviorally defined subgroups. A randomized controlled trial from 2011 found that EPT was less costly and it treated more partners than standard partner referral. A Cochrane Systematic Review published in 2013 concluded that more research was needed on EPT. A randomized controlled trial published in 2015 concluded that more education is needed in order to make EPT effective.

An ACEP clinical policy supporting expedited partner therapy could provide guidance and education to members on the use of EPT. Model legislation could provide further guidance, specifically in states where EPT is potentially allowable or prohibited. Partnering with state and local health departments could provide education to the public, while providing protocols for practitioners.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
  Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement
  Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.
Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 51(20)

SUBMITTED BY: Emergency Telehealth Section
Louisiana Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Telehealth Disaster Pilot and Educational Resources

PURPOSE: 1) Create new policy promoting federal, state, and private funding for pilot projects and studies to provide care to disaster victims and rescue workers using telehealth and other technology. 2) Study the effectiveness of using telehealth for the evaluation and treatment of disaster victims. 3) Create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools.

FISCAL IMPACT: Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts, and policy development.

WHEREAS, Natural and man-made disasters occur within the United States and throughout the world and affect people of all races, ages, genders, and people groups; and

WHEREAS, During disasters there is often a shortage of medical providers to provide emergency/disaster care to victims of disasters and disaster workers; and

WHEREAS, Even during disasters when there are significant medical relief efforts including supplies and personnel in a disaster area, often the medical areas are underutilized because many patients are unable to reach these medical areas to receive evaluation and/or treatment; and

WHEREAS, Funding is important for the success of disaster care delivery and education of first responders and disaster workers of natural and man-made disasters; and

WHEREAS, Telehealth, digital health, and other technology could improve the delivery of care to victims of disasters and reach victims in remote or other hard-to-travel or access areas, that might otherwise not be able to be treated; and

WHEREAS, Many first responders may not be familiar with the use of telehealth or being able to properly serve as a presenter in a disaster or emergency setting during care using telehealth or other technology; and

WHEREAS, Telehealth is well accepted by providers and patients and being effectively used in many medical facilities and in some disaster settings with good preliminary results; therefore be it

RESOLVED, That ACEP create new policy that promotes federal, state, and private funding for pilot projects and studies to help provide care, once a disaster is officially declared by a state or federal agency, entity or official, to disaster victims and rescue workers using telehealth and other technology as tools and to study the effectiveness of using telehealth as a vehicle for the evaluation and treatment of disaster victims and patients; and be it further

RESOLVED, That ACEP create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools to improve access, evaluation of, and the care delivered to victims of natural and man-made disasters.
Background

The resolution requests ACEP to: 1) Create new policy promoting federal, state, and private funding for pilot projects and studies to provide care to disaster victims and rescue workers using telehealth and other technology. 2) Study the effectiveness of using telehealth for the evaluation and treatment of disaster victims. 3) Create new policy that encourages federal, state, and private funding to develop and implement telehealth and other technology educational programs and training of first responders and disaster workers to become more familiar with such tools.

In accordance with ACEP’s policy statement “Emergency Medicine Telehealth” (most recently revised in February 2020), ACEP has supported the delivery of emergency telehealth services by board-certified emergency physicians.

Disaster medicine is a unique and continuously evolving environment for emergency care. The unique nature of disaster care includes, but is not limited to, challenges of access to patients, austere conditions, environmental challenges, and shortages of facilities and personnel. The marriage of telehealth, disaster medicine response, and new technologies such as drone use, is still a novel and increasingly used concept. ACEP is in a unique position in having the expertise and means to accomplish furthering the concepts described in the resolution.

From an advocacy perspective, ACEP has pushed for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. The Medicare statute currently restricts reimbursement for telehealth to services performed in rural areas. During the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) used its unique “1135” waiver authority that only exists during a national emergency to temporarily waive this restriction, as well as another restriction called the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home). This waiver significantly expanded the use of telehealth during a national emergency.

The Federal Communications Commission (FCC) has implemented initiatives to support health care providers who want to stand up telehealth programs in rural and underserved communities during the COVID-19 PHE. Specifically, FCC established a $200 million telehealth program for healthcare providers responding to the COVID-19 PHE. Congress appropriated the funds as part of the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act. Through the COVID-19 Telehealth Program, the FCC helped healthcare providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. The FCC has closed applications for this program.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
    Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
    Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources for research, surveys, data collection, advocacy efforts, and policy development.

Prior Council Action

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the positive, negative, and potential unintended consequences of telemedicine; and develop appropriate policy assuring appropriate doctor-patient relationships are maintained.
Resolution 36 (14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in Telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 20(13) Disaster Research adopted. Directed ACEP to work with other organizations to develop guidelines for evaluation of new or ongoing projects in disaster preparedness, response, effectiveness of interventions, and outcomes research and research funding.

Prior Board Action


Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

June 2018, approved the revised policy statement “Disaster Medical Services,” reaffirmed April 2012 and October 2006; revised and approved June 2000; reaffirmed March 1997; originally approved June 1985.

June 2016, approved the policy statement “Ethical Use of Telemedicine in Emergency Care.”

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted.


Amended Resolution 20(13) Disaster Research adopted.

Background Information Prepared by: Patrick R. Elmes, EMT-P
EMS & Disaster Preparedness Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 52(20)

SUBMITTED BY: Robert McNamara, MD
Thomas Scaletta, MD, FACEP

SUBJECT: The Corporate Practice of Medicine

PURPOSE: 1) Review and report on the legal and regulatory matters related to the corporate practice of medicine in each state; 2) Develop policy stating that upon request from groups facing loss of their contract to a corporate entity, ACEP and the relevant state chapter will provide a written review of the legality of the corporation obtaining the contract for emergency services; 3) ACEP and the chapter will work with other organizations in petitioning appropriate state authorities to investigate if the corporate practice of medicine is occurring in a state where it is prohibited; and 4) Convene a meeting of other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

FISCAL IMPACT: Budgeted committee and staff resources for policy development Additional unbudgeted and substantial staff resources to develop a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine in each state. Additional staff resources to advocate for states to investigate whether the potential corporate practice of medicine is occurring contrary to state law. Unbudgeted travel and meeting costs of up to $10,000 to convene a meeting of specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

WHEREAS, A significant number of the nation’s emergency departments are controlled by a staffing company with private equity backing or ownership; and

WHEREAS, Optum, a subsidiary of the United Healthcare insurer, has recently taken ownership of emergency medicine practices; and

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states to keep the business interest out of the physician-patient relationship; and

WHEREAS, The CPOM doctrine has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

WHEREAS, In states where the CPOM doctrine and the state Medical Practice Acts prohibit lay ownership of a medical practice an ACEP member can be subject to a detrimental licensure action through the State Board of Medicine if they are found to be aiding or abetting the illegal practice of medicine; and

WHEREAS, The original Bylaws of ACEP stated that “an emergency physician will not associate himself in any fashion with any institution which permits medical practice other than by a physician;” and

WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response to antitrust concerns raised by ACEP, that ACEP could respond to “behavior of market participants that it believes are detrimental to its members or the public”; and

WHEREAS, The CPOM can be detrimental to the member and the public; therefore be it

RESOLVED, That ACEP will prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; and be it further
RESOLVED, That ACEP adopt as policy: “The ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services.”; and be it further

RESOLVED, That ACEP, in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, will petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies of anesthesia and radiology in this effort and solicit the support of the state medical society; and be it further

RESOLVED, That ACEP will convene a meeting with representatives of physician professional associations representing anesthesiologists, radiologists, hospitalists, dermatologists, and other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

References:
https://www.texmed.org/CPMwhitepaper/
https://www.ama-assn.org/media/7661/download

Background

This resolution calls for ACEP to review and report on the legal and regulatory matters related to the corporate practice of medicine in each state. Additionally, it directs ACEP to develop policy stating that upon request from groups facing loss of their contract to a corporate entity, the College and the relevant state chapter will provide a written review of the legality of the corporation obtaining the contract for emergency services, and that the College and chapter will work with other organizations in petitioning appropriate state authorities to investigate if the corporate practice of medicine is believed to be taking place in a state where it is prohibited. It also directs ACEP to convene a meeting of other specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

A 2015 AMA Issue Brief on the corporate practice of medicine states: “The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. This doctrine arises from state medical practice acts and is based on a number of public policy concerns, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation’s obligation to its shareholders may not align with a physician’s obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician’s independent medical judgment. While most states prohibit the corporate practice of medicine, almost every state has broad exceptions, such as for professional corporations and employment of physicians by certain healthcare entities.”

It also notes that “every state allows for the creation of professional corporations, which are corporations organized for the specific purpose of rendering a professional service. State statutes often specify how the professional corporations should be structured, who can participate as shareholders or owners and who must serve on the board of directors. Most states restrict the shareholders, owners, or board of directors of a professional corporation to persons licensed to render the same professional service as the professional corporation.” About 30 states have explicit restrictions, and exceptions, to the corporate practice of medicine.

Some state medical boards have issued opinions as to whether certain practices violate corporate practice of medicine restrictions and, according to the AMA, the question is often decided on whether employment agreements specify that physicians maintain independent medical judgement in those arrangements.

As independently incorporated entities, ACEP chapters have autonomy to determine their own actions, within the parameters of ACEP and chapter bylaws and may not choose to work with ACEP as directed in the resolution.
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ACEP’s policy statement “Emergency Physician Rights and Responsibilities” states that “Emergency physician autonomy in clinical decision making should be respected and should not be restricted other than through reasonable rules, regulations, and bylaws of his or her medical staff or practice group. This includes reasonable, good faith deviations from current, published ACEP Clinical Policies based upon the particular clinical situation in a given patient. Emergency physician autonomy should not be restricted by cost-saving guidelines, rules, or protocols. The physicians must have the ability to do what they believe in good faith is in the patient’s best interest at all time.”

ACEP’s policy statement “Emergency Physician Contractual Relationships” states that “quality medical care is provided by emergency physicians organized under a wide variety of group configurations and with varying methods of compensation. ACEP does not endorse any single type of contractual arrangement between emergency physicians and the contracting vendor.”

Last year, the Council and the Board adopted Resolution 58(19) Role of Private Equity in Emergency Medicine. Part of the resolution directed the College to study the market penetration of non-physician owned emergency medicine groups and their impacts on physicians. Additionally, it called for ACEP to work with other organizations to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur. In response to the resolution, ACEP President William Jaquis, MD, FACEP, appointed an Emergency Medicine Group Ownership Task Force. The task force is chaired by former ACEP President Andrew Sama, MD, FACEP, and consists of members representing a variety of different employment models. The task force developed an RFP to study the market penetration of all emergency medicine ownership models, and research their respective impacts on physicians and their practices and, to the extent possible, their unique impacts on quality of care and cost of care. In August, the Board of Directors accepted the recommendation to retain the services of Milliman to lead this research effort. As of this writing, final contract negotiations are underway, with the project likely to begin in September and a goal of providing a final report to the 2021 Council. A status report on this resolution has been prepared for the 2020 Council.

As referenced in the sixth Whereas statement, the original ACEP Bylaws from 1968 included a provision that “No person shall remain a member of the College unless he is of good moral character and agrees to abide by the Principles of Medical Ethics of the American Medical Association and the American College of Emergency Physicians Principles of Ethical Practice.” The Principles of Ethical Practice consisted of six statements, one of which read: “The emergency physician shall not associate himself in any fashion with any institution which permits medical practice by other than a physician.” In 1976, the ACEP Council removed the Principles of Ethical Practice from the Bylaws and made them separate official ACEP policy. Additionally, in 1976, the Bylaws were amended to state that the AMA Principles of Medical Ethics and ACEP’s Principles of Ethical Practice and other related ACEP policy statements are the principles of ethics of ACEP. In 1979, the Board of Directors approved removing all references to ACEP’s Principles of Ethical Practice from College literature and that the AMA Principles of Medical Ethics would be referenced instead. In June 1997, the Board of Directors adopted the “Code of Ethics for Emergency Physicians,” most recently approved January 2017.

As referenced in the seventh Whereas statement, in 2004, ACEP sought and received an Advisory Opinion from the Federal Trade Commission (FTC) regarding issues raised in two Council resolutions referred to the Board in 2003. The resolutions were 17(03) Certificate of Compliance and 18(03) Intention to Bid for a Group Contract. While the FTC Advisory Opinion noted that ACEP could respond to “behavior of market participants that it believes are detrimental to its members or the public,” it raised a number of potential antitrust concerns about actions contemplated by both resolutions. The FTC Advisory Opinion stated that “ACEP may not unreasonably restrict competition among its members in order to force all contractual relationships between emergency physicians and holders of contracts to provide emergency services to hospitals into its preferred model.”

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Improve the practice environment and member well-being.
Fiscal Impact

Budgeted committee and staff resources for policy development. Additional unbudgeted and substantial staff resources to develop a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine in each state. Additional staff resources to advocate for states to investigate whether the potential corporate practice of medicine is occurring contrary to state law. Unbudgeted travel and meeting costs of up to $10,000 to convene a meeting of specialties affected by private equity involvement to examine joint efforts to combat the corporate control of medicine by lay entities.

Prior Council Action

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted. The resolution called for ACEP to study and report annually the market penetration of non-physician ownership of emergency medicine groups and the effects that these groups have on physicians and ACEP advocacy efforts. It further directed the College to advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcies, or other adverse events of their employer/management company. Additionally, ACEP was directed to partner with other medical societies to determine the circumstances under which corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur.

Resolution 18(03) Intention to Bid for Group Contracts referred to the Board of Directors. The resolution called for ACEP to require member to abide by a policy regarding “Duty to Inform Other ACEP Members of Intention to Bid for Their ED Group Contract.”

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including “With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.”

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and continue to promote the adoption of the principles outlined in the “Emergency Physician Rights and Responsibilities” policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Resolution 58(95) Sales of Emergency Department Contracts not adopted. The resolution asked that ACEP’s lobbying efforts be directed toward federal and state legislation that would ban the sale of emergency department contracts.

Resolution 5(76) Principles of Ethical Practice adopted. This Bylaws amendment removed the “Principles of Ethical Practice” from the ACEP Bylaws and made it an official policy of the College. Additionally amended the Bylaws to state that the AMA Principles of Medical Ethics and ACEP’s Principles of Ethical Practice and other related ACEP policy statements are the principles of ethics of ACEP.

Prior Board Action

August 2020, approved the recommendation of the Emergency Medicine Group Ownership Task Force to contract with Milliman to conduct research on the landscape and market penetration of group ownership models and seek to identify unique impacts of different models on emergency physicians, cost of care, and quality of care.

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

June 2018, approved the revised policy statement “Emergency Physician Contractual Relationships;” revised and


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

September 2004, approved submitting the report to the Council on Referred Resolution 17(03) and Referred Resolution 18(03) with the FTC Advisory Opinion.

September 2003, approved the submission of the request for an FTC Advisory Opinion

1979, approved removing all references to ACEP’s Principles of Ethical Practice from College literature and that the AMA Principles of Medical Ethics would be referenced instead.

Resolution 5(76) Principles of Ethical Practice adopted.

**Background Information Prepared by:** Craig Price, CAE
Senior Director, Policy

**Reviewed by:** Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 53(20)

SUBMITTED BY: Maryland Chapter of Emergency Physicians

SUBJECT: In Memory of Lindsey J. Myers, MD

WHEREAS, With the untimely death of Lindsey Jo Myers, MD, on April 11, 2020, ACEP lost a gifted communicator, a tireless emergency medicine advocate, and a committed believer in the Hippocratic Oath; and

WHEREAS, Dr. Myers received her medical degree from the Eastern Virginia School of Medicine in 2008 and completed her emergency medicine residency at Geisinger Medical Center in Danville, Pennsylvania in 2011 where she was a life flight physician as well; and

WHEREAS, Dr. Myers had a long and distinguished service as a member of ACEP and both the North Carolina and then the Maryland Chapter totaling 10 years; and

WHEREAS, Dr. Myers served her community for ten years as an emergency physician and tirelessly worked at Carteret Health Care in Morehead, North Carolina, East Medical Center in New Bern, North Carolina, and Peninsula Regional Medical Center in Salisbury as well as Atlantic General Hospital in Berlin, Maryland; and

WHEREAS, Dr. Myers additionally practiced emergency medicine and touched many lives with her kindness, compassion, and desire to truly help mankind; and

WHEREAS, Dr. Myers was recognized for her deep empathy and compassion for medicine which earned her the exuberant gratitude and admiration of her patients, colleagues, friends, and family and will forever be an inspiration to them; and

WHEREAS, Dr. Myers will be missed by her many friends and colleagues who were privileged to know her for her strength of character, the warmth of her smile, and as the epitome of what an emergency physician is, but most importantly that she knew that kindness mattered; therefore, be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician Lindsey Jo Myers, MD and extends condolences and gratitude to her family and friends for her service to the specialty of emergency medicine and to patient care.
RESOLUTION: 54(20)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Herbert Arnold (“Arn”) Muller, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a pioneer and founding father of the specialty when Herbert Arnold (“Arn”) Muller, MD, FACEP, passed away on April 29, 2020, at the age of 90; and

WHEREAS, Dr. Muller, after serving in the United States Air Force, moved to Hershey, Pennsylvania in 1973 where he was the first emergency physician and founding chief of the Division of Emergency Medicine (now the Department of Emergency Medicine) at Penn State Health Milton S. Hershey Medical Center; and

WHEREAS, In 1979, Governor Dick Thornburgh appointed Dr. Muller Secretary of Health for the Commonwealth of Pennsylvania, during which he assisted in the development of trauma systems and the accreditation of trauma centers, helped to establish the Pennsylvania Bureau of Emergency Medical Services, lobbied for EMT training standards, and advocated for radiation safety, most notably with his leadership during the Three Mile Island nuclear accident; and

WHEREAS, Dr. Muller served on the Board of Directors of the Pennsylvania College of Emergency Physicians (PACEP), including as PACEP President from 1976 to 1977; and

WHEREAS, Dr. Muller served as President of the American College of Emergency Physicians (ACEP) from 1982 to 1983; and

WHEREAS, Dr. Muller dedicated himself to the fledgling specialty of emergency medicine in the 1970s through its formal recognition in 1979; and

WHEREAS, Dr. Muller finished his career as Chief of Staff, from 1987 to 2003, at the Lebanon, Pennsylvania VA Medical Center; and

WHEREAS, Dr. Muller was a true “renaissance man” who traveled the world, served his community, and dedicated himself to his beloved wife of 64 years, Anne, and their five children; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and expresses its appreciation for the professional accomplishments and personal influence of “Arn,” a consummate gentleman and emergency medicine pioneer, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Anne, daughters Janice and Sarah, and sons Carl “Gus,” Peter, and Paul, and the extended Muller family gratitude for his tremendous service to public health and to the specialty of emergency medicine as one of its founding fathers.
RESOLUTION: 55(20)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of J. Ward Donovan, MD, FACEP, FACMT

WHEREAS, The specialty of emergency medicine and the subspecialty field of medical toxicology lost a distinguished leader and pioneer when J. Ward Donovan, MD, FACEP, FACMT, passed away on June 27, 2020, at the age of 73; and

WHEREAS, Dr. Donovan completed emergency medicine residency training in 1977 at the Penn State Milton S. Hershey Medical Center and served a visiting professorship in Toxicology at the Royal Infirmary of Edinburgh, Scotland in 1985-1986; and

WHEREAS, Dr. Donovan served on the Board of Directors of the Pennsylvania College of Emergency Physicians (PACEP) from 1978 to 1984 and from 1987 to 1991, including as PACEP President from 1990 to 1991; and

WHEREAS, Dr. Donovan served as Acting Chief of the Division of Emergency Medicine at the Penn State Milton S. Hershey Medical Center from 1980 to 1982, as Chief of the Division of Emergency Medicine at the Hershey Medical Center from 1982 to 1985, and as Director of the Emergency Medicine Residency Program at Penn State from 1980 to 1985; and

WHEREAS, Dr. Donovan was Medical Director of the Penn State Poison Center from 1986 to 2003 and then as the Chief of the Section of Medical Toxicology at Pinnacle Health System in Harrisburg, Pennsylvania; and

WHEREAS, Dr. Donovan was a pioneer and leader in the subspecialty of medical toxicology, including serving as a Board Member of both the American Academy of Clinical Toxicology and the American College of Medical Toxicology where he served as President from 1996 to 1998, and in 2008 received the prestigious Matthew J. Ellenhorn Award for Outstanding Achievements in Medical Toxicology from the American College of Medical Toxicology; and

WHEREAS, Dr. Donovan tirelessly dedicated himself to his patients, frequently being on 24-hour call for multiple days in a row; and

WHEREAS, Dr. Donovan’s legacy will live on in the countless emergency medicine residents, faculty, and medical toxicology fellows whom he trained and mentored; and

WHEREAS, Dr. Donovan was a dedicated and loving spouse, father, and grandfather with a passion for hunting, fishing, and as an accomplished competitive speed skater; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of J. Ward Donovan, MD, FACEP, FACMT, who dedicated himself to his patients, to his profession, and to his family, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Joan, daughter Erin, son-in-law, Greg, and grandchildren, Seamus and Aoife, and to the extended Donovan family gratitude for his tremendous service to the specialty of emergency medicine and to his leadership, vision, and commitment in the development of emergency medicine and medical toxicology.
WHEREAS, The specialty of emergency medicine, the Government Services Chapter of the American College of Emergency Physicians (GSACEP), and the Texas College of Emergency Physicians (TCEP) lost a compassionate physician, EMS physician and leader, military officer and leader, colleague, and friend in Brigadier General, USAF (RET) (BVT), Craig A. Manifold DO, FACEP, FAAEM, FAEMS, who passed away unexpectedly on September 20, 2020, at the age of 57; and

WHEREAS, Dr. Manifold received his medical degree from the Philadelphia College of Osteopathic Medicine, completed a transitional internship at Wilford Hall Medical Center, and residency in emergency medicine at the Joint Military Medical Centers in San Antonio; Texas, and

WHEREAS, Dr. Manifold served his country faithfully and honorably in the Active Duty Air Force, Air Force Reserves, and Texas Air National Guard, deployed in support of Operations Southern Watch, Noble Eagle, Urgent Fury, and Enduring Freedom, always committed to the advancement of military medicine and those we serve; and

WHEREAS, Dr. Manifold served in numerous leadership positions within the military including being appointed as the first emergency physician to serve as team leader for the USAF Mobile Field Surgical Team, serving as Associate Residency Director for the Wilford Hall Medical Center Emergency Medicine Residency, Chief of Professional Services, Medical Group Commander, and culminating his military career as the Joint Surgeon for the Texas National Guard until his retirement from the Texas Air National Guard in 2019; and

WHEREAS, Dr. Manifold, an ACEP member for more than 28 years, served the College in a variety of leadership positions, including the ACEP EMS Committee Chair from 2014 – 2016 and an EMS committee member for many years; and

WHEREAS, His dedication and commitment to the field of prehospital medicine led him to serve as medical director across multiple settings, such as ground, air, law enforcement, critical care, and U.S. governmental agencies, where he gained an affinity and expertise in disaster response; and

WHEREAS, He was called to participate in and lead numerous evacuations and rescues, notably during hurricane Katrina as the Chief of Flight Medicine and Deputy Commander of the deployed medical teams, where he led the evacuation of 5,000 civilians from the New Orleans Ernest Morial Convention Center; and

WHEREAS, Dr. Manifold responded to hurricanes Gustav, Rita, and Ike, and in the wake of Hurricane Harvey, he led the National Guard medical response in its entirety as the Joint Surgeon, Texas Military deployment, in charge of all the National Guard medical response teams from Texas, Colorado, Nebraska, Oklahoma, North Carolina, and Delaware; and

WHEREAS, Dr. Manifold’s years of EMS experience and perspicacity led to his appointment on both the Texas Governor’s EMS and Trauma Advisory Council and the Medical Director Committee, roles which allowed him to serve his fellow Texans for which the Texas College of Emergency Medicine is deeply grateful; and
WHEREAS, His leadership acumen, selfless service, and commitment to improving the fields of military medicine and civilian prehospital medicine earned him recognition and awards across many organizations, such as, but not limited to, the Legion of Merit, Meritorious Service Medal, Joint Service Commendation, U.S. Army, and U.S. Air Force Commendation medals, Texas Superior Service Medal, MAJCOM Flight Surgeon of the Year Award, NAEMT Presidential Leadership Award, Michael Copass EMS Leadership Award, and multiple Command awards for exemplary service, including the Humanitarian Service Medal; and,

WHEREAS, Above all, Dr. Manifold was a devoted family man and champion for the fields of prehospital medicine, military medicine, and emergency medicine; and

WHEREAS, It was Dr. Manifold’s compassionate humanity and humble servant leadership that will be missed most of all by those who loved and admired him, and to quote his obituary, “Craig’s family was his first love. But his professional career – and its impact upon people and emergency medicine across the nation and world – is remarkable for its breadth and depth.”;” therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Craig Manifold, DO, FACEP, FAAEM, FAEMS, on the State of Texas, the Texas College of Emergency Physicians, and the Government Services Chapter of ACEP; and be it further

RESOLVED, That the aforementioned groups acknowledge the substantial loss to the medical community and bereavement of his many colleagues and friends, but above all extend condolences to his beloved wife of 31 years, Denise L. Moore, and their precious children Hanna Moore Manifold Cappadonna, her husband, Barrett; Della Caroline Manifold-Stolle, and her husband, Steven; and his son, Caleb Andrew Manifold.

RESOLUTION: 57(20)

SUBMITTED BY: Richelle J. Cooper, MD, MSHS, FACEP
David W. Wright MD, FACEP

SUBJECT: Douglas W. Lowery-North, MD, MSPH, FACEP

WHEREAS, The specialty of emergency medicine lost a compassionate physician, dedicated educator, mentor, air force reserve flight surgeon, and colleague in Douglas W. Lowery-North, MD, MSPH, FACEP, who passed away on August 4, 2020 at the age of 58; and

WHEREAS, Dr. Lowery-North graduated from Vanderbilt University (Phi Beta Kappa) and then attended Vanderbilt University School of Medicine (AOA), then completing his emergency medicine residency at the UCLA – UCLA/OV Emergency Medicine program and completed a Master's of Public Health in Biostatistics and Informatics at Emory’s Rollins School of Public Health; and

WHEREAS, Dr. Lowery-North served as chief resident, and then faculty and Associate Program Director at the UCLA Department of Emergency Medicine and as the Medical Student Course Director and Fourth Year Clerkship Director at the UCLA Department of Emergency Medicine; and

WHEREAS, Dr. Lowery-North served as faculty at Emory University School of Medicine and Emory University Department of Emergency Medicine, served as the first physician Director of the Emory University Hospital Emergency Department, Vice Chair of Clinical Operations, Chief Information Officer and Executive Vice Chair at Emory University Department of Emergency Medicine; and

WHEREAS, Dr. Lowery-North served as a Captain and Flight Surgeon in the California Air National Guard, and as a Flight Surgeon in the Air Force Reserve for 10 years; and

WHEREAS, Dr. Lowery-North provided service on numerous institutional and national committees for SAEM and ACEP including the ACEP Simulation Interest Group and ACEP Emergency Medical Informatics Interest Group; and

WHEREAS, Dr. Lowery-North was recognized for his excellence in teaching with numerous awards including Outstanding Medical Student Teacher of the Year – Emergency Medicine, Emory University School of Medicine, Teacher of the Year Award at Emory University Emergency Medicine Residency, Dean’s Teaching Award at Emory University School of Medicine, National Faculty Teaching Award from ACEP; and

WHEREAS, Dr. Lowery-North was known as an exemplary clinician, who was looked up to by fellow physicians, nurses, physician assistants, EMS personnel, and hospital staff; and

WHEREAS, Dr. Lowery-North mentored hundreds of undergraduate (pre-med) students, medical students, resident trainees, and faculty in emergency medicine with his warm and caring approach, always making time and insisting everyone call him by his first name, always interested in the person and proud of what they did, inspiring those who met him to strive to make themselves better because they knew he believed in them, as he made his life’s journey about supporting those around him; and

WHEREAS, Dr. Lowery-North touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, pioneer, friend, and devoted husband and father; and
WHEREAS, Dr. Lowery-North shaped the future of emergency medicine in Los Angeles and Atlanta and with his leadership, vision, enthusiasm, and dedication; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Douglas W. Lowery-North, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Douglas W. Lowery-North, MD FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of California, Georgia, Oregon, and the United States.
The 2019 Council adopted Amended Resolution 12 ACEP Composition Annual Report:

RESOLVED, That ACEP provide the Council with an annual report on the demographics of its councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP’s committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

The attached reports contain the demographic information that was requested in the resolution.

Although ACEP’s membership system has the ability to capture the information, the data is limited to the extent that members provide the information in their membership profile and how often the information is updated. It is apparent that many members have not updated their profile information recently. For example, in the Education category, the “Councillors and Alternate Councillors” report indicates there are 39 medical students. This data cannot be accurate because medical students are not eligible to serve as councillors or alternate councillors per the ACEP Bylaws. These 39 membership records were reviewed to ensure that the members were eligible to serve as a councillor or alternate councillor. The verification revealed that the majority of these 39 individuals were board certified in emergency medicine and, therefore, had not updated their membership profile data.

Many members choose not to answer the profile questions. The term “no value” in any of the reports indicates that the information was not provided by the member.

Currently, members are asked to provide the profile information when joining ACEP and there are periodic reminders to update or complete the profile information. Staff are exploring ways to encourage members to provide their demographic information. Changes to the profile questionnaire are also needed so that additional demographic information can be obtained, such as sexual orientation.
## ACEP Composition Age Demographics

### All Members

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## ACEP Composition Age Demographics

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# ACEP Composition Age Demographics

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| Research, Scholarly Activity, and Innovation Section|       | 2     |
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| Rural Emergency Medicine Section                    |       | 2     |
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| Society of Academic Emergency Medicine              | White | 1     |
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| Sports Medicine Section                              | Other | 2     |
| Tactical Emergency Medicine Section                 |       | 3     |
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# ACEP Composition Certification Demographics

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# ACEP Composition Employment Environment Demographics

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## ACEP Composition Employment Environment Demographics

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# ACEP Composition Employment Environment Demographics

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Memorandum

To: 2020 Council

From: William P. Jaquis, MD, MSHQS, FACEP
President

Date: October 2, 2020

Subj: Amended Resolution 58(19) Role of Private Equity in Emergency Medicine
Status Report

The 2019 Council adopted Amended Resolution 58(19) Role of Private Equity in Emergency Medicine:

RESOLVED, That ACEP study and report annually the market penetration of non-physician ownership, namely private equity, insurance company ownership, hospital ownership, and corporate non-physician ownership and management of emergency groups; and be it further

RESOLVED, That ACEP study and report the effects on individual physicians, ACEP advocacy efforts, of the actions of private equity groups, insurance company ownership, hospital ownership, corporate non-physician ownership and management of emergency physician groups; and be it further

RESOLVED, That ACEP advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcy, etc. or other adverse events of their employer/management company; and be it further

RESOLVED, That ACEP partner with the American Medical Association, other interested national medical specialty societies, and other appropriate bodies to determine the circumstances under which corporate or private equity investment could lead or has led to market efforts that increases the cost of health care to consumers without a commensurate increase in access or quality; and be it further

RESOLVED, That should there be circumstances under which corporate or private equity investment in health care could lead or has led to negative market effects that ACEP work with other interested parties to advocate for corrections to the market.

Because this was submitted as late resolution, no background or statement of fiscal impact was prepared before consideration and adoption.

ACEP leadership and staff developed a plan to address key components of the resolution and appointed a task force to lead the research aspects of the resolution. Former ACEP President Andrew Sama, MD, FACEP, was appointed to chair the task force and task force members were selected to reflect a variety of group ownership models. The task force roster and work histories are provided in Attachment A.

The task force began meeting in March and held nine meetings between March and August. The early work of the task force focused on the scope of the research project and the development of an RFP. The requested work would define the landscape and market
penetration of different EM group ownership models across the country and identify unique impacts that different models have on emergency physicians and their practices.

Additionally, the task force determined that pertinent research into possible market effects of different ownership models, particularly as they relate to cost of care and quality of care, should be sought to try to understand the impact, if any, that different models may have on the public. The RFP outlined the following goals and objectives:

- Describe various practice models of emergency physicians and their prevalence across the country.
- Describe the pros/cons of each practice model from the standpoint of the physician and the practice and/or hospital.
- Describe any economic impacts to patients or the health care system unique to any practice model.
- Describe the growth and market forces (such as coordination of care, improved profit, decreased cost) leading to changes in ownership of emergency medicine groups.
- Describe how these changes in ownership impact physicians and cost and quality of patient care.
- Discuss how the group management landscape has been impacted by initial ramifications of the COVID-19 pandemic.

The approved RFP (Attachment B) was sent to 12 research consulting firms that were identified as potentially interested and capable of managing the project, as well as to members of the ACEP Research Committee and Emergency Medicine Research Section. Seven proposals were submitted in response to the RFP. Proposals were submitted by RAND, Milliman, PriceWaterhouseCoopers, MedAxiom, ECG Management Consultants, FTI Consulting, and Brigham and Women’s Hospital with Comagine Health. The full proposals ranged in projected cost from $150,000 to $686,000.

After reviewing the proposals, the list of applicants was reduced to four, who were each asked to respond to a series of follow up questions. Based on those responses, three finalists were interviewed by the task force via a Zoom meeting.

The task force overwhelmingly believed that Milliman and RAND submitted the strongest proposals. Both proposed a variety of data collection techniques and utilization of multiple appropriate public and proprietary data sources that would have the best chance of yielding results that address the key issues raised in the RFP. All of the finalists acknowledge the particular challenges involved in linking ownership models to factors such as their impact on quality of care and cost of care. Milliman and RAND indicated the appropriate insights related to these challenges, and both described a comprehensive approach to try to obtain and analyze data from multiple channels that may provide meaningful results. The track record and organizational depth of both organizations is impressive, and the task force believed that either would be excellent partners for this project.

Deliberation of the task force noted RAND’s extensive resources and expertise, not only across the health care field, but also in emergency medicine. The primary researcher on RAND’s proposal for this project is an emergency physician who worked on the 2013 RAND report on the value of emergency medicine. It was also noted that RAND carries a very high degree of credibility within the field of medicine, and that the results of its findings in this report would carry significant weight within emergency medicine and the medical community.
However, the majority of the task force believed that Milliman’s experience, resources and the strength of its proposal were on par with RAND’s. Additionally, there was a significant difference in the costs of the two proposals. Milliman’s bid for the project was $300,000 to $350,000, with a potential for additional cost if it is determined jointly that additional data needs to be acquired by licensing data from a third-party. RAND’s bid for the project was $500,000.

The Board of Directors met by conference call on August 20, 2020 and discussed the finalist proposals, the key elements that should be included in the project, and the overall cost of the unbudgeted effort. They discussed the need for the researchers to gather information on a variety of impacts that ownership models might have on physicians, including such issues as physician autonomy and utilization of nurse practitioners and physician assistants. There was also discussion about the inherent difficulties in collecting payment data needed to get at the cost of care, as well as finding sufficient comparable and valid quality data that can be linked to different ownership models in a meaningful way. The Board voted to accept the task force’s recommendation and pursue a two-phased approach with Milliman.

Specifically, the first phase would involve Milliman identifying all relevant public and proprietary data sources, developing a matrix of data sources matched to each element of the project, and determining gaps where sufficient data may not exist to meaningfully link results and impacts to individual ownership models. Phase 1 would also include a high-level market scan of emergency medicine models, using proprietary metrics, e.g. location, size, specialties, primary health system, and primary facility of employment. The projected cost for the first phase is $75,000. At the end of the first phase (projected to take three to four months) ACEP will formally review Milliman’s findings and determine what additional research and analysis are possible and warranted. A report on Phase 1, including both the documentation of the emergency medicine market scan of ownership models and the recommendations for conducting the desired research, will be presented to the Council and Finance Committee at that time. If all elements of the project are approved for further study and analysis, the full version of Phase 2, including data acquisition, analysis and a final report would cost about $250,000. If meaningful data is not found for some or all of the desired project elements, Phase 2 could either not be initiated at all or scaled back at a lower price to focus only on those areas where meaningful data can be obtained. The preliminary timeline calls for a final report on Phase 2 at the 2021 Council meeting.

At its September 23, 2020 meeting, the Board of Directors approved a budget modification of $75,000, funded from operations, to proceed with Phase 1 of the project. As of the date of this memo, discussions are ongoing with Milliman to finalize the agreement.

The initial proposal from Milliman is provided as Attachment C and the responses to the follow-up questions that the task force posed to Milliman after receiving its initial proposal is Attachment D.
EM Group Ownership Task Force Members and Work Experience

Andrew Sama, MD, FACEP (Chair)

Current Position
- President of Progressive Emergency Physicians
- Executive Vice President of Emergency Care Partners
- 5% of ownership
- Advisor, Private equity Emergency Medicine Group
- Attending privileges:
  - Good Samaritan Hospital – West Islip, NY
  - Mercy Medical Center – Rockville Centre, NY
  - St. Francis Hospital – Roslyn, NY
  - Long Island Community Hospital – Patchogue, NY

Previous Employment
- Chairman, North Shore University Hospital (Northwell) Emergency Medicine
- Senior Vice President, Emergency Services – North Shore Long Island Jewish (Northwell)
- Executive Director of Innovation Strategies – Northwell
- Chairman, Department of Emergency Medicine – Long Island Jewish Medical Center
- Associate Director, Clinical Research Unit-In-Patient Section, Department of Research
- Chairman, Department of Emergency Medicine – Good Samaritan Hospital
- Chairman, Department of Emergency Medicine – St. John’s Episcopal Hospital

Previous Academic Appointments
- Professor of Emergency Medicine & Medicine, New York University School of Medicine
- Chair and Professor, Department of Emergency Medicine, North Shore-LIJ Hofstra School of Medicine

ACEP
- Board Member (2007-2013)
- Secretary-Treasurer (2009)
- Vice President (2010)
- President (2012)
- Chairman of the Board (2013)

Potential Conflicts – Not to my knowledge. Current position and ownership noted above

Angela Cai, MD, MBA

Current Position
- Resident Physician PGY3, SUNY Downstate/Kings County, Brooklyn, NY
- Kings County Hospital, a county safety net serving within the New York Health & Hospitals system (the nation’s largest public health system)
- University Hospital of Brooklyn, a public tertiary referral hospital in the State University of New York system and Brooklyn’s only academic medical center
- NYU Langone Brooklyn Hospital, an academic community site part of the private New York University Langone Health System

ACEP
- Federal Governmental Affairs Committee member (2018-present)
- Emergency Medicine Policy Institution (formerly EMAF), Board Member (2018-present)
- NEMPAC Board of Trustees (2018-2019)

Potential Conflicts
- None
Stephen Epstein MD MPP FACEP

Current Position
- Academic emergency physician in a multi-specialty group practice with an exclusive contract with our hospital system
- Employee model with salary determined by personal P&L, no financial stake in the practice

Previous Employment
- None

ACEP
- Massachusetts ACEP
  - Past President, Councillor
  - Co-chair, Crowding/Boarding Task Force
  - Chair, Massachusetts EM PAC
- National ACEP
  - Immediate Past Chair, CEDR
  - Vice-Chair, CEDR 2.0 Task Force
  - Chair, AMA Section Council on Emergency Medicine
  - HIT Task Force
  - FGA Committee

Potential Conflicts
- None

Christopher S. Goode, MD, FACEP

Current Positions
- Chairman, Department of Emergency Medicine, West Virginia University School of Medicine
- Assistant Vice President, Emergency Medicine, West Virginia University Health System
- Employed physician of a medical school and health system. The health system owns, operates, or is affiliated with 17 hospitals in WV, Ohio, Pennsylvania, and Maryland. We employ over 200 emergency medicine physicians, urgent care physicians, hospitalists, and intensivists through multiple employment arrangements including academic appointments, community employment contracts, and independent contractors
- Mentor resident physicians and fellows in job search, contract review, and other compensation related matters

National ACEP Positions
- Council Member (2013-present)
- Bylaws Committee Member (2014-2017)

Other National Positions
- Member, Professional Development Workgroup, Association of Academic Chairs in Emergency Medicine

Current Pertinent State Positions
- Treasurer, WV ACEP PAC
- Member, Board of Directors, West Virginia United Insurance Services Inc.

Conflicts of Interest
- None to Report
Keith Grams, MD FACEP
Current Position
  • Chair of emergency medicine, Rochester Regional Health
  • Hospital employee

Previous Employments
  • Hospital Employee at multi-hospital not for profit system
  • Member of a contracted group, owned by a university health system

ACEP
  • New York ACEP
    o Vice-president
    o Member of Board of Directors
    o Chair of Government Affairs Committee
    o Past Chair, Practice Management Committee

Potential Conflicts
  • None

Jay Mullen, MD, FACEP
Current Position
  • CEO of a democratic EM group in Maine, Vermont and Massachusetts.
  • No outside ownership.
  • <10% owner of group

Previous Employment
  • Hospital Employee at multi-hospital not for profit system
  • Previous hospital medical staff president
  • No paid management positions at hospital

ACEP
  • Maine ACEP
    o Immediate Past President, Legislative co-chair, alternate councilor
    o Chair of Regional EM Leadership
    o Member of Board of Directors
  • National ACEP
    o Chair elect of Democratic Group Practice Section
    o Reimbursement Committee
    o Steering Committee

Potential Conflicts
  • <10% owner of democratic group without PE
  • Member of EMBC (business coalition of independent democratic groups)

Michael Osmundson, MD MBA FACEP
Current Position
  • Regional President of multi-state, majority physician-owned and led EM group (USACS)
  • Physicians own 69%, minority private equity ownership (27%) and health system (4%) ownership
  • Every physician is an equity partner
  • I own <0.1%
  • Was at ground zero for Summa transition
  • Clinical faculty NEOCOM
Previous Employment

- Employee of single hospital group (4 physician owners, no ownership track)
- Partner/Founder of democratic, single hospital group
- Partner in regional democratic group
- No paid management positions at hospital
- Associate professor EM, Mercer Medical School

ACEP

- Washington ACEP
  - Member of Board of Directors
- California ACEP
  - Former President
  - Board Member

Potential Conflicts

- Leader in a national majority physician-owned EM practice with health system and PE ownership

Bing Pao, MD, FACEP

Current Position

- Director of Provider Relations, Vituity
- No outside ownership
- 100% General Partnership

ACEP

- California ACEP
  - Past Board Member
  - Past Chair, Reimbursement Committee
  - Councillor
- National ACEP
  - Reimbursement Committee
  - APM Task Force

EDPMA

- Chairman of the Board
- Past Chair State Regulatory and Insurance Committee

Physicians for Fair Coverage

- Alternate Board Member
- Past Treasurer

California Medical Association

- Past Chair, Hospital Based Practice Forum
- Organized Medical Staff Section
- Delegate

Conflict of Interest - None

Michael A. Ruzek DO FACEP

Current Position

- Medical Director of Emergency Department at Capital Health at Deborah Emergency Services
- Employed by Envision Physician Services
  - Attending Privileges
    - Capital Health Regional Medical Center- Trenton, NJ
    - Capital Health Hopewell Campus- Pennington NJ
o Capital Health at Deborah Emergency Services-Browns Mills, NJ
o Saint Barnabas Medical Center-Livingston, NJ

ACEP
- NJ ACEP
  o NJ-ACEP Executive Board Treasurer
  o Member of NJ-ACEP Board of Directors
- National ACEP
  o Chair of Young Physician Section
    - Representing 15,000 physicians who have been in practice 10 years or less
  o Education Steering Committee
  o Emergency Medicine Practice Committee
- Other Boards
  o Former Board Member of New Jersey Association of Osteopathic Physicians & Surgeons

Potential Conflicts
- None
Emergency Medicine Group Ownership Data Collection and Analysis

Request for Proposal

Summary
The American College of Emergency Physicians is soliciting proposals to collect and analyze data related to the market penetration and impacts of different emergency medicine group ownership models throughout the United States. The project will identify the ownership models of emergency physician practices across the country and investigate how differences in models impact physicians and patient care. We will also determine if and to what extent market distortions exist due to particular practice structures or consolidation of practices, investigate if market forces are driving consolidation of emergency medicine practices, and, to the extent possible, identify how COVID-19 has impacted the emergency medicine group management landscape.

Contact Information
Craig Price
Senior Director, Policy
American College of Emergency Physicians
4950 West Royal Lane
Irving, TX 75063
Phone: 972-550-0911 x3236
Email: cprice@acep.org

Key Dates
Proposal Submission Deadline June 30, 2020
Notification of Finalists July 15, 2020
Selection of Winning Submission July 30, 2020
Project Period August 2020 – September 2021

Submission Requirements
Font Size: 12-Point (Times New Roman or Arial)
Spacing: Double Spaced
Margins: One Inch
Email Proposal to: Craig Price at cprice@acep.org

ACEP Background

The American College of Emergency Physicians (ACEP) is the oldest and largest organization representing the interests of emergency physicians. ACEP represents the entire spectrum of emergency physicians with its 40,000 members working in small rural hospitals, large community hospitals, urban academic centers, government agencies, and every other type of emergency care setting. ACEP members conduct research, teach residents, and provide 24 hour/7 days a week of medical care to millions of patients every year. ACEP promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public.

ACEP has 53 chapters; one in every state, the District of Columbia, Puerto Rico, and a chapter representing those emergency physicians in uniformed and government services. ACEP’s chapters are active in education and advocacy. ACEP’s staff of 130 has its headquarters in Dallas, Texas, and a public affairs office in Washington, DC.

Project Background

Physicians practicing emergency medicine do so under a wide variety of employment models. From practicing in small, democratic groups to being employed by hospitals, academic institutions, contract management groups, or other entities, ACEP members work in very different environments that each pose their own unique set of pros and cons. ACEP does not promote any one practice model over the others and supports the right of individual physicians to practice in the model of their choosing. However, ACEP has adopted several policies related to employment models, physician employment contracting, physician group contracts, and physicians’ rights and responsibilities related to their employer:
A recent trend in emergency medicine has been the growth of private equity firms purchasing group practices. As a result, many ACEP members began raising concerns as to how private equity ownership might impact individual physicians and the quality and cost of patient care.

The influence of corporate investment in medicine is not unique to emergency medicine. In response to a resolution introduced by national specialty societies in dermatology, and joined by similar societies from anesthesia, cardiology, radiology, and ophthalmology, the AMA produced a report on corporate investors that was adopted in June 2019 (Council on Medical Service Report 11-A-19). The AMA also adopted a policy on corporate investors last year and has adopted several additional relevant policies over the years, including:

- Corporate Practice of Medicine H-215.981
- Corporate Ownership of Established Private Medical Practices H-160.960
- AMA Principles for Physician Employment H-225.950
- Physician Independence and Self-Governance D-225.977
- Financial Incentives Utilized in the Management of Medical Care H-285.951
- Physician Employment Trends and Principles H-225.947
- Physician-Hospital Relationships H-225.997
- Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
- Health Care Entity Consolidation D-383.980
- Restrictive Covenants of Large Health Care Systems D-383.978

Other national medical societies have also looked at corporate investment and private equity ownership of physician practices within their specialties. The American College of Radiology supported the study “Corporatization in Radiology”. Several reports have been developed about private equity in dermatology, including “Pulling Back the Curtain on Private Equity” and “Dermatology Practice Consolidation Fueled by Private Equity Investment”. Ophthalmology’s experience was explored in "Is a Private Equity Deal Right for You?” (Part 1 and Part 2). (See other reports and articles cited in the Additional Background Resources section below.)

Concerns about the potential impact of private equity ownership on emergency medicine led to the introduction of a resolution at the 2019 ACEP Council meeting. The ACEP Council is a deliberative governing body of the College that meets annually to elect ACEP’s president and members of the Board of Directors, as well as to provide direction to the Board on issues of concern to emergency medicine through the passage of resolutions. At its October 2019 meeting, the Council adopted Resolution 58 “Role of Private Equity in Emergency Medicine.” The resolution (attached) directed the College to take a number of actions related to studying non-physician ownership and management of emergency physician group practices.

In response to the adoption of the resolution, ACEP’s president appointed the Emergency Medicine Group Ownership Task Force to develop a plan to address some of the provisions of the resolution. The task force met several times via conference call from March to May 2020 to develop the parameters of a research project that will utilize primary and secondary research to identify and detail the universe of emergency medicine ownership models, their market penetration, and their impact on physicians and patient care.

**Additional Background Resources**

o “Physician Employment Trends” from the Physician Advocacy Institute.  
   http://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment
o “Physician practice consolidation: It’s only just begun.” February 2020 article in STAT.  

o “Health-Care Consolidation Strong in 2019—Expect Even Stronger 2020”. January 2020 article in  
   Bloomberg Law.  
   expect-even-stronger-2020
o “Corporate and Hospital Profiteering in Emergency Medicine” (JEM 2016). https://www.jem- 
   journal.com/article/S0736-4679%2816%2900007-X/fulltext
o “EPs’ Employee Status Signals Increasing Corporate Dominance in EM” (Emergency Medicine News  
   April 2020).  

o “The Impact of Hospital Consolidation on Medical Costs” (NCCI Insights July 11, 2018).  
   https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical- 
   Costs.aspx
o “Surprise! Out-of-Network Billing for Emergency Care in the United States”  
   https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_onn_paper2_tables_appendices.pdf
o “Private equity's thirst for health care providers” https://www axios.com/private-equity-thirst-for-health-care- 
   providers-1528737485-195192d5-db93-4c57-9a28-4b7af191d42e.html

o “Air Ambulances Are Flying More Patients Than Ever, and Leaving Massive Bills Behind”  
   massive-bills
o “Why private-equity firms are buying up primary-care practices”  
   https://www.modernhealthcare.com/article/20150418/MAGAZINE/304189980/why-private-equity-firms-are- 
   buying-up-primary-care-practices
o “Why PE Firms are Buying Orthopedic and Ophthalmology Practices” https://www.pehub.com/why-pe- 
   firms-are-buying-orthopedic-and-ophthalmology-practices/

o “The Company Behind Many Surprise Emergency Room Bills”  
o “Two Physician Groups Pay Over $33 Million to Resolve Claims Involving HMA Hospitals”  
   https://www.justice.gov/opa/pr/two-physician-groups-pay-over-33-million-resolve-claims-involving-hma- 
   hospitals
o “DOJ settles with EmCare, accused of improperly steering patients”  

o “Former HMA CEO To Pay $3.46M To Resolve False Billing, Kickback Allegations”  
   https://www.healthleadersmedia.com/former-hma-ceo-pay-346m-resolve-false-billing-kickback-allegations

   health-care-consolidation-is-changing-emergency-medicine/

o “Provider Consolidation Drives Up Health Care Costs”  
   https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation- 
   drives-health-care-costs/
o “Healthcare consolidation goes beyond usual players” https://www.modernhealthcare.com/mergers- 
   acquisitions/healthcare-consolidation-goes-beyond-usual-players
o “Finding value in healthcare through mergers and alliances” https://www.bakertilly.com/insights/finding- 
   value-in-healthcare-through-mergers-and-alliances
o “Healthcare market consolidations: Impacts on costs, quality and access”  
   https://www.brookings.edu/testimonies/health-care-market-consolidations-impacts-on-costs-quality-and- 
   access/

o “HFMA Report, Health Care 2020, Consolidation”  
   https://www.hfma.org/content/dam/hfma/document/research_reports/PDF/51087.pdf
“Pace of physician practice acquisition by health plans may accelerate post-pandemic”

“Analysis: What are the implications for the healthcare industry with more private equity groups buying up various specialty physician practices?”
https://www.hfma.org/topics/finance-and-business-strategy/article/analysis--what-are-the-implications-for-the-healthcare-industry-.html

“How Do Healthcare Mergers and Acquisitions Impact Patients?”

“Howcare Mergers, Consolidation Increase Patient Safety Risks”

“Why Health Care Mergers Can Be Good for Patients”


**Project Goals and Objectives**

- Describe various practice models of emergency physicians and their prevalence across the country.
- Describe the pros/cons of each practice model from the standpoint of the physician and the practice and/or hospital.
- Describe any economic impacts to patients or the health care system unique to any practice model.
- Describe the growth and market forces (such as coordination of care, improved profit, decreased cost) leading to changes in ownership of emergency medicine groups.
- Describe how these changes in ownership impact physicians and cost and quality of patient care.
- Discuss how the group management landscape has been impacted by initial ramifications of the COVID-19 pandemic.

**Data Identification, Collection, and Analysis**

The research effort will include market research, research of health care data, exploration of existing relevant research developed by other entities, and a survey of ACEP members. The research firm will regularly confer with the ACEP task force throughout the process to ensure appropriate and effective data source identification, data selection and collection, data analysis, and report development. The firm will be tasked with collecting and analyzing data on all emergency medicine group ownership models including:

- Private Equity (majority and minority ownership)
- Hospital
- Academic Group
- Foundation (with/without affiliation)
- Health Plan-Owned
- Municipality
- University
- Health System
- Multispecialty Medical Group
- Government Entity
- Military
- Emergency Physician-Owned (concentration of ownership among physicians)
- Other Physician-Owned (Non-emergency physicians)

Information sought regarding the entities identified in these or other categories include the percent of ownership, length of each organization’s existence, size of entity (number of emergency department visits, number of physicians), geographic locations, and for multispecialty group owners, the other specialties within the group. The research will seek to identify how each practice model operates and the positive or negative impacts each may have on physicians and patient care, covering topics such as:

- Organization (Sole specialty, multispecialty, etc.)
- Control
- Governance (Board elected or appointed, Board structure, physician vs nonphysician)
- Clinical decision-making (e.g. physicians feeling pressure to admit more patients based upon the structure in which they practice). Specified division of governance between the practice of medicine and business decisions.
- Minority and majority private equity ownership.
  - Financial transparency/profits (Open book policy, percentage of revenue that goes to overhead, percentage of revenue that goes to providers vs. administrators, etc.)
  - Responsibility
    - Administrative: Are administrative duties shared?
  - Liability (Group liability coverage? Tax, Compliance, Auditing, Accounting)
  - Investment (What is the ownership structure? Majority or minority ownership? Are physicians required to buy into a group and if so, how much? Opportunity for equity?)
  - Staffing and Scheduling (Staffing ratios, advanced practice providers, scribes, trainees (residents, students). Physicians’ control over their schedule and input into how the department is staffed? Percentage of board-certified emergency physicians vs. non-board certified emergency physicians?)
  - Compensation/benefits (Average salary, average benefits, bonus structure, profit sharing, and dividends).
  - Job satisfaction
  - Impact on emergency physician job opportunities/availability
  - Physician equity
  - Due process, job security, and restrictive covenants
  - Potential impact to the patient, as applicable
  - Ownership model trends

To help determine any potential market distortions, research would seek to identify market consolidation through merger and acquisition activity, hospital sales, group sales, and hospital closures, and note any impacts these actions may have had related to physician compensation, cost of care, and access to care. The firm will analyze existing quality and cost data delineated geographically, as well as population data from disparity databases to determine if results are distinguished by ownership models. The selected firm will also investigate if and how evolving payment practices or other market forces (consolidation in other areas of the health care system, valuations of emergency medicine groups, quality reporting requirements under MACRA/MIPS, acquisition-friendly tax policy, etc.) may be driving emergency physician practice consolidation. Findings in this area may help inform future ACEP educational and advocacy efforts to ensure protection and promotion of market conditions and ownership practices that best serve the interests of emergency physicians and their patients. In addition, the data collected will be used to provide a snapshot of how the group management landscape has been impacted by the initial ramifications of the COVID-19 pandemic.

**Report Development**

Under the direction of the task force, the firm will develop a comprehensive report providing results of data analysis in an easily digestible format, which meets the goals and objectives of the project. The report is to be completed by September 2021 and will be made available to the ACEP Council at its October 2021 meeting.

**Proposal Components**

**Qualifications**
Describe how you will complete each of these tasks. (For example, what resources do you have to identify, collect, analyze and report data.)
Describe your organization’s ability to perform the required work. Provide specific examples of your past experience with similar projects.
Provide hard copies or links to previous similar projects performed by your organization.
Provide at least three references from past professional relationships or similar projects.
Provide bios of key personnel who will be assigned to the project.
Limitations
Provide an explanation of any elements of the project that you do not believe can be achieved by your organization in the manner described in this RFP such as any limitations on your ability to obtain sufficient data to meet the deliverables requested in the RFP.

Budget
Please provide a detailed budget for the project, with charges based on actual expenses and deliverables, including such line items as:
- Personnel
- Supplies/Fees
- Travel
- Administrative Costs
- Other Costs
- Milestones, deliverables, and payment structure

ACEP has not determined the maximum amount it will spend on the project. In addition to providing a bid for the entire project, to the extent possible, please provide menu pricing showing fees you would charge for completing different components or modules of the project.

It would also be helpful if you could identify aspects of the project that you could complete at approximately 50% and 75% of your total bid for completing the full project.

You may submit a partial budget that does not cover all elements if you believe there are limitations that may preclude you from fulfilling the full scope of the RFP.

Conflict of Interest
Please disclose any and all actual, potential, or perceived conflicts of interest that your organization and assigned personnel may have in relation to any aspect of the project.
June 30, 2020

Mr. Craig Price  
Senior Director, Policy  
American College of Emergency Physicians  
4950 West Royal Lane  
Irving, TX 75063

Re: Proposal for Research and Analysis of Ownership Models

Dear Mr. Price,

On behalf of Milliman, Inc. (Milliman), thank you for the opportunity to respond to the American College of Emergency Physicians (ACEP) Request for Proposal (RFP) to provide research and analysis on the range of ownership models for emergency medicine groups.

As one of the world’s largest independent professional services firms specializing in healthcare, Milliman is well-qualified to support this research project. We have proposed a team of senior consultants with relevant expertise and experience in the technical requirements of data collection, analysis, and interpretation, as well as the contextual elements of physician practice ownership and management, market dynamics, and healthcare delivery and financing. The combination of our specialized expertise, proprietary data, and ability to collaboratively manage complex research and data projects uniquely positions Milliman to help ACEP achieve its research objectives.

We appreciate the opportunity to be considered for this important work. Should you have any questions, please don’t hesitate to contact me at barbara.culley@milliman.com or 206.504.5813.

Sincerely,

Barbara Culley  
Healthcare Management Consultant
Proposal

Background

For over fifty years, the American College for Emergency Physicians (ACEP) has provided support to 40,000 emergency medicine physicians, residents, and medical students. In support of the organization’s focus on promoting the quality of emergency care and advocating for members, the ACEP Council determined a need to study the impact of private equity ownership in emergency medicine. The project goals are to research and analyze the various ownership models for emergency medicine, understand the positive and negative aspects of each model, research the impact to physicians and their patients, and analyze market penetration.

This proposal details Milliman’s qualifications to support the research project, our approach to the work, and our estimate of the budget/cost to perform the work.

1. Qualifications

Project Approach and Deliverable Development

The objective for this engagement is to provide ACEP with an analysis of current emergency medicine models using primary and secondary research methods resulting in a comprehensive report of the data and information regarding emergency physician ownership models. We structure the project in key tasks described below.

Task 1. Project Initiation, Collaboration, and Management

We will begin the project by conducting a kick-off meeting with ACEP leadership to confirm project goals and approach, establish the communications approach for the project, and discuss project logistics. We will also settle on the coordination meeting cadence and project schedule/milestones.

Throughout the project timeline, we will conduct regularly scheduled project update/coordination meetings with ACEP staff and the task force as appropriate. For budget planning purposes, we have assumed these coordination meetings will occur twice per month for the duration of the project, but this schedule can be adjusted to accommodate the cadence of the work.

Task 2. Identify Universe of Data Sources

Next, we will identify the universe of data sources that can be drawn upon to respond to the areas of inquiry and specific questions posed in the RFP. Based on the information provided in the RFP, we expect to draw upon three primary sources of data: (1) Milliman proprietary sources; (2) third-party sources; and (3) primary research sources. Each of these sources is described below. It should be noted that we will conduct the literature review as part of this task to ensure that data sources identified in other research can be considered.
- **Milliman Proprietary Sources.** Access to proprietary data sources is one of the key characteristics that differentiates Milliman from other research organizations. For this project, we expect to use two core proprietary data sources:

  - **Milliman Consolidated Health Sources Database (CHSD).** The Milliman CHSD contains historical healthcare claim data for 90 million lives. It includes claims from multiple types of insurance coverage including commercial, Medicare, and Medicaid. The Milliman CHSD can be used to answer detailed questions about the cost and utilization of healthcare services throughout the United States, including emergency medicine, at a state or MSA specific level.

  - **Torch Insight.** Torch Insight, licensed from Leavitt Partners Insight, is a platform that provides comprehensive market data about local market physicians, physician practices, hospitals, and accountable care organizations. In particular, Torch Insight provides information about hospitals, physician/hospital affiliations, physician practices, and service volumes. The platform includes information on 290,000 physician practices including 2,000+ practices with emergency medicine as the primary specialty. Torch Insight can be used to answer questions about physician/hospital affiliations, reimbursement arrangements, physician service volumes, market share, and ownership models.

- **Third Party Sources.** In addition to the Milliman proprietary data sources, there are additional third party information sources that may support answering some of the questions posed in the RFP. State medical societies, government agencies, non-profits, and industry associations often collect and report market data that can be used to answer the types of questions posed by ACEP. For example, the Medical Group Management Association (MGMA) DataDive has an extensive array of data on physician practices by specialty including compensation/income and benefits, staffing ratios, and other overhead/administrative costs.

- **Primary Research Sources.** In addition to existing data sources, we will conduct primary research including a literature review and a survey of ACEP members (see Task 3).

Some third party sources charge fees to license the data while others are available in the public domain. Our budget proposal does not include these third party license fees, which will depend on which sources are licensed for this project. Access to the Milliman CHSD and Torch Insight is included in this proposal and will not incur additional fees.

We will present the universe of data sources to the task force for consideration.
**Task 3. Data Selection and Collection**

Once we have identified the universe of data sources, we will work with the task force to define the optimal research approach that balances investment and timeline against scope of information developed. Based on our experience with similar research projects, we know that the level of effort/amount of resources required to answer different questions is highly variable. Some of the questions posed by ACEP can be easily answered with data already available to Milliman. Other questions will require licensing of third party sources or development of primary research. We will advise the task force of these considerations as part of this task.

Once the task force has selected the data sources, Milliman will undertake the data collection. For the third party proprietary sources, if requested by the task force, we will initiate licensing and data acquisition. If necessary, we will provide the data management infrastructure (e.g., servers) necessary to store the data and enable analysis in Task 4.

**Survey of ACEP Members**

As indicated in the RFP, a survey of ACEP members will be a key component of the research effort in particular the list of questions detailed on pages 6 and 7 of the RFP specific to the various ownership models. We will work with the task force to determine the number of participants needed to generate reliable results for each ownership model. A simplified description of our approach to the survey is:

1. Identify data elements to be collected by survey.
2. Determine appropriate data collection method (e.g., online survey, interviews, and focus groups).
3. Develop the data collection instrument(s).
4. Identify participants.
5. Conduct survey(s).

In developing the data collection instrument, we will work collaboratively with the task force. In addition, we will rely on ACEP to identify the survey participants and, if appropriate, provide access to contact information and promotion. It should be noted that this is key support essential to completing the project.

**Task 4. Analyze the Data**

Our data science team will analyze the various data elements collected in Task 3 toward the goal of developing results/responses for the report as follows:

1. Organize the various questions among different areas of inquiry.
2. Confirm the data sources and data elements relevant to each question/area of inquiry.
3. Identify appropriate analytic methods and design analyses.
4. Conduct analyses and generate results.

**Task 5. Prepare the Report**

In our experience, research reports such as this study are best developed using a collaborative approach of drafts, reviews, and feedback.

We will begin by developing an outline for review, feedback, and approval by the task force. Given the duration of the project, we will prepare the report of findings concurrent with the work described in Tasks 2, 3, and 4. As report content is developed, we will add it to the report draft. We will present sections of the report to the task force at the regular status meetings and full draft versions at agreed to checkpoints.

Milliman employs a strong ethic of peer review in all projects. This process requires a secondary review of the work performed, reports prepared, and overall project management. The reviewer is selected as someone familiar with the project, but who has not performed significant work on the specific project. This allows for impartial review and the opportunity for additional insights. The review is structured to identify any outstanding issues that were not addressed, to ensure that the information is presented in a logical and complete manner, and to ensure that the overall quality of the work meets Milliman’s high standards. This process will help ensure the report is in an easily digestible format and meets the goals and objectives of the project.

**Ability to Complete the Work**

We have selected a highly qualified team with the experience and expertise needed to effectively support the project. The team proposed for this engagement is comprised of individuals with previous relevant experience, e.g. research and analysis, provider surveys, interviews, and focus groups, data compilation and evaluation, and translating data into understandable information. Brief profiles of key team members are included below.

**Barbara Culley, MPA, NHA.**
Barbara will serve as the Research Lead for this project. She has over 20 years of experience in operational leadership roles in multiple care delivery settings including hospital, ambulatory services, emergency department, and long-term care.

**Andrew Naugle, MBA.**
Andrew will provide oversight of the project and conduct the quality review of deliverables. He has over 20 years of experience in healthcare management consulting on complex projects including research, analysis and strategy work, healthcare system improvements, surveys, focus groups, and interviews, and healthcare data analysis.
David Mirkin, MD.
Dr. Mirkin currently serves as the Chief Medical Officer for Milliman MedInsight. In that role, he interfaces with physicians and physician practices on a wide range of projects. He has more than 30 years of experience with payer and delivery system operations, analytic methods, and interpreting healthcare data.

Court Bowers, MSHLM
Court will serve as a Research Analyst for this project. His primary area of experience is in quantitative analysis and modeling in the healthcare sector.

We may assign additional resources to this research project as necessary to complete the work in the most efficient and professional way. Professional biographies for the key team members are provided in Attachment B.

Prior work examples
Research (both Milliman’s own and research on behalf of clients) is a key Milliman service offering. Most of Milliman’s client research is confidential and cannot be republished here. However, one research project that we can reference is the CAQH Index. Andrew Naugle, who will provide oversight for this project, served for several years as a member of the CAQH Index Advisory Council, which produced this annual research report. The CAQH Index estimates the penetration of electronic transactions among healthcare providers and payers and quantifies the potential savings associated with increased adoption. The CAQH Index is prepared using data collected from payer and provider organizations.

Milliman’s own research is more widely distributed. Each year, we self-publish dozens of research reports, briefs, whitepapers, and information sheets on a wide range of topics. Here are links to a few research projects from across Milliman’s health practice, which illustrate the scope and breadth of our research.

Milliman Medical Index. This annual study quantifies the annual cost of employer sponsored health insurance for a family of four in the U.S.

Potential Out of Pocket Costs for Patients Requiring Hospitalization for COVID-19. This report examines the out-of-pocket cost exposure for patients requiring hospitalization for COVID-19 by type of insurance coverage, state, severity, and age band.


Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act. This study, prepared for the Society of Actuaries, looks at how the affordable care
act was implemented in each of the 50 U.S. states and how those implementation differences impacted the insurance markets.

**U.S. Organ and Tissue Transplants: Cost Estimates, Discussion, and Emerging Issues.**
This triennial study estimates the cost of organ and tissue transplants in the U.S.

**References**

**American Dental Association**
Rita Tiernan
Senior Manager, Council on Members Insurance and Retirement Programs
tiernanr@ada.org

**American Medical Association**
Dave Sosnow
Vice President, Marketing and Product Management
dave.sosnow@ama-assn.org

**State of Washington, Health Care Authority**
Cathie Ott
Assistant Director
Division of ProviderOne Operations and Services
cathie.ott@hca.wa.gov

2. **Limitations**
The RFP identifies several important research questions and an extensive array of data and information related to physician practices (e.g., ownership, management, and performance) as well as market dynamics. We believe all of ACEP’s research questions can be informed by this research: some of the information sought by ACEP is directly available from existing data sources, some can be derived from data sources, and some can be collected through interviews/surveys. There will, however, be some data and information that is not available at scale, that is anecdotal, or that is insufficient to draw conclusions without caveats. The research team will help inform the task force about these limitations as the research progresses.

3. **Project Timeline and Budget**

**Timeline**
We understand that the ACEP intends for the report to be complete by September 2021 with presentation to the ACEP Council in October. We are confident the work can be completed on this schedule as illustrated in the following table.
We anticipate each of the major tasks will take approximately 4-5 months. We will produce a formal timeline and activities and milestones following the kick-off meeting to take into consideration the task force’s meeting cadence.

**Budget**

Based on our experience with similar projects on the scope of services described above, fees for this engagement are expected to be $300,000 to $350,000 plus expenses if any.

Milliman bills for consulting services on a time and expense basis. Each consultant has an hourly billing rate based on his/her skills, expertise, and experience. Staff record time spent on a project and we calculate professional fee amounts based on the sum of each consultant’s billable hours plus direct expenses.

Our consultant rates are inclusive of supplies, fees, and administrative costs. We do not anticipate onsite visits for the RFP scope of work. Should ACEP request participation at any forum, we bill travel expenses at cost.

If the scope of the project changes, we will keep you informed of the impact on the estimated budget and timing. If, at any point, it appears that costs may exceed the high end of the range shown, we will discuss the situation with you before proceeding.
We will bill you monthly for the work completed in the preceding month. Charges are due upon receipt.

We understand that ACEP would like an estimate of project components that could be complete at 50% and 75% of the total budget. The table below shows the budget estimates for the various project tasks and key activities/ milestones.

<table>
<thead>
<tr>
<th>Task</th>
<th>Estimated Budget</th>
<th>Key Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Project Initiation, Collaboration, and Management</td>
<td>$20,000</td>
<td>Kick-off meeting, for twice monthly coordination/status meetings, project management the duration.</td>
</tr>
<tr>
<td>2. Identify Universe of Data Sources</td>
<td>$30,000</td>
<td>Literature review, identification of data sources/ limitations</td>
</tr>
<tr>
<td>3. Data Selection and Collection</td>
<td>$130,000 to $150,000</td>
<td>Data sources identified, data acquisition, primary research, physician survey</td>
</tr>
<tr>
<td>4. Analyze the Data</td>
<td>$80,000 to $100,000</td>
<td>Synthesis of findings, development of observations and conclusions</td>
</tr>
<tr>
<td>5. Prepare the Report</td>
<td>$40,000 to $50,000</td>
<td>Collaborative report development with multiple draft reviews by the task force. Final report and presentation of findings.</td>
</tr>
<tr>
<td><strong>Total All Tasks</strong></td>
<td><strong>$300,000 to $350,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

The scope of the project could be reduced by approximately 50% (reduction of $150,000-$175,000) by reducing the number of status meetings to one per month, limiting the data collection to an online survey of physician practices only, limiting the analysis to conclusions that can be drawn using simplified analytic techniques, and providing one draft of the report for the task force’s review.

The scope of the project could be reduced by 25% (reduction of $225,000-$262,500) by limiting the data collection to existing sources, publicly available third party sources, plus a limited sample survey of physician practices, and limiting the analysis to conclusions that can be drawn using simplified analytic techniques.

Our budget is presented in ranges to reflect unknowns regarding the scope of work. We are willing to accept a fixed price agreement based on agreed-to resource requirements (e.g., number of coordination meetings, number of report drafts, number of survey participants, etc.).
4. **Conflict of Interest**

Milliman is an independent professional services firm. We are owned and managed by our 350+ principals, senior consultants elected by their professional peers in recognition of their superior technical abilities, focus on client service, and business acumen. This ownership structure helps to ensure our organization is free from conflicts of interest that might impact the independence of our work and the advice we provide to clients. We have no known actual, potential, or perceived conflicts of interest that could impact our work on this project.

5. **Terms and Conditions**

This proposal is subject to the terms and conditions of Milliman’s standard Consulting Services Agreement (CSA). A copy of this agreement is provided in Attachment A.
Attachment A – Consulting Services Agreement

This Consulting Services Agreement ("Agreement") is entered into between Milliman, Inc. ("Milliman") and American College of Emergency Physicians ("Client") as of August 1, 2020. Client has engaged Milliman to perform consulting services as described in a statement of work or engagement letter which references this Agreement. Such services may be modified from time to time and may also include general actuarial consulting services. The terms and conditions of this Agreement will apply to all subsequent engagements of Milliman by Client unless specifically disclaimed in writing by both parties prior to the beginning of such engagement. In consideration for Milliman agreeing to perform these services, Client agrees as follows:

1. **BILLING TERMS.** Client acknowledges the obligation to pay Milliman for services rendered, whether arising from Client’s request or otherwise necessary as a result of this engagement, at Milliman’s hourly billing rates for the personnel utilized plus all out-of-pocket expenses incurred. Milliman will bill Client periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to terminate this Agreement if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

2. **TOOL DEVELOPMENT.** Milliman shall retain all rights, title, and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret, and other intellectual property rights) in and to all technical or internal designs, data, databases, methods, ideas, concepts, know-how, techniques, generic documents, and templates that have been previously developed by Milliman or developed during the course of the provision of the services (the "Milliman Tools") provided such generic documents or templates do not contain any Client Confidential Information, as defined in the Section below entitled "Confidential Information". Rights and ownership by Milliman of the Milliman Tools shall not extend to or include all or any part of Client’s Confidential Information. To the extent that Milliman may include in Milliman’s work any Milliman Tools, Milliman agrees that Client shall be deemed to have a fully paid up license to make copies of the Milliman Tools as part of this engagement for its internal business purposes and provided that such Milliman Tools cannot be modified or distributed outside the Client without the written permission of Milliman or except as otherwise permitted herein under the Section below entitled "No Third Party Distribution".

3. **LIMITATION OF LIABILITY.** Milliman will perform all services in accordance with applicable professional standards. In the event of any claim(s) arising from services provided by Milliman at any time, the total liability of Milliman, its officers, directors, agents, and employees to Client shall not exceed, in the aggregate, three million dollars ($3,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract, or otherwise. In no event shall Milliman be liable for lost profits of Client or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.
4. **DISPUTES.** In the event of any dispute arising out of or relating to the engagement of Milliman by Client, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in insurance, actuarial science, or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorneys’ fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential and, except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other party, except that disclosure is permitted to a party’s auditors and legal advisors.

5. **CHOICE OF LAW.** The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this Agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

6. **NO THIRD PARTY DISTRIBUTION.** Milliman’s work is prepared solely for the internal business use of Client. Milliman’s work may not be provided to third parties without Milliman’s prior written consent. Milliman does not intend to benefit any third party recipient of its work, even if Milliman consents to the release of its work to such third party.

7. **USE OF NAME.** Client agrees that it shall not use Milliman’s name, trademarks, or service marks, or refer to Milliman directly or indirectly in any media release, public announcement, or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites, or business presentations, without Milliman’s prior written consent for each such use or release, which consent shall be given in Milliman’s sole discretion.

8. **CONFIDENTIALITY.** In connection with this Agreement, each party hereto (a “disclosing party”) may disclose its confidential and proprietary information to the other party (a “receiving party”). Subject to the exceptions listed below, a disclosing party’s “Confidential Information” means as information disclosed by the disclosing party to the receiving party under this Agreement that is either: (i) clearly marked or otherwise clearly designated as confidential or proprietary; or (ii) should be reasonably understood by the receiving party to be the confidential or proprietary information of the disclosing party. Confidential Information shall include, without limitation, the terms of this Agreement. During the term of this Agreement and after its expiration or termination, a receiving party shall not disclose to any third party a disclosing party’s Confidential Information without the prior written consent of the disclosing party. In addition, each party agrees to take reasonable measures to protect the other party’s
Confidential Information and to ensure that such Confidential Information is not disclosed, distributed, or used in violation of this Agreement (which measures shall be no less than that which a reasonable person would take with respect to like confidential, proprietary, or trade secret information). Notwithstanding anything to the contrary, the obligations of the receiving party set forth in this paragraph shall not apply to any information of the disclosing party which: (i) is or becomes a part of the public domain through no wrongful act of the receiving party; (ii) was in the receiving party’s possession free of any obligation of confidentiality at the time of the disclosing party’s communication thereof to the receiving party; (iii) is developed by the receiving party completely independent from the Confidential Information of the disclosing party; or (iv) is required by law or regulation to be disclosed, but only to the extent and for the purpose of such required disclosure after providing the disclosing party with advance written notice, if reasonably possible, such that the disclosing party is afforded an opportunity to contest the disclosure or seek an appropriate protective order.

9. **DATA RELIANCE.** In performing the services hereunder, Milliman will rely on data and other information provided to it by Client. Milliman will not audit, verify, or review the data and other information for reasonableness or consistency. Such a review is beyond the scope of Milliman’s assignment. If the underlying data or information is inaccurate or incomplete, the results of Milliman’s analysis may likewise be inaccurate or incomplete.

10. **GENERAL.** This Agreement and any amendment hereto may be executed in two or more counterparts (including by facsimile or email attachment), each of which will be considered an original and all of which together will constitute one agreement. This Agreement shall not be deemed or construed to be modified, amended, or waived, in whole or in part, except by a separate written agreement duly executed by the parties to this Agreement. No document, purchase order, or any handwritten or typewritten text which purports to alter or amend the printed text of this Agreement shall alter or amend any provision of this Agreement or otherwise control, unless Milliman and Client both specify in writing that such terms or conditions shall control. Neither party shall be liable for any delay or failure to perform due to causes beyond its reasonable control. Milliman and Client are independent contractors and this Agreement will not establish any relationship of partnership, joint venture, employment, franchise, or agency between Milliman and Client. Neither Milliman nor Client will have the power to bind the other or incur obligations on the other party’s behalf without the other party’s prior written consent. Failure to enforce any term or condition of this Agreement shall not be deemed a waiver of the right to later enforce such term or condition or any other term or condition of this Agreement.

[Signature Page Follows]
This Consulting Service Agreement between Milliman, Inc. and American College of Emergency Physicians is executed as of August 1, 2020 as set forth above.

Milliman, Inc.  

By ____________________________  
Print Name: ________________________  
Title: ____________________________  
Date: ____________________________

American College of Emergency Physicians  

By ____________________________  
Print Name: ________________________  
Title: ____________________________  
Date: ____________________________
Attachment B – Key Personnel Professional Bios

Barbara Culley
MPA, NHA

CURRENT RESPONSIBILITY
Barbara is a senior healthcare management consultant with the Seattle office of Milliman.

EXPERIENCE
Barbara has significant experience across the continuum of healthcare spanning from inpatient to outpatient organizations, insurance plans, managed care and fee-for-service providers, and the delivery of long-term care services in the public and private sectors. This movement across healthcare services and settings provides a broad understanding of the industry.

Barbara specializes in market research, operations assessment and improvement, strategy development, and regulatory compliance. She has over 20 years of experience in healthcare operations and quality improvement programs, including NCQA and WSQA. Barbara has worked extensively to manage complex operational and implementation projects resulting in targeted outcomes with innovative approaches to the challenges. She has led initiatives to identify and implement opportunities for new revenue streams and systems in care delivery settings.

Barbara has specific expertise in analyzing operational efficiency and financial performance, and then development of comprehensive solutions to identified drivers of performance issues.

Most recently Barbara has focused on the holistic assessment of client operations including market and competitor scans to create options to address financial and compliance challenges, with actionable plans and tools for issue resolution. She has assisted clients in planning for future positioning, and assisting clients with RFP responses. Client work includes assessment of health plan operations, from provider network, quality assurance, medical management programs, customer service, behavioral health integration, and Medicaid program transition readiness evaluation and assistance.

PRESENTATIONS AND PUBLICATIONS
• “Implications of the COVID-19 pandemic on health payer operations,” Milliman, March 2020
Proposal for Research and Analysis of Emergency Medicine Practice Ownership Models

- “Strategies Employers can Consider to Understand and Combat Opioid Abuse,” Benefits Perspectives, Milliman, January 2019
- “Communicating with Patients with Hearing Loss,” Milliman Healthcare Analytics Blog, 2018
- “Using MedInsight to Identify Opportunities to Impact the Opioid Crisis,” Milliman webinar, 2017
- “Implications of direct-to-consumer genetic testing,” Milliman white paper, 2017

AFFILIATIONS
Nursing Home Administrator, Washington State

EDUCATION
BA, Western Washington University
MPA, University of Washington
Andrew L. Naugle  
MBA  
Principal & Healthcare Management Consultant  

**CURRENT RESPONSIBILITY**  
Andrew is a principal in the Seattle office of Milliman. He joined the firm in 2000.  

**EXPERIENCE**  
Andrew specializes in helping provider organizations, insurers, exchanges, and other risk bearing entities with strategic planning and execution. He specializes in administrative operations, use of technology, and healthcare analytics.  

During his 20-year career in the insurance industry, Andrew has consulted with clients on a broad range of topics including:  

- Leading strategic and enterprise transformation initiatives  
- Conducting market research, surveys, interviews, and focus groups  
- Designing, evaluating, and improving administrative operations  
- Assessment of transactional, medical management, and analytics capabilities  
- Administrative expense allocation, benchmarking, and optimization projects  
- Coordinating application processes and writing applications for certificates of need, insurance licenses, product applications, and government proposals  
- Managing vendor selection processes  
- Designing and implementing policies, procedures, and work instructions  
- Writing insurance related documents such as proposals, articles, speeches, prepared testimony, and marketing copy  

Andrew currently leads a consulting team that assists clients with strategic and operational consulting engagements in the U.S. and abroad.  

He also has 20 years of experience with public-sector programs such as Medicare, Medicaid, TRICARE, and the VA. He has assisted clients in development of winning proposals for state and federal contracts.  

**PRESENTATIONS AND PUBLICATIONS**  
- Milliman Medical Index. Milliman. (2020)  
• “Excess Health Insurance Administrative Expenses,” The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Roundtable on Evidence-Based Medicine, Institute of Medicine, 2010

AFFILIATIONS
Professional, Academy for Healthcare Management
Board of Governors, Washington Athletic Club
HR & Benefits Committee, Washington Athletic Club

EDUCATION
BA, English, Wabash College
MBA, University of Notre Dame
David P. Mirkin
MD
Principal, Physician Healthcare Management Consultant
Chief Medical Officer, Milliman MedInsight

CURRENT RESPONSIBILITY
David is a principal and healthcare management consultant with the New York office of Milliman. He also is the Chief Medical Officer for Milliman’s MedInsight data warehousing and decision support analytic tool system. He joined the firm in 1995.

EXPERIENCE
David is a family practitioner with 30 years of experience in medical management. He serves as a senior consultant assisting clients in a variety of areas, including utilization management, provider profiling, disease management, length-of-stay management for hospitals, return-on-investments evaluations for disease management and wellness programs, and clinical data analysis.

David has significant international experience consulting to clients in the U.K., Europe, South America, Middle East and Asia. In addition to consulting he supervises MedInsight’s clinical and IT staff in India developing products and tools for US and international healthcare organizations. David is the innovator for several MedInsight tools including the Chronic Condition Hierarchical Groups (CCHGs) and the Care Management Impact Model (CMIM).

Prior to joining Milliman, he was corporate medical director and senior medical director for Medicare risk at FHP International. He also was a member of a four physician family practice group in rural Idaho for ten years.

PROFESSIONAL DESIGNATIONS
David holds active medical licenses in California, Utah, and Pennsylvania.

AFFILIATIONS
Member, Editorial Board, The American Journal of Managed Care
Member, Editorial Board, Population Health Management
Member, Advisory Board Institute for Value Based Insurance Design
David has been active in the sports medicine field and worked as a volunteer physician at the United States Olympic training center in Colorado Springs, Colorado

EDUCATION
Doctor of Medicine, University of Washington
David’s post-graduate training was at the San Bernardino County Medical Center, where he completed a residency in family medicine in 1981. He served as chief resident for the medical center from 1980 to 1981.
He attended the University of Utah Graduate School of Business Executive MBA program, Salt Lake City, Utah.
Court Bowers, MSHLM
Healthcare Management Consultant

CURRENT RESPONSIBILITY
Court is a healthcare management consultant in Milliman’s Seattle office. He assists health insurers, accountable care organizations, and care delivery systems to improve their operations and develop strategies for the future using quantitative analysis and modeling.

EXPERIENCE
Court is a skilled healthcare consultant and quantitative analyst, who has worked with state regulatory entities, health plans, delivery systems, public plan sponsors, multinational organizations, and managed care organizations.

He has consulted on a range of topics, including market analysis, process improvement, organizational change management planning, strategic roadmap development, assessing organizational effectiveness and administrative operations benchmarking, prescriptive modeling, and using machine learning to drive organizational change.

His understanding of health plan and clinical operations, quality improvement, reporting initiatives, and analytics uniquely positions him to assist clients by creating practical and successful solutions to meet business challenges.

Court’s professional experience includes:

- Creating staffing and financial models.
- Quantitative analysis of financial, operational, quality, and healthcare claims data.
- Assessing algorithm development and business intelligence needs and leading technology deployments.
- Developing and implementing financial performance improvement programs for managed care organizations and state government health plans.
- Assessing and redesigning organizational structures and processes to improve operational effectiveness.
- Constructing and optimizing preferred and specialty provider networks.
- Developing product value propositions and go-to-market strategies for healthcare product and service vendors.
- Leading complex operations and clinical quality improvement initiatives.
- Optimizing care intervention programs and predictive risk identifiers.
- Designing and implementing operational policies, procedures, and workflows.
- Leading systems implementation projects and programs.

Court uses his data-driven approach to problem solving and analysis to create compelling solutions that are tailored to meeting clients’ needs and helping them achieve their goals.
EDUCATION
BS, Business Management & Economics, University of Texas at Dallas
Graduate Certificate, Healthcare Information Technology, University of Texas at Dallas
MS, Healthcare Leadership & Management, University of Texas at Dallas
July 27, 2020

Mr. Craig Price  
Senior Director, Policy  
American College of Emergency Physicians  
4950 West Royal Lane  
Irving, TX 75063

Re: Questions Regarding Research and Analysis of Ownership Models RFP

Dear Mr. Price,

Thank you for the thoughtful and thorough review of the Milliman RFP response. We appreciate the opportunity to clarify our response by answering the follow up questions from the RFP task force. They are included in this correspondence.

We are very excited at the prospect of partnering with the American College of Emergency Physicians (ACEP) on this important undertaking. We believe Milliman is uniquely qualified to assist ACEP in developing the research and observations of the ownership models impacting emergency medicine providers, particularly the impact of corporate ownership models. We understand the healthcare industry and our clients know they can depend on Milliman to provide data-driven, actionable information to meet the demands of the evolving market. Our experience, our proprietary data, and our knowledgeable team bring the qualities we believe will be highly valuable to conduct the research which can inform ACEP future strategies.

Should you have any further questions, please don’t hesitate to contact me at barbara.culley@milliman.com or 206.504.5813.

Sincerely,

Barbara Culley  
Healthcare Management Consultant
Milliman Response: Research and Analysis of Ownership Models RFP Questions

1. Please provide details on your proposed payment schedule, including a description of any linkage between payments and the successful completion of specific deliverables, milestones and benchmarks.

Our proposal budget was developed on a time and expense basis, however, we have the flexibility to invoice on a deliverable basis, if preferred. Please see the following table, which was originally submitted with our response. We have added a new column identifying deliverables associated with each task. If desired, billing can be tied to the successful delivery of each task deliverable.

<table>
<thead>
<tr>
<th>Task</th>
<th>Estimated Budget</th>
<th>Key Activities</th>
<th>Deliverable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Project Initiation, Collaboration, and Management</td>
<td>$20,000</td>
<td>Kick-off meeting, for twice monthly coordination/status meetings, project management the duration.</td>
<td>Project kick-off meeting.</td>
</tr>
<tr>
<td>2. Identify Universe of Data Sources</td>
<td>$30,000</td>
<td>Literature review, identification of data sources/ limitations</td>
<td>Finalized list of data sources including identification of third-party data source agreements as needed.</td>
</tr>
<tr>
<td>3. Data Selection and Collection</td>
<td>$130,000 to $150,000</td>
<td>Data sources identified, data acquisition, primary research, physician survey</td>
<td>Finalized physician surveys, sample selection, and third party data access as identified in Task 2.</td>
</tr>
<tr>
<td>4. Analyze the Data</td>
<td>$80,000 to $100,000</td>
<td>Synthesis of findings, development of observations and conclusions</td>
<td>Preliminary outline of findings for ACEP review and feedback.</td>
</tr>
<tr>
<td>5. Prepare the Report</td>
<td>$40,000 to $50,000</td>
<td>Collaborative report development with multiple draft reviews by the task force. Final report and presentation of findings.</td>
<td>Final report incorporating data, methods, and findings. Final presentation of report to stakeholders.</td>
</tr>
<tr>
<td>Total All Tasks</td>
<td>$300,000 to $350,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
We anticipate finalizing the project billing approach during contracting. We are open to meeting ACEP’s priorities and preferences regarding the linkage between payments and deliverables.

2. Please confirm your understanding that the research project entails a profile of the universe of different emergency medicine group practice models, their market penetration, characteristics, and potential impacts.

We understand that ACEP wishes to include the full range of emergency medicine group practice models. As noted in the RFP, those models are:

- Private Equity (majority and minority ownership)
- Hospital
- Academic Group
- Foundation (with/without affiliation)
- Health Plan-Owned
- Municipality
- University
- Health System
- Multispecialty Medical Group
- Government Entity
- Military
- Emergency Physician-Owned (concentration of ownership among physicians)
- Other Physician-Owned (Non-emergency physicians)

We also understand that the scope of the work includes understanding market penetration, key characteristics, and potential impacts to physicians and patient care for each of the above models. The RFP provides example attributes, e.g. the percent of ownership, length of each organization’s existence, size of the entity (number of emergency department visits, number of physicians), geographic locations, the other specialties in the group for multispecialty group owners. Specific attributes of interest include, but are not limited to:

- Organization name
- Organization type
- Control, e.g. governance, clinical decision-making, and minority and majority private equity ownership.
- Financial transparency/profits
- Responsibilities for administrative duties, rewards for the quality of care, practicing high quality of care, measuring and ensuring high quality of care, and methods to promote emergency physicians ability to practice high quality of care
- Liability
- Investment
- Staffing and Scheduling
- Compensation/benefits
- Job satisfaction
- Impact on emergency physician job opportunities/availability
- Physician equity
- Due process, job security, and restrictive covenants
- Potential impact to the patient, as applicable
- Ownership model trends
- COVID impacts

Other key characteristics may emerge as the project team initiates discussion. A profile of each organization in the sample will include the characteristics noted above as information is obtainable by research, survey, and interview methodologies.

3. **Please provide as much information as possible regarding your proposed methodology and data collection methods.** Ensure that you have provided the projected sample size of your surveys and/or numbers of people interviewed, and provide as much specificity as possible regarding the number and type of other data sources and how they will be used to inform the final report.

Our approach to research includes three methodologies to provide a holistic view of the emergency medicine ownership model landscape. We will use four data sources as this approach provides a more balanced data set versus other approaches that rely on interviews and surveys only. We will evaluate the data elements to determine the optimal source for data. Each approach has advantages and disadvantages, which are discussed in the below sections.

**Surveys**

The online survey will be designed to capture key attributes and provider perspectives from each of the ownership models. The questions will be developed to solicit input on key characteristics and the providers’ perspectives on model participation.

We will track completion and send reminders to encourage participation. We will rely on contact information and messaging from ACEP on the importance of participation in this research. We will discuss the possible use of incentives as a means to increase participation with the ACEP project team.

We utilize a sampling process that uses a sample of thirty selected organizations for each of the identified ownership models, e.g. 13 models, each with a target sample size of 30, for a total of 390 organizations in the model cohort. We utilize a sample size of 30 following the central limit hypothesis which uses a general rule that a sample of n≥30 applies assuming the population has a normal distribution.
We will utilize the Torch Insight data to develop a sample set that represents the geographic and size distribution of the models. This approach allows for an adequate sample representing the various models to provide confidence that the research results provide useful data while utilizing resources efficiently.

The advantage of surveys is that the approach allows a very efficient online platform to reach multiple participants with standardized questions. The ease of use can increase participation. The disadvantage is that non-responses to questions may occur in the absence of a facilitated interview. Surveys tend to keep the feedback within boundaries, which is positive in that it creates comparable data across the sample. The disadvantage is that details or other concerns may be missed.

**Interviews**

Interviews will be conducted using a script and standardized questions for uniformity needed for comparison across models. We will design the survey to gather model details, provider experience with the model(s), and key questions that align with existing research that can be used as a baseline; for example, The Physicians’ Foundation 2018 survey of over 8,700 physicians. We will document the completed interviews individually and in aggregate for trend identification.

The sample will include a total of 30 interviews as a target, distributed across the ownership models, size, and geographic locations. We use the same central limit approach to establish the target sample size for the interviews, as was used in setting the target sample size for surveys.

We will use the Torch Insight ownership model data to determine distribution based on model occurrence. We will work toward a full sample, e.g. if interviews are substantively incomplete, we will determine if an additional participant for that model can be engaged within project time and budget.

The advantage of interviews is that dialog can produce rich and detailed information that can identify underlying issues or concerns that fall outside of the identified discussion topics. The disadvantage is that the approach is significantly less efficient in that interviews consume more time for the physician and research resource budget. This time commitment can detract from physician willingness to participate. We suggest utilizing ACEP messaging on the research project to identify willing interview participants.

**Primary research**

We will research publicly available information and existing research on the core topics of interest, e.g. provider perspectives on ownership models. We will use this information for comparison to survey and interview findings, to complete organizational profile
information, and to identify trends from prior research periods, e.g. 2018 Physician’s Foundation survey.

We do not use a sample size to limit primary research, as we will continue to investigate available materials for the majority of the project duration. We have scheduled research activities during seven of the ten months of the proposed project timeline.

The advantage of primary research is the significant amount of available data and studies to use for comparison, trend identification, and additional data that may further inform the project findings. The disadvantage is that not all research and data are publicly available or at a fine enough level of detail to correlate to interview and survey findings. For example, emergency medicine physician job security by model is not widely researched.

In addition to the surveys, interviews, and primary research, we anticipate utilizing data from additional data sources. We address the data we anticipate using to inform the final report in the following sections.

**Utilizing data sources**

We have identified the following six data sources that we propose using in this project. We will work with you to discuss the relative value of each data set and estimated costs if there are additional fees to purchase or access the data source.

**Proprietary Milliman data**

A hallmark of Milliman is our significant focus and investment in assembling and managing large (e.g., greater than 80 million lives), diverse data sets that enable us to conduct detailed research internally and on behalf of our clients. We are proposing to use several of our proprietary data sets in this engagement, augmented by third party data, much of which we already have available and incorporated into our standard internal data access processes. Additionally, we have identified several other data sources which may be accessed through a license fee model if desired.

**Milliman Consolidated Health Cost Guidelines Source Administrative Claims Database (CHSD)**

The Milliman Consolidated Health Cost Guidelines Source Database contains proprietary historical claims experience from numerous data contributors including large employers, health plans, and governmental and public organizations nationwide. The database contains detailed, de-identified enrollment and paid medical and pharmacy claims for over 80 million individuals across commercial, Medicare Advantage, and Managed Medicaid lines of business nationally. Milliman currently has data through 2018. Typically, data is available down to the MSA level.
We anticipate using this data to identify emergency medicine claims occurrence across geography, mapping this data against geographic distribution of the various model types. This perspective will provide insight on whether model types impact use of emergency departments and related hospital admissions.

Use of this data is included in our proposed project pricing and will not require additional access fees.

*Torch Insight*

The Torch Insight database is addressed in the response to question 7 below. We anticipate using this data to understand the geographic distribution and prevalence of the range of emergency medicine ownership models. This data will then be used to align other data findings, e.g. the emergency medicine claims analysis from the CHSD and survey/interview findings. Additionally, the mapping of ownership models will inform the sample selection to represent geographic distribution and size.

Use of this data is included in our proposed project pricing and will not require additional access fees.

*Third Party data*

We will use external sources because they can be a very efficient way to significantly expand the sample size to augment credible data underlying certain questions. Additionally, third party data sources can provide a more efficient way of collecting certain data elements which they have already collected.

*MarketScan® Commercial Claims Database*

The IBM Watson Health MarketScan Commercial Claims Database (MarketScan) contains all paid claims generated by more than 28 million in 2018 commercially insured lives. The MarketScan database represents the inpatient and outpatient healthcare service use of individuals nationwide who are covered by the benefit plans of large employers, health plans, government, and public organizations. The data includes diagnosis codes, procedure codes, and DRG codes, as well as NDC codes and the amounts paid by commercial insurers. The MarketScan database links paid claims and encounter data to detailed patient information across sites and types of providers (and over time). The annual medical database includes private sector health data from approximately 100 payers. Milliman currently has data through Q3 2019.

We will use this data to correlate with the claims data in the CHSD if needed, potentially using patient attributes to inform the final report.

Use of this data is included in our proposed project pricing and will not require additional access fees.
CMS 100% Limited Data Set

The Medicare 100% sample is a limited data set containing all Medicare paid claims generated by 100% of Medicare fee-for-service (FFS) beneficiaries. Information includes county of residence, diagnosis codes, procedure codes, DRG codes, site of service information, beneficiary age, eligibility status and an indicator for HMO enrollment. The Medicare data does not include carrier, DMEPOS, or Part D prescription drug data. Milliman currently has data through Q4 2019.

We will use this data to provide information for those served by Medicare. By combining the available claims data, we will develop a fuller understanding of geographic utilization of emergency services. This will be used together with other data sources to synthesize into a comprehensive national view of emergency medicine services.

Use of this data is included in our proposed project pricing and will not require additional access fees.

Medical Group Management Association (MGMA) DataDive

MGMA has developed benchmarking data on key physician attributes by specialty that can provide insights in a more cost effective method on topics including compensation, staffing ratios, and other model characteristics costs identified in the RFP. Additionally, MGMA had compiled data on the impacts of COVID. By utilizing existing research, we are able to finely tailor the survey and interviews to those areas where data is not available and to correlate with responses to surveys and interviews where there is overlap. For example, as COVID is a recent factor, interviews and surveys provide a sample response, which is then compared to MGMA COVID data for analysis.

Use of the MGMA data will require access fees in addition to the proposed project budget. We will discuss with the project team during project initiation whether purchasing this additional data set will be useful to help achieve the project goals.

The American Medical Association (AMA) 2018 Physician Practice Benchmark Survey

We will utilize this data to compare to our research, survey, and interview findings on physician practice arrangements as an additional data point.

Use of this data would not require access fees.

Additionally, we will work with the ACEP project team to identify relevant ACEP data available to utilize and compare to other data.

4. Please provide sufficient detail and clarity to demonstrate that the quality data sources you intend to utilize to measure impacts on quality are at least
We will utilize multiple, credible sources to evaluate standardized quality measures, as described below.

**Centers for Medicare and Medicaid Services (CMS) Hospital Compare**

One nationally recognized source of quality data is the CMS Hospital Compare data. We will specifically utilize the Timely & effective care - Emergency department (ED) measures for sample selected organizations with a hospital-based model. Those measures include:

- Volume
- Wait to transfer to inpatient room
- Arrival to discharge time (also for psychiatric patients)
- Percent left without being seen
- Percent of stroke symptom patients receiving brain scan within 45 minutes

This data provides standardized measures reported nationally, which can be compiled and correlated to the data from other sources.

**CMS Merit-based Incentive Payment System (MIPS)**

MIPS provides a standardized set of metrics for providers. We will utilize the MIPS quality measures on patient outcomes, appropriate use of medical resources, patient safety, efficiency, patient experience and care coordination. Additionally, we will review the emergency medicine Specialty Measure Sets as reported for the organizations included in the sample.

As emergency physicians enter quality data to the ACEP’s Clinical Emergency Data Registry (CEDR), we anticipate working with the project team to access the CEDR data to use in the review of MIPS quality metrics.

**National Committee on Quality Assurance (NCQA)**

The provider and practice report cards make available quality scores against standard measures. We will evaluate the NCQA data for each of the sampled practices as an indicator of quality.

5. **Could you provide more detail on the methodology and external data sources you would envision utilizing, particularly in terms of identifying the impact of different ownership models on quality of care and cost of care to payers, as well as to patients?**
In addition to the information provided in the response to question 3, and question 7, we envision creating a profile on each sampled organization using the external resources already noted. In particular, we will use Torch Insight to understand the location, size, and participants in the range of ownership models identified in the RFP.

This question gets to the heart of the work for this project. The analysis using the data gathered from the identified sources is the step that brings the disparate data together to create a holistic profile to then evaluate how models align with quality, costs, provider perspectives, and patient satisfaction. Synthesis includes looking at the data in detail and in aggregate, plotting data, and reviewing interviews to weave together the pieces into coherent observations based on data and information gathered.

Ideally, if we know of situations where there has been a transition in ownership models, we would look for longitudinal data to provide year-over-year comparison for performance before and after implementing a new ownership model to understand impacts of the model change.

We anticipate that we would work with the ACEP project team to access the CEDR data to assist in this analysis. If available, we would request quality program metrics from the providers surveyed and interviewed.

6. **Please provide more details on how quality of care for different ownership models will be measured.**

In addition to the response on quality in question 4, an additional component of quality is provider engagement and satisfaction. Areas of interest for the ACEP project include provider control, staffing ratios, and administrative duties, which are noted in industry surveys as key factors in provider satisfaction.

We will utilize available research, e.g. The Physicians’ Foundation 2018 survey, which includes morale, practice patterns, and demographic data. While this survey was not emergency medicine specific, it provides an overall picture of key issues related to provider satisfaction and engagement.

We will additionally address this topic in the provider surveys and interviews for inclusion in the data set. Using this data, we will compare findings against ownership models to evaluate possible underlying relationships.

Patient satisfaction is an important component for measuring emergency medicine quality. We will use the ten publicly reported HCAHPS measures, and HCAHPS Summary Star Rating for evaluating patient emergency room satisfaction. We will then evaluate this data with the practice model distribution information to identify patterns
and correlations.

Different models have different areas of quality focus and approaches, e.g. team versus independent practitioners. Staffing ratios and use of staff to top of license are components of quality and provider satisfaction which will be included in surveys and interviews to understand correlation with different models. Questions on physician incentives for quality of care and autonomy to practice quality care will be included in the survey and interviews as a component of understanding the model impact to quality.

7. In noting your access to Torch Insight data, you stated that the “platform includes information on 290,000 physician practices including 2,000+ practices with emergency medicine as the primary specialty.” Could you expound on how those emergency medicine practices are defined and the data contained about them?

Torch Insight uses multiple sources of data, including Medicare claims, CMS Physician Compare, and the CMS Enrollment file to compile a comprehensive physician group directory with unique calculated metrics. Torch Insight uses the Group PAC ID, a unique ID assigned by PECOS that the individual providers use, to do initial groupings of physicians. We also use claims analysis and primary research to identify physician groups that in reality, operate as combined organizations, and the NPI file to identify clinics where these groups operate.

The combination of these data, individual physician data, and Torch Insight analysis, allow us to identify unique metrics on physician groups on a national scale (~290,000 physician groups). We have identified a selection of these metrics below that we anticipate using for the ACEP analysis including:

1. **Physician group size**: FTE count
2. **Primary specialty**: the most common specialty of physicians in the group
3. **Number of different specialties**: in the group
4. **Employment categorization**: fully integrated with a system, partially employed, independent
5. **Employment percentage**: the percent of the group that is employed by their primary health system
6. **Alignment to Health System categorization**: the degree to which the groups send their patients to a single health system

All of the measures listed above are unique metrics generated by Torch Insight and would be of exceptional valuable to the ACEP analysis. This dataset includes 2,000+ physician groups with a primary specialty of emergency medicine, or we can broaden our scope to include groups where a significant minority of the group’s members are in emergency medicine.
8. The section of your proposal that addresses the budget for reduced-scale projects states that these less expensive options would include “limiting the analysis to conclusions that can be drawn using simplified analytic techniques.” Please provide a comparison of what is involved in analysis utilizing simplified analytic techniques as compared to the analytic techniques you would use under the full proposal.

The majority of the proposed budget falls into the Task 3. Data Selection and Collection and Task 4. Analyze the Data. The main method of reducing the budget is to reduce the number hours in research, thereby reducing the amount of data that would be included in the research and analysis work.

25% budget reduction scenario. With a 25% reduction, we would propose a reduction of hours committed to primary research, reduce the claims analysis to CHSD only, and eliminate third party data resources that require additional funding, reducing budget, and scope of data analyzed.

50% budget reduction scenario. A 50% reduction is achieved by reducing administrative costs (e.g., status meetings and multiple draft review cycles) to preserve as much of the research and analysis budget as possible. Additionally, we propose eliminating the interviews, which are typically resource intensive. We would reduce the claims analysis to CHSD only, reduce the amount of time spent on primary research, and reduce the databases included in the analysis to Milliman proprietary data and Torch Insight only. This results in simplified analysis due to limited data sources, reducing the depth of information and data available for synthesis into findings.

We understand that ACEP is seeking to understand the impact of various ownership models, e.g. corporatization, on the quality and experience of emergency medicine. The deliverable report will be helpful in providing important data supporting ACEP strategies.

We believe our unique combination of experience, proprietary data, understanding of the healthcare industry, and ability to manage and complete complex research projects uniquely positions us to help ACEP achieve the project goals.

We hope to work with you on this important project and we are happy to answer additional questions as they arise.
Memorandum

To: 2020 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: September 23, 2020

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2020-21. The committee will hold a conference call meeting on Monday, October 5, to discuss their recommendations. The committee’s recommendations will be discussed by the Board at their meeting on October 24. The Compensation Committee’s report will be distributed to the Council as soon as it is available. The Council will also be informed if the Board does not adopt the Compensation Committee’s recommendations.

The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board’s proposed compensation, the Compensation Committee’s recommendation will then take effect.

The current officer and non-officer stipends are:

- President $139,933
- President-Elect $101,759
- Chair $33,713
- Vice President $33,713
- Secretary-Treasurer $33,713
- Immediate Past President $33,713
- Speaker $33,713
- Vice Speaker $17,371
- Non-Officer Board Members $10,428
This report will be provided as soon as it is available.
Memorandum

To: 2020 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: September 24, 2020

Subj: Action on 2018 Resolutions

The 2018 Council considered 51 resolutions: 43 were adopted, 5 were not adopted, 3 were referred to the Board of Directors.

The attached report summarizes the actions taken on the 2018 resolutions adopted by the Council and those that were referred to the Board.
Resolution 1 Commendation for Hans R. House, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Hans R. House, MD, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of emergency medicine.

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

Resolution 2 Commendation for Jay A. Kaplan, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Jay A. Kaplan, MD, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

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

Resolution 3 Commendation for Les Kamens
RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Les Kamens for his dedicated support and service.

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

Resolution 4 Commendation for Rebecca B. Parker, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Rebecca B. Parker, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

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

Resolution 5 Commendation for Eugene Richards
RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Eugene Richards for capturing the breathtaking moments that comprise the lives and careers of emergency physicians across the United States.

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

Resolution 6 Commendation for John J. Rogers MD, CPE, FACEP
RESOLVED, that the American College of Emergency Physicians recognizes and commends John J. Rogers, MD, CPE, FACEP, for his lifetime of outstanding and selfless service, leadership, and commitment to the College, the specialty of emergency medicine, and the patients in the communities which we serve.

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

Resolution 7 In Memory of Lawrence Scott Linder, MD, FACEP
RESOLVED, That the American College of Emergency Physicians and the Maryland Chapter hereby acknowledge the many contributions that Lawrence Scott Linder, MD, FACEP, made as one of the leaders in emergency medicine and the greater medical community; and be it further RESOLVED, That the American College of Emergency Physicians extends to his wife, Jeanette Linder, MD, his daughter, Kaylie, our condolences and gratitude for Dr. Linder’s trailblazing leadership and service to the specialty of emergency medicine and to the patients and physicians of Maryland and the United States.

Action: A framed resolution was prepared for Dr. Linder’s family.
Resolution 8 In Memory of Kevin Rodgers, MD, FAAEM, FACEP
RESOLVED, That the American College of Emergency Physicians extends to the family of Kevin Rodgers, MD, FACEP, FAAEM, his friends, and his colleagues our condolences and our immense gratitude for his tireless service to his residents, his students, and the countless patients globally who will continue to benefit from his incredible life spent in service to others.

Action: A framed resolution was prepared for Dr. Rodgers’ family.

Resolution 9 American College of Osteopathic Emergency Physicians Councillor Allocation – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article VIII – Council be amended to read:
The Council is an assembly of members representing ACEP’s chartered chapters, sections, the Emergency Medicine Residents’ Association (EMRA), the American College of Osteopathic Emergency Physicians (ACOEP), Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), and the Society for Academic Emergency Medicine (SAEM). These component bodies, also known as sponsoring bodies, shall elect or appoint councillors to terms not to exceed three years. Any limitations on consecutive terms are the prerogative of the sponsoring body.

Section 1 — Composition of the Council

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

An organization currently serving as, or seeking representation as, a component body of the Council must meet, and continue to meet, the criteria stated in the College Manual. These criteria do not apply to chapters or sections of the College.

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

ACOEP shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of ACOEP.

AACEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of AACEM.

CORD shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of CORD.

SAEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of SAEM.

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section if the number of section dues-paying and complimentary candidate members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year.

A councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Each component body shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body's councillor at Council meetings at which such councillor is not available to participate. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.

Action: The Bylaws were updated. A comparison of ACEP and ACOEP membership lists was conducted in February 2019. The ACOEP list contained 5,260 names and of that list, 1,978 were also ACEP members (approximately 38%). However, 476 of those were medical students, which means that 1,502 (approximately 28%) were physician members who were also ACEP members. A manual search on each non-member name was also conducted to ensure that the names were not missed when the computerized comparison was conducted. Per ACEP’s College Manual, Criteria for Eligibility and Approval of Organizations Seeking Representation in the Council (item E.), “a majority of the organization’s physician members are ACEP members,” which means that ACOEP was not eligible to have a seat for the 2019 Council meeting. ACOEP was still ineligible to be represented in the Council for the 2020 meeting.
Resolution 13 Growth of the ACEP Council  
RESOLVED, That the Council direct the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether a Bylaws amendment should be submitted to the 2019 Council addressing the size of the Council and the relative allocation of councillors.

Action: A task force was appointed. The task force provided their report to the Council Steering Committee in May 2019. The Steering Committee recommended that the report and the options developed by the task serve as the topic of the Town Hall Meeting during the 2019 Council meeting. The Town Hall meeting focused on the Growth of the Council and five scenarios were presented for consideration by the Council. The majority response from the Council was to take no action at this time to change the current councillor allocation method as delineated in the Bylaws.

Resolution 14 Diversity of ACEP Councillors  
RESOLVED, That ACEP strongly encourage its chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to, residents, fellows, and young physician members.

Action: A notice was sent to chapters on March 27, 2019, reminding them of the adopted resolution. A follow up message was sent to chapters on February 17, 2020.

Resolution 16 No More Emergency Physician Suicides  
RESOLVED, That ACEP study the unique, specialty-specific factors leading to depression and suicide in emergency physicians; and be it further  
RESOLVED, That ACEP formulate an action plan to address contributory factors leading to depression and suicide unique to our specialty and provide a report of these findings to the 2019 Council.

Action: Assigned to the Well-Being Committee to work with the Academic Affairs Committee (for resident perspective), and the Wellness Section.  
The committee worked on an action plan and additional background information, including:  
- Reviewed the ICPH 2017 qualitative paper of stories told by survivors of suicide.  
- Distributed a quantitative survey (+/- space for participants to provide contact information for semi-structured interviews) to attendees of the ACEP19 didactic session “Physician Do No Harm – A Comprehensive Look at Physician Suicide Workshop.”  
- Developed content and resources for distribution during National Suicide Awareness week, September 8-14, 2019.  
- The ACEP website includes links to suicide prevention resources:  

Additionally in 2020:  
- June 2, 2020 – issued a joint statement with multiple organizations and a press release about breaking down barriers to improving clinicians’ access to mental health care. The Dr. Lorna Breen Heroes’ Foundation is a signer on the press release. ACEP’s DC office has been working with the Breen family to better spotlight the issue.  
- Participated in the National Physician Suicide Day campaign.  
- ACEP supports the Dr. Lorna Breen Health Care Provider Protection Act and has shared information across social media and in our email newsletters to help raise awareness and generate support.  
- “Speaking the Unspeakable” is an article that appeared in ACEP Now, September 2020  
- “The Pandemic’s Toll: An Emergency Physician’s Suicide” Annals of Emergency Medicine, September 2020  
- ACEP Frontline podcast with the Breen family available on iTunes, Google Play and Soundcloud  
- The article “One of Us” in the September 2020 issue of ACEP Now details four steps that institutions can take to mark NPSA Day, plus recent physician suicide statistics  
- ACEP has multiple resources on the website about physician wellness, including the new Peer Support Project. That project was created to complement ACEP’s ongoing efforts to reduce barriers to seeking mental health support. Here are links to the Member Wellness & Assistance Program and the Physician Wellness Hub.

Resolution 18 Reducing Physician Barriers to Mental Health Care (as amended)  
RESOLVED, That ACEP work with partner organizations to promote a culture where physician mental health issues can be addressed proactively, confidentially, and supportively, without fear of retribution; and be it further
RESOLVED, That ACEP work with the American Medical Association, Federation of State Medical Boards, and the American Psychiatric Association to encourage those state medical boards that request a broad report of mental health information on licensure application forms to end this practice unless there is a current diagnosis that causes physician impairment or poses a potential risk of harm to patients; and be it further

RESOLVED, That ACEP work with ACEP chapters to encourage those state medical boards that inquire about both the physical and mental health of applicants to use the language recommended by the Federation of State Medical Boards: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?”

Action: The AMA, FSMB and APA have issued formal guidelines opposing expansive questions about mental health. In June 2018, the AMA amended its policy on “Access to Confidential Health Services for Medical Students and Physicians.” The policy states in part, “Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.”

Assigned third resolved to Chapter & State Relations staff to disseminate information to chapters in states where the medical licensure application is not compliant with the FSMB preferred language and request changes to the application and to develop a template letter for use by those chapters. On July 10, 2019, information was distributed to chapters: 1) background document briefly explaining the issue and offering talking points; 2) template letter to be used to request state medical board to make changes consistent with the FSMB language if they are using inappropriate questions; and 3) template letter to be used to request hospital administrators to alter their credentialing application and process.

Assigned to the Well-Being Committee to work with the Emergency Medicine Practice Committee and determine if ACEP’s “Physician Impairment” policy statement needs to be revised or if a new a policy statement is needed to address physician mental health. The Board approved the revised policy statement “Physician Impairment” at their February 2020 meeting.

May 2020 – ACEP staff met with the Joint Commission to discuss the issue of physicians being penalized by state licensing boards and other entities for seeking mental health treatment. This is a serious barrier to physicians pursuing treatment-- and now even more than ever, it is essential for physicians to seek help when needed. The Joint Commission issued a statement on May 12 and it is on their website.

June 2, 2020 – ACEP issued a joint statement with multiple organizations and a press release about breaking down barriers to improving clinicians’ access to mental health care. The Dr. Lorna Breen Heroes' Foundation is a signer on the press release. ACEP’s DC office has been working with the Breen family to better spotlight the issue.

ACEP has developed an advocacy strategy around this important issue and has been compiling a comprehensive and up-to-date list of state medical boards who ask problematic questions about physician mental health history. The FSMB was contacted for the information but was not able to respond in a timely manner. ACEP distributed a survey to members to help collect this information.

Resolution 19 Reduction of Scholarly Activity Requirements by the ACGME (as amended)

RESOLVED, That ACEP reaffirms its position on the importance of scholarship as well as protected clinical hours for our core faculty to teach our residents and will advocate with the Accreditation Council for Graduate Medical Education to preserve core faculty teaching and academic time, including support of scientifically rigorous research and education that improves the patient care in emergency medicine; and be it further

RESOLVED, That ACEP develop model policy language on the importance of scholarship and the need for supported core faculty teaching and academic time, which training programs can access and present to hospital systems as evidence for the need for financial support for scholarly activity and protected teaching academic time; and be it further

RESOLVED, That ACEP explore additional ways to provide financial support to residency and training programs to protect core faculty in carrying out scholarly activities; and be it further

RESOLVED, That ACEP work with the Council of Emergency Medicine Residency Directors and the Society for Academic Emergency Medicine to establish initiatives and processes to ensure all areas of scholarship teaching time and academic time are supported; and be it further

RESOLVED, That ACEP provide a statement to the Accreditation Council for Graduate Medical Education to request that accreditation requirements for scholarship and protected clinical time for teaching be explicit to ensure institutional and program funding support is directed toward these activities.

Action: Assigned to the Academic Affairs Committee.

On November 6, 2018, ACEP sent a letter to the ACCME commenting on the proposed changes to the Common Requirements Section VI as a follow up to the letter sent on March 21, 2018. The Academic Affairs Committee
collaborated with eleven emergency medicine organizations to develop a manuscript and joint policy statement calling for core faculty protected time. The manuscript was accepted for publication by *Academic Emergency Medicine* on November 20, 2019.

The Board of Directors approved the joint policy statement “Compensated Time for Faculty Academic Administration and Teaching Involvement” in June 2019. Work on this resolution will continue as the changes to the ACGME Common Program Requirements are implemented across programs.

On September 30, 2019, the ACGME announced that it was “important to preserve the ability of individual Review Committees to develop requirements regarding support for core faculty members based on the unique needs of the specialty.” The decisions of the individual review committees still need to be reviewed, but it appears that protected time for faculty has been salvaged based on this announcement.

**Resolution 20 Verification of Training**

RESOLVED, That ACEP work with stakeholders including the Federation of American Hospitals (FAH), American Hospital Association (AHA), and others as appropriate, to develop a standardized and streamlined application process for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of training form for hospital credentialing and be it further

RESOLVED, That ACEP support the development of a standardized peer reference form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of employment form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized employment application for board eligible or board certified emergency physicians for hospital credentialing;

*Action*: Assigned to the Emergency Medicine Practice Committee. Information on standardized methods for verification of training were compiled. The National Association of Medical Staff Services (NAMSS) and American Medical Association staff were contacted. It was identified that a standardized form, the “Verification of Graduate Medical Education Training Form” was drafted in 2016 and updated in 2017. For 2016 and future graduates, this form is completed one time by the program director at the completion of internship, residency or fellowship. One form is to be completed for each program completed. The completed, signed form is then included in the trainee’s file for verification when requested in the future. NAMSS continues to work with stakeholders on this issue and have identified blockchain technology as a potential way forward to verify and share credentialing information. Data elements have been defined and forms have been developed to standardize the process but, there is still significant work to be done to develop mechanisms to share and verify credentialing data. Although the College could potentially participate in the ongoing stakeholder process if invited to do so, this is an issue that must be addressed by the House of Medicine at large and not emergency physicians alone. The Board approved the committee’s recommendation to take no further action on the resolution in June 2019.

**Resolution 21 Adequate Resources for “Safe Discharge” Requirements (as amended)**

RESOLVED, That ACEP oppose any “safe discharge” mandates and believes that a discharge from the emergency department is a clinical decision of the emergency physician; and be it further

RESOLVED, That ACEP oppose local, state, and federal mandates on discharge requirements.

*Action*: This resolution is a policy statement. It was assigned to the Emergency Medicine Practice Committee to review and provide a recommendation on whether additional information is needed to include in the policy statement. In June 2019, the Board of Directors approved the policy statement, “Safe Discharge from the Emergency Department.”

Assigned to Public Affairs staff for federal advocacy initiatives and to the State Legislative/Regulatory Committee to assist chapters with state advocacy initiatives.

The State Legislative/Regulatory Committee compiled materials that were distributed to chapters prior to ACEP19.

**Resolution 22 Addressing Mental Health Treatment Barriers Created by the Medicaid IMD Exclusion (as amended)**

RESOLVED, That ACEP inform members about the Medicaid Institutions for Mental Diseases Exclusion and its impact on ED psychiatric patients; and be it further

RESOLVED, That ACEP continue to work through legislation or regulation to repeal the Medicaid Institutions for Mental Diseases Exclusion; and be it further

RESOLVED, That ACEP support Medicaid waiver demonstration applications that seek to receive federal financial participation for Institutions for Mental Diseases services provided to Medicaid beneficiaries.
Action: Assigned to Public Affairs staff for federal advocacy initiatives and to Chapter & State Relations staff to develop information for distribution to chapters.

On November 13, 2018, CMS sent a letter to State Medicaid directors that included a new demonstration opportunity for states to treat adults and children with serious mental illnesses. Specifically, states can apply for a Medicaid Section 1115 waiver to receive matching federal funds for short-term residential treatment services in an IMD. This policy broadens the ability for states to work around the current Medicaid IMD exclusion. Before this announcement, CMS only allowed states to waive the Medicaid IMD exclusion for patients with substance abuse disorders. This information was sent to ACEP chapters encouraging members to explore this opportunity.

ACEP’s Legislative & Regulatory Priorities for the First and Second Sessions of the 116th Congress included “seek permanent repeal of the Medicaid IMD exclusion.” ACEP has supported eliminating the IMD exclusion for many years. Partial repeal of the IMD exclusion was achieved in the 2018 “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act” (H.R. 6). The provision temporarily repeals the IMD Exclusion for fiscal years 2019-2023 and allows states to file state plan amendments (SPAs) to receive federal funding for services rendered at an IMD for up to 30 days or residential substance use disorder treatment annually per beneficiary (between the ages of 21-64). ACEP has long advocated for the full repeal of the IMD exclusion and will continue to work with Congress on this priority.

Resolution 23 Advocating for CMS Policy Restraint to Avoid Restricting Quality Emergency Care (as amended)

RESOLVED, That ACEP request that any CMS policies restricting the administration of rapid sequence intubation drugs in the emergency department, under the direction of emergency physicians or by EMS physicians, be revised or revoked as soon as possible; and be it further

RESOLVED, That ACEP request that CMS policy reflect the consensus guideline on unscheduled procedural sedation of the American College of Emergency Physicians.

Action: Assigned to Public Affairs staff for regulatory initiatives. CMS has issued clarifying guidance to State Survey Agency Directors on hospital anesthesia/sedation services. In this guidance, CMS states that one physician must oversee anesthesia/sedation services in the hospital. However, as long as one physician is overseeing the program, the hospital can use multiple policies and guidelines. The guidelines clearly state that hospitals may follow the guidelines of specialty organizations (specifically citing ACEP’s clinical policies) and that emergency physicians are “uniquely qualified” to administer all levels of sedation “from moderate to deep to general.” The guidance does not dictate which guidelines hospitals must use. ACEP distributed a membership communication highlighting this guidance and included the policy statement “Procedural Sedation in the Emergency Department.” ACEP has developed resources for emergency physicians to help them educate their hospitals about the CMS guidelines and advocate for policies that allow emergency physicians to deliver anesthesia and sedation.

Resolution 24 ED Copayments for Medicaid Beneficiaries

RESOLVED, That ACEP oppose imposition of copays for Medicaid beneficiaries seeking care in the ED; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

Action: Assigned to Public Affairs staff for federal advocacy initiatives. The first resolved is a policy statement. Assigned to the State Legislative/Regulatory Committee to review and provide a recommendation on whether additional information is needed to include in the policy statement. Assigned second resolved to the AMA Section Council on Emergency Medicine.

The AMA Section Council on Emergency Medicine submitted a resolution to the AMA in November 2018. The AMA decided to reaffirm its existing policies, which many believed already support this position. On February 26, 2019, ACEP sent a letter to the AMA requesting to engage in a dialogue to discuss how the AMA can operationalize advocacy efforts to help in the fight against state attempts to impose and expand copayment requirements on Medicaid patients seeking emergency care, whether the copayments required are for all Medicaid patient visits or just those that a state deems to be non-emergent. On March 20, 2019, ACEP received a response from the AMA indicating that AMA Advocacy staff are willing to work with ACEP on this issue. ACEP and AMA staff have agreed to coordinate efforts to oppose any future attempts by states to impose Medicaid co-pays for “non-emergent” ED use.

In July 2019, the Board reviewed the information paper “Medicaid Cost Savings Measures for Emergency Care” developed by the Federal Government Affairs Committee and the Legislative/Regulatory Committee. The information paper summarizes the status of Medicaid copayment waivers and available data on the effects of those waivers.

In October 2019, the Board approved the policy statement “Opposition to Copays for Medicaid Beneficiaries.”
Resolution 25 Funding for Medication Assisted Treatment Programs (as amended)
RESOLVED, That ACEP pursues legislation for federal and state appropriation funding and/or grants for purposes of initiating and sustaining medication assisted treatment programs in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow up.

Action: Assigned to Public Affairs for federal advocacy initiatives. Assigned to Chapter & State Relations staff to assist chapters with state advocacy initiatives. The Preventing Overdoses While in Emergency Rooms (POWER) Act was enacted and addresses this resolution. Assigned to the State Legislative/Regulatory Committee to develop model state legislation for chapters to use to access the funding.

- The Preventing Overdoses While in Emergency Rooms (POWER) Act
  (H.R. 5176 – McKinley/Doy; S. 2610 – Capito/Murphy)
  - Provides grants to establish policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department, and to develop best practices to provide a “warm handoff” to appropriate community resources and providers to keep patients engaged in treatment. MAT is a proven medical treatment that can relieve withdrawal symptoms and psychological cravings of opioid use disorder.
  - Studies show success for this model – after one month, 78 percent of patients remained in addiction treatment programs with ED-initiated MAT, compared to 37 percent when given only a simple referral in the ED to treatment in the community.

The State Legislative/Regulatory Committee has collected considerable information and continued to work on developing model state legislation in the 2019-20 committee year.

Resolution 26 Funding of Substance Use Intervention and Treatment Programs (as amended)
RESOLVED, ACEP advocate for federal and state appropriations and/or federal and state grants for use in fully funding substance abuse intervention programs that are accessible seven days a week and 24 hours each day and will be initiated in emergency departments; and be it further
RESOLVED, That ACEP advocate for federal and state funding for substance abuse intervention programs that will be fully accessible and utilizable to their full potential by all patients regardless of insurance status or ability to pay.

Action: The Preventing Overdoses While in Emergency Rooms (POWER) Act was enacted and addresses this resolution. The legislation provides grants to establish policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department and to develop best practices to provide a “warm handoff” to appropriate community resources and providers to keep patients engaged in treatment.

Assigned to the State Legislative/Regulatory Committee to develop model state legislation for chapters to use to access the funding.

The State Legislative/Regulatory Committee has collected considerable information and continued to work on developing model state legislation in the 2019-20 committee year.

Resolution 28 Inclusion of Methadone in State Drug and Prescription Databases
RESOLVED, That ACEP adds to its legislative agenda to advocate for an end to the prohibition and corresponding inclusion of Methadone in state and federal prescription databases.

Action: Concerns were raised about the advisability of adding this to ACEP’s legislative agenda because it may have unintended consequences and may violate patient confidentiality. The Board discussed the concerns that were raised and adopted the resolution. The resolution was assigned to the Ethics Committee to work with the Medical-Legal Committee and the State Legislative/Regulatory Committee to review and provide a recommendation to the Board. In October 2019, the Board of Directors approved the Ethics Committee’s recommendation to implement the resolution and assign an objective to the Ethics Committee for the 2020-21 committee year to develop an information paper to address adding methadone to state prescription drug monitoring programs.
ACEP’s Legislative & Regulatory Priorities were updated to include this directive.

Resolution 29 Insurance Collection of Patient Financial Responsibility (as amended)
RESOLVED, That ACEP add to its legislative and regulatory agenda to advocate for bills and policy changes that would require healthcare insurance companies to pay the professional fee directly to the clinician and subsequently collect whatever patient responsibility remains according to the specific healthcare plan directly from the patient; and be it further
RESOLVED, That ACEP creates an information paper and/or legislative toolkit to assist members in advocating for applicable changes to state insurance laws; and be it further
RESOLVED, That ACEP advocates for a federal law requiring healthcare insurance companies to pay the professional fee directly to the clinician and subsequently the insurance company may collect whatever remaining patient responsibility is required according to the specific healthcare plan directly from the patient.
**Resolution 30 Naloxone Layperson Training**

**RESOLVED**, That ACEP supports state chapters in drafting and advocating for state legislation to recommend naloxone training in schools; and be it further

**RESOLVED**, That ACEP works with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

**Action:** Assigned first resolved to the State Legislative/Regulatory Committee. Assigned second resolved to Public Affairs staff for federal advocacy initiatives.


The State Legislative/Regulatory Committee compiled information that was distributed to chapters prior to *ACEP19*.

**Resolution 31 Payment for Opioid Sparing Pain Treatment Alternatives (as amended)**

**RESOLVED**, That ACEP advocate for insurance coverage of opioid sparing therapies without requiring preauthorization or outright denial of these prescribed therapies.

**Action:** The Alternatives to Opioids (ALTO) in the ED Act was enacted in June 2018 and addresses this resolution. The legislation provides grants to help emergency departments and hospitals implement non-opioid, evidence-based pain management protocols, based on the successful and proven ALTO program developed at St. Joseph’s in Paterson, New Jersey. Assigned to the State Legislative/Regulatory Committee to develop model state legislation for chapters to use to access the funding. Their work will be completed prior to *ACEP19* and distributed to chapters.

On June 13, 2019, the House of Representatives approved a bipartisan amendment to provide $10 million for the Alternatives to Opioids (ALTO) in the Emergency Department program that was authorized in the 2018 opioids bill, the *SUPPORT for Patients and Communities Act* (P.L. 115-271). The amendment was offered to the Fiscal Year 2020 Labor/Health and Human Services (L/HHS) appropriations bill. ACEP DC staff worked with Rep. Pascrell's office to ensure the amendment was made in order and passed successfully. ACEP submitted a letter of support from and Rep. Pascrell’s office informed submitted ACEP's letter of support for the amendment into the Congressional Record.

The [Pain Management & Addiction Medicine Section](https://www.acep.org/sections/17337) continues to develop resources on pain management and addiction medicine. ACEP has developed the [E-QUAL Network Opioid Initiative](https://www.acep.org/sections/17337), which includes toolkits, webinar series, podcasts, and other resources. The Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committees have developed [opioid resources](https://www.acep.org/sections/17337) that are available on the ACEP website.

**Resolution 32 POLST Forms (as amended)**

**RESOLVED**, That ACEP advocates and assist chapters for broad recognition of POLST, including the use of nationally-recognized, standardized POLST forms; and be it further

**RESOLVED**, That ACEP supports legislation where states recognize and honor POLST forms from other states; and be it further

**RESOLVED**, That ACEP encourages appropriate stakeholders (e.g., medical record systems, health information exchanges) to incorporate POLST into their products thus encouraging widespread national availability and adoption.

**Action:** Assigned first and second resolveds to Chapter & State Relations staff to assist chapters with state advocacy initiatives and promote ACEP’s policy statement “[Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Treatment (POLST)](https://www.acep.org/sections/17337).” Assigned third resolved to the Emergency Medicine Informatics Section for a recommendation to the Board.

Several states have incorporated POLST into their health information exchanges. The Office of the National Coordinator for Health Information Technology has prepared some [guidance](https://www.acep.org/sections/17337). The Emergency Medicine Informatics Section provided the following information:

As portable medical orders designed to help future clinicians honor and implement a patient’s treatment wishes, the desirability of POLST forms, readily accessible in any emergency setting, is apparent. However, adoption and integration of POLST into electronic medical records (EMRs), and perhaps to a lesser degree Health Information Exchanges (HIEs), is to a large extent not dependent on technical factors. Currently, “POLST forms are different in each state — the order of the sections or the options within a section may be different — but they cover the same information.”
This variability may impede integration into the ED EMR/HIE workflow as it would require customization of these systems state-by-state. While technically possible, as a matter of course this is impractical from a cost, content management, and maintenance perspective. For example, POLST forms may encompass orders for the patient regarding resuscitation, medical interventions, fluids and nutrition – with dated physician signatures and contact information. However, the granularity of orders between different versions of POLST and even within a single POLST, may differ, creating inconsistent, even conflicting orders. Further, many executed POLST forms are retained in paper form. While technically possible, transforming these paper documents into codified orders would be very difficult (perhaps a manual process). Finally, the format of these orders may differ substantially from other EMR orders and may be internally inconsistent. Links to POLST repositories (assuming they exist in the state) would also require local customization. For example, in Arizona there is an “Arizona Advance Directive Registry” managed by the Secretary of State’s Office. It requires manual (paper) process to submit the advance directives and (apparently) also to register for both patients & providers. As a result, at a base level at most, EMR and HIE vendors may only be able to provide a simple web link to such repositories and even that may fail because of a lack of registration. “Widespread national availability and adoption” of POLST is not likely to be enhanced with EMR/HIE integration, and perhaps the opposite: It is unlikely vendors will address POLST integration until there is a critical mass of participation, uniformity of content, and established data integration standards. Recommendations: 1) Initiating POLST in the ED may be a worthwhile initiative but is less dependent on information technological capabilities than other public policy factors. 2) Initial efforts regarding POLST may best be focused on the first two RESOLVEDS, i.e. state adoption, form standardization, patient adoption, and provider registration or perhaps a uniform federal POLST initiative. 3) Once the above efforts have been accomplished, integration into various IT platforms should be relatively straightforward. 4) In our opinion, from an IT perspective, focusing on the third RESOLVED before accomplishing these other activities may create significant inefficiencies (aka “cart before the horse”). The Board reviewed the task force’s final report and recommendations in October 2019. The newly formed Health Information & Technology Committee was assigned objectives that continue on the work developed by the task force.

**Resolution 33 Separation of Migrating Children from Their Caregivers (as amended)**

RESOLVED, That ACEP opposes the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child’s well-being.

**Action:** This resolution is a policy statement. Assigned to the Public Health & Injury Prevention Committee to work with the Pediatric Emergency Medicine Committee to review and provide a recommendation on whether additional information is needed to include in the policy statement. ACEP issued a press release in June 2018 stating opposition to the “Zero Tolerance” immigration policy.

The Public Health & Injury Prevention Committee developed the policy statement “Separation of Children from Family Guardians” that was approved by the Board in June 2019.

**Resolution 34 Violence is a Health Issue**

RESOLVED, That ACEP will recognize violence as a health issue addressable through both the medical model of disease and public health interventions; and be it further

RESOLVED, That ACEP will pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

**Action:** ACEP has several policy statements addressing a wide variety of violence related issues and prevention for emergency physicians and patients that address the first resolved. Assigned second resolved to Public Affairs staff for federal advocacy initiatives. Assigned to the Federal Government Affairs Committee to determine whether model legislation should be developed.

ACEP’s Legislative & Regulatory Priorities for the First Session of the 116th Congress include “advocate for increased awareness of violence against healthcare workers in the ED and for increased safety measures in the ED.

In March 2019, ACEP sent a letter of support for H.R. 1309: The Workplace Violence Prevention for Health Care and Social Service Workers Act, asking Congress to consider how EDs are staffed to ensure the important provisions of this legislation are implemented appropriately. ACEP's letter requested additional clarity of the legislation's wording to ensure any new federal requirements do not create any unintentional burdens for entities that do not control the health care workplace. The House has approved the legislation, but as of January 2020, the Senate has not yet acted. Some senators have expressed interest in the issue and ACEP is continuing to work on a Senate strategy.

Resources on workplace violence are available on the ACEP website.

The Federal Government Affairs Committee determined that model legislation does not need to be developed at this time. A number of bills exist in the House and Senate to address a wide variety of aspects of violence, including efforts to improve Hospital-based Violence Intervention Programs (HVIPs). Other examples include H.R. 207, the Stop the Violence Act of 2019, to provide grants through the Centers for Disease Control and Prevention (CDC) to support...
violence prevention efforts, and a similar bill, H.R. 2464, the End the Cycle of Violence Act, to provide grants through the Department of Health and Human Services (HHS) to support violence prevention efforts. Additionally, ACEP has supported several bills, such as legislation to address workplace violence directed toward physicians and health care workers in health care institutions (H.R. 1309, the Workplace Violence Prevention for Health Care and Social Service Workers Act), as well as firearms-safety related legislation such as H.R. 8, the Bipartisan Background Checks Expansion Act to help prevent dangerous individuals from purchasing firearms, and others.

ACEP has partnered with ENA to launch a joint campaign, “No Silence on ED Violence,” to combat violence in the emergency department. The campaign launched at ENA’s annual conference in September 2019 and at ACEP19. Elements of the campaign include a standalone website with resources to help members address the problem in their hospitals and advocate for change at the hospital, state, and federal level. Advocacy resources include materials to support state legislative efforts for chapters and a social media campaign to engage ACEP and ENA members in sharing their stories to help highlight the extent of the problem. A public relations campaign launched in November 2019 to increase public and media awareness of the issue.

In September 2019, ACEP launched the new comprehensive, public website www.EmergencyPhysicians.org (replacing www.emergencycareforyou) that will provide the latest news, advocacy updates, and public health and safety tips directly from emergency physicians. The site includes information on violence in the ED.

**Resolution 36 ACEP Policy Related to Medical Cannabis (as amended)**

RESOLVED, That ACEP supports rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy or harm and the application of such results to the understanding and treatment of disease.

**Action:** This resolution is a policy statement. Assigned to the Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committee to review and provide a recommendation on whether additional information is needed to include in the policy statement. Assigned to the Federal Government Affairs Committee to determine whether model legislation should be developed.

The Emergency Medicine Practice Committee developed the policy statement “Medical Cannabis” that was approved by the Board in June 2019.

The Federal Government Affairs Committee determined that model legislation does not need to be developed at this time. ACEP supported bipartisan legislation (H.R. 3797) that was introduced in the House of Representatives by Rep. Earl Blumenauer (D-OR) on July 17, 2019. The legislation would amend the Controlled Substances Act (CSA) to make marijuana accessible for use by qualified researchers for medical purposes.

**Resolution 38 Antimicrobial Stewardship (as amended)**

RESOLVED, That ACEP work with relevant stakeholders to educate the public on the health implications of antimicrobial resistance and the importance of antimicrobial stewardship in the emergency department; and be it further

RESOLVED, That ACEP offer education aimed at emergency department clinicians on the hazards of antimicrobial overuse and strategies to prescribe antimicrobials appropriately; and be it further

RESOLVED, That ACEP disseminate an evidence-based resource and/or toolkit for emergency department clinicians to identify and implement clinician-level and system-level opportunities for antimicrobial avoidance.

**Action:** Assigned first resolved to the Public Relations Committee to develop messaging. The second resolved is addressed through the courses ACEP has already developed: Balancing Antibiotic Stewardship with Sepsis, Uncomplicated Diverticulitis: No More Antibiotics, and Antibiotics for Abscesses. The content for the “Balancing Antibiotic Stewardship with Sepsis” CME was developed as part of ACEP’s Emergency Quality Network (E-QUAL) Sepsis Initiative and is also available without need for login through the Sepsis Webinar Series webpage. Additional educational and CME opportunities on antibiotic stewardship are available and can be found on VirtualACEP. There are currently 13 active CME opportunities on antibiotic stewardship recorded at the 2015, 2016, and 2017 annual meetings.

The CDC has released the Core Elements of Hospital Antibiotic Stewardship Programs, an evidence-based antimicrobial stewardship toolkit for hospitals and for long-term care centers. An emergency department specific tool kit, based on CDC funded research and designed by emergency physicians, is in development. Assigned third resolved to the Public Health & Injury Prevention Committee to review the CDC toolkit, determine if ACEP should promote its availability, or if ACEP should develop a resource/toolkit.

Public Relations staff continue to speak with media to promote antibiotic stewardship in the ED. ACEP members were enlisted to author a DocBlog. Additionally, ACEP members have been solicited to write articles on related topics such as the role of antibiotics in treating UTI, promoting emergency thought leadership and clinical expertise in addressing sepsis, injury, inflammation, and other conditions responsibly and appropriately. Additional CDC materials and related items will be included as they become available.
The Public Health & Injury Prevention Committee reviewed a toolkit released by the CDC [Core Elements of Hospital Antibiotic Stewardship Programs](https://www.cdc.gov/drugresistance/pdf/core-elements-of-hospital-antibiotic-stewardship-program-2018.pdf), an evidence-based antimicrobial stewardship toolkit for hospitals and for long-term care centers. An emergency department specific tool kit, based on CDC funded research and designed by emergency physicians, was also in development. The committee agreed that ACEP should support the program and recommended that further work be done beyond the CDC toolkit to support and provide resources for EDs that are addressing antimicrobial stewardship. In June 2019, the Board approved disseminating the CDC’s [MITIGATE Antimicrobial Stewardship Toolkit](https://www.cdc.gov/drugresistance/hospital/mitigate.html) to members.

**Resolution 39 Care of the Boarded Behavioral Health Patient (as amended)**
RESOLVED, That ACEP develop a psychiatric boarding toolkit to help address the following:
- patient handoff and frequency of evaluation while boarding;
- activities of daily living for the boarded patient;
- initiation of mental health treatment while boarding; and
- development of ED psychiatric observational medicine.

*Action:* Assigned to the Emergency Medicine Practice Committee and to seek input from the Coalition on Psychiatric Emergencies. The committee reviewed work that was already completed and contacted ACEP chapters and other organizations working on this issue including Project Beta, the National Institute of Mental Health, The Wellbeing Trust, American Association for Emergency Psychiatry, California ACEP, the American Institute of Architecture, and the Veterans Administration. The committee compiled a list of resources that were reviewed by the Board in October 2019. The committee has continued communication with the Institute for Healthcare Improvement and the Wellbeing Trust to review conclusions to disseminate and build on their work.

**Resolution 40 Care of Individuals with Autism Spectrum Disorder in the Emergency Department**
RESOLVED, That ACEP work with relevant stakeholders to develop and disseminate educational materials for emergency physicians on the common conditions that cause individuals with Autism Spectrum Disorder to present to the emergency department, their assessment and management, and best practices in adapting the existing emergency department treatment environment to meet the needs of this population.

*Action:* Assigned to the Emergency Medicine Practice Committee and to consult with the California Chapter about potential collaboration since one of their members is already working with a committee at UCLA on this issue and has suggested partnering with ACEP. ACEP is also working on the “Serving Safely” grant that is targeted toward improving policing responses to individuals with autism or intellectual developmental disabilities (IDD). ACEP was identified as a partner because of the ED’s frequent role in the coordination of treatment and referral for these patients.

The Emergency Medicine Practice Committee and content experts developed the information paper “Autism Spectrum Disorder Point of Care Tool” that provides succinct information on autism spectrum disorders (ASD), barriers to care for these patients, best practices for interacting with ASD patients, medical and/or psychiatric conditions that may be present, recommendations for managing agitation, and additional resources on this condition. The Board reviewed the resource in October 2019. The point-of-care tool is available on the ACEP website: [ASD Tool](https://www.acep.org/care-of-ASD-patients) and it will be added to the mobile app in the near future.

**Resolution 41 Emergency Department and Emergency Physician Role in the Completion of Death Certificates (as amended)**
RESOLVED, That ACEP develop a toolkit to address the emergency physician’s role and responsibility for the completion of death certificates for patients who have died in the emergency department under their care.

*Action:* Assigned to the Emergency Medicine Practice Committee. The committee developed the policy statement “The Role of Emergency Physicians in the Completion of Death Certificates” that was approved by the Board in June 2019.

**Resolution 44 Firearm Safety and Injury Prevention Policy Statement (as substituted)**
RESOLVED, That ACEP update the Firearm Safety and Injury Prevention Policy to reflect the current state of research and legislation.

*Action:* Assigned to the Public Health & Injury Prevention Committee and to seek input from the task force that developed the current policy statement.

The committee prepared a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The draft policy was shared with the January 2013 Firearms Task Force that drafted the policy statement. Input from the task force was split. Some members of the task force were not in favor of revising the policy statement. It was noted that the resolution calls for updates to the policy that reflect the current state of
research and legislation. This was interpreted by some task force members to mean that changes should only be made to the policy if there has been new research or legislation, and since there has been no new research or legislation, no changes should be made to the policy. Other members of the task force provided some recommended changes to the draft.

A second draft was prepared based on the initial comments from some of the task force members. Limited comments were received from the task force in response to the second draft. The second draft and the input opposing revisions to the policy statement were shared with the committee. After consideration of the options, the committee supported pursuing revision of the current policy statement. The draft revised policy was reviewed by the Board in June 2019. The Board referred the draft policy back to the committee to provide references where possible to support the proposed changes. The Board approved the revised policy statement in October 2019.

**Resolution 45 Support for Extreme Risk Protection Order to Minimize Harm (as amended)**

RESOLVED, That ACEP support extreme risk protection orders legislation at the national level; and be it further.

RESOLVED, That ACEP promote and assist state chapters in the passage of state legislation to enact extreme risk protection orders by creating a toolkit and other appropriate resources to disseminate to state chapters; and be it further

RESOLVED, That ACEP encourage and support further research of the effectiveness and ramifications of extreme risk protection orders (ERPO) and Gun Violence Restraining Orders (GVRO).

**Action:** Assigned the first and third resolveds to Public Affairs staff for federal advocacy initiatives. Assigned second resolved to the State Legislative/Regulatory Committee.

The State Legislative/Regulatory Committee has compiled considerable information and is continuing to work on this resolution in the 2019-20 committee year.

ACEP sent a letter in support of H.R. 1236 the “Extreme Risk Protection Order Act of 2019” on October 1, 2019. The legislation would provide grants to states to implement ERPOs and would also create a federal ERPO program. As of January 2020, the legislation has not been considered by the full House of Representatives.

**Resolution 46 Law Enforcement Information Gathering in the ED Policy Statement (as amended)**

RESOLVED, That ACEP revise the policy statement “Law Enforcement Information Gathering in the Emergency Department” to reflect the recent relevant court decisions regarding consent for searches with or without a warrant to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

**Action:** Assigned to the Ethics Committee to work with the State Legislative/Regulatory Committee. In October 2019, the Board approved assigning an objective to the Ethics Committee in the 2020-21 committee year to develop a Policy Resource & Education Paper (PREP) as an adjunct to the policy statement “Law Enforcement Information Gathering in the Emergency Department.”

**Resolution 47 Supporting Medication for Opioid Use Disorder (as amended)**

RESOLVED, That ACEP work with the Pain Management & Addiction Medicine section to develop guidelines on the initiation of medication for opioid use disorder for appropriate emergency department patients; and be it further

RESOLVED, That ACEP advocate for policy changes that lower the regulatory barriers to initiating medication for opioid use disorder in the emergency department; and be it further

RESOLVED, That ACEP support the expansion of outpatient and inpatient opioid treatment programs and partnership with addiction medicine specialists to improve ED to outpatient care transitions.

**Action:** Assigned first resolved to the Pain Management & Addiction Medicine Section and the Emergency Medicine Practice Committee. The section is currently working on guidelines. Assigned second resolved to Public Affairs staff for federal advocacy initiatives. The Alternatives to Opioids (ALTO) in the ED Act and the Preventing Overdoses While in Emergency Rooms (POWER) Act were recently enacted and address the third resolved. Assigned to the State Legislative/Regulatory Committee to develop model state legislation for chapters to use to access the funding.

The State Legislative/Regulatory Committee has collected considerable information and is continuing to work on this resolution in the 2019-20 committee year.

The Pain Management & Addiction Medicine Section and the Emergency Medicine Practice Committee developed the point-of-care tool BUPE for the use of Buprenorphine in the ED.

On June 13, 2019, the House of Representatives approved a bipartisan amendment to provide $10 million for the Alternatives to Opioids (ALTO) in the Emergency Department program that was authorized in the 2018 opioid bill, the SUPPORT for Patients and Communities Act (P.L. 115-271). The amendment was offered to the Fiscal Year 2020 Labor/Health and Human Services (L/HHS) appropriations bill. ACEP DC staff worked with Rep. Pascrell's office to ensure the amendment was made in order and passed successfully. ACEP submitted a letter of support from and Rep. Pascrell's office informed submitted ACEP's letter of support for the amendment into the Congressional Record.

The Pain Management & Addiction Medicine Section continues to develop resources on pain management and
addiction medicine. ACEP has developed the **E-QUAL Network Opioid Initiative**, which includes toolkits, webinar series, podcasts, and other resources. The Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committees have developed **opioid resources** that are available on the ACEP website.

In May 2020, ACEP sent a letter to Rep. Tonko (D-NY) supporting H.R. 2482, the “Mainstreaming Addiction Treatment Act of 2019,” which would remove the x-waiver requirement also signed onto a letter to Congressional leadership written by the Pew Charitable Trusts supporting the same legislation. A letter was also sent to HHS expressing ACEP’s support for legislative and regulatory actions that would improve access to OUD treatment.

**Resolution 48 Recording in the Emergency Department (as amended)**

RESOLVED, That ACEP explore implications, solutions, and education/training to address (audio/video) recording in the emergency department to include surreptitious recording; and be it further

RESOLVED, That ACEP work with other interested parties, such as the American Medical Association and American Hospital Association, to coordinate regulatory and legislative efforts to address the implications of (audio/video) recording in the emergency department.

**Action:** Assigned first resolved to the Ethics Committee to work with the State Legislative/Regulatory Committee to review the policy statement “Recording Devices in the ED” and determine if any revisions are needed. Assigned second resolved to Public Affairs staff for federal advocacy initiatives.

The Ethics Committee developed the revised policy statement “**Audiovisual Recording in the Emergency Department**” (replacing the policy statement “Recording Devices in the Emergency Department”) that was approved by the Board in June 2019.

**Resolution 49 In Memory of C. Christopher King, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by C. Christopher King, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of C. Christopher King MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine, and to the patients and physicians of Pennsylvania, New York, and the United States.

**Action:** A framed resolution was prepared for Dr. King’s family.

**Resolution 50 In Memory of John Emory Campbell, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by John Emory Campbell MD, FACEP, as one of the leaders in Emergency Medicine and a pioneer of prehospital trauma education; and be it further

RESOLVED, That the American College of Emergency Physicians extends its condolences to Dr. Campbell’s family, friends, and colleagues for his tremendous service to Emergency Medicine and Emergency Medical Services.

**Action:** A framed resolution was prepared for Dr. Campbell’s family.

**Resolution 51 In Memory of Adib Mechrefe, MD, FACEP**

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Adib Mechrefe, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Mary (Freij) Mechrefe, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Rhode Island and the United States.

**Action:** A framed resolution was prepared for Dr. Mechrefe’s family.

**Council Standing Rules Resolutions**

**Resolution 11 Codifying the Leadership Development Advisory Committee (as amended)**

RESOLVED, That the Council Standing Rules be amended to include a new section titled “Leadership Development Advisory Group” to read:

The Leadership Development Advisory Committee (LDAC) is a Council Committee charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAC will offer to interested members
guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee.

**Action:** The Council Standing Rules were updated.

**Resolution 12 Nominating Committee Revision to Promote Diversity**

RESOLVED, That the “Nominating Committee” section of the Council Standing Rules be amended to read:

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practice institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates.

**Action:** The Council Standing Rules were updated.

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**Resolutions Referred to the Board of Directors**

**Resolution 27 Generic Injectable Drug Shortages**

RESOLVED, That ACEP prepare a press release calling for repeal of the group purchasing organization (GPO) safe harbor.

**Action:** Assigned to Public Affairs staff to review and provide a recommendation to the Board regarding further action on the resolution. In October 2019, ACEP staff provided information to the Board about actions that have been taken to address drug shortages, including ACEP’s work with the Drug Shortages Task Force. The Board approved taking no further action on the resolution. The FDA released the task force’s report on October 29, 2019.

**Resolution 35 ACEP Policy Related to Immigration**

RESOLVED, That ACEP affirms the right for all patients to access and receive emergency care regardless of country of origin or immigration status; and be it further

RESOLVED, That ACEP encourages emergency departments to establish policies forbidding collaboration between hospital staff and immigration authorities, unless required by signed warrant; and be it further

RESOLVED, That ACEP opposes determination of “public charge” used in determining eligibility for legal entry into the United States or legal permanent residency that would include health benefits or coverage.

**Action:** The first resolved is addressed by ACEP’s policy statement “Delivery of Care to Undocumented Persons.” Assigned second resolved to the Medical-Legal Committee to review and provide a recommendation to the Board regarding further action. The third resolved has already been addressed. On December 10, 2018, ACEP sent a letter to the Department of Homeland Security expressing objection to the proposed rule that would change the definition of public charge.

In June 2019, the Board approved the Medical-Legal Committee’s recommendation to take no further action on the resolution. The committee noted that policies already exist throughout the health care community to protect patient information, unless disclosure is required by law, and creating additional policy specific to providing information to immigration authorities would essentially be superfluous. Further, the committee noted the Fourth Amendment provides patients with a reasonable expectation of privacy and protects against unreasonable search and HIPAA requires patient information to be protected unless by a court order or in special circumstances not relevant to this issue. The U.S. Immigration and Customs Enforcement Agency also has policy stating that hospitals are included in the definition of “sensitive zones” where access by immigration officials is severely limited except in extraordinary circumstances.

**Resolution 42 Expert Witness Testimony**

RESOLVED, That ACEP revise the “Expert Witness Guidelines for the Specialty of Emergency Medicine” policy statement to define an expert witness as a person actively engaged in the practice of medicine during the year prior to the initiation of litigation who has the same level or greater training in the same field as the subject of the tort for a majority of their professional time.

**Action:** Assigned to the Medical-Legal Committee to review and provide a recommendation to the Board regarding further action on the resolution.

In June 2019, the Board approved the Medical-Legal Committee’s recommendation to take no further action on the resolution. The committee recognized that the intent of a requirement that experts be actively engaged in the practice of emergency medicine during the preceding year is to ensure their knowledge base is current. However, a one-year
requirement would eliminate many qualified experts who recently retired from practice. The requirement would also apply to defense experts, which could have the unintended consequence of limiting the number of qualified experts available to defend emergency physicians. The committee believes the requirement of three years in the current policy statement is appropriate. Concerns were also raised about the requirement that the expert have the same level or greater training than the defendant. A common plaintiff strategy is to try to give more weight to the expert’s opinion than the defendant’s decision making by using an expert with greater training, such as a physician with a fellowship in infectious disease, ultrasound, etc.
Memorandum

To: 2020 Council

From: Sonja Montgomery, CAE
        Governance Operations Director

Date: September 23, 2020

Subj: Action on 2017 Resolutions

The 2017 Council considered 62 resolutions: 39 were adopted, 5 were not adopted, 5 were withdrawn, 11 were referred to the Board of Directors, and 2 were referred to the Council Steering Committee.

The attached report summarizes the actions taken on the 2017 resolutions adopted by the Council and those that were referred to the Board and to the Council Steering Committee.
Resolution 1 Commendation for James M. Cusick, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends James M. Cusick, MD, FACEP, as a practicing emergency physician rendering excellent care to the patients we serve, for his leadership in the College as Council Vice Speaker and Council Speaker over the past four years, and for his lifetime of service and dedication to the specialty of Emergency Medicine.

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

Resolution 2 Commendation for Robert E. O’Connor, MD, MPH, FACEP
RESOLVED, That the American College of Emergency Physicians commends Robert E. O’Connor, MD, MPH, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. O’Connor.

Resolution 3 Commendation for Gordon B. Wheeler
RESOLVED, That the American College of Emergency Physicians commends Gordon B. Wheeler for his service as Associate Executive Director of Public Affairs.

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

Resolution 4 In Memory of Charles of R. Bauer, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Charles R. Bauer, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Charles R. Bauer MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of Texas and the United States.

Action: A framed resolution was prepared for Dr. Bauer’s family.

Resolution 5 In Memory of Diane Kay Bollman
RESOLVED, That ACEP and the Michigan College of Emergency Physicians hereby acknowledges the many contributions made by Diane Kay Bollman as one of the leaders in emergency medicine and the greater medical community; and be it further
RESOLVED, That ACEP and the Michigan College of Emergency Physicians extend to the family of Diane Kay Bollman, her friends, and her colleagues, our condolences along with our profound gratitude for her tremendous service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States and likely beyond.

Action: A framed resolution was prepared for Ms. Bollman’s family.

Resolution 6 In Memory of Aaron T. Daggy, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Aaron T. Daggy, MD, FACEP, as one of the leaders in pre-hospital medicine, EMS and fire, and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Aaron T. Daggy, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of New York and the United States.

Action: A framed resolution was prepared for Dr. Daggy’s family.
Resolution 7 In Memory of Geoffrey E. Renk, MD, PhD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Geoffrey Edmund Renk, MD, PhD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to his wife, Lisa Flaggman, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

Action: A framed resolution was prepared for Dr. Renk’s family.

Resolution 8 In Memory of Salvatore Silvestri, MD
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the contributions made by Sal Silvestri, MD, as a leader in emergency medicine and EMS; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Sal Silvestri, MD, our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to learn so much from a kind, gentle, caring leader in our emergency medicine world.

Action: A framed resolution was prepared for Dr. Silvestri’s family.

Resolution 9 In Memory of Robert Wears, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Wears, MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of the specialty; and be it further
RESOLVED, That national ACEP and the Florida College of Emergency Physicians extends to his wife, Dianne Wears, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine.

Action: A framed resolution was prepared for Dr. Wears’ family.

Resolution 10 Chapter Bylaws Conformance Standards – Housekeeping Change – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1, be amended to read:
A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and to the “Guidelines for Bylaws and Model Chapter Bylaws for Chapters of the American College of Emergency Physicians,” current approved chapter bylaws guidance documents. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

Action: The Bylaws were updated.

Resolution 12 Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two, be amended to read:
“ACEP Past Presidents, and ACEP Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions.”

Action: The Bylaws were updated.

Resolution 13 Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment
RESOLVED, That the “Debate” section, paragraph one, of the Council Standing Rules be amended to read:
“Councillors, members of the Board of Directors, past presidents, and past speakers, and past chairs of the Board 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, past chair, etc.), and whether they are speaking “for” or “against” the motion;” and be it further

RESOLVED, That the “Nominations” section, paragraph one, of the Council Standing Rules be amended to read:

“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, or past chair of the Board, after which nominations will be closed and shall not be reopened;” and be it further

RESOLVED, That the “Past Presidents and Past Speakers Seating” section of the Council Standing Rules be amended to read:

“Past Presidents, and Past Speakers, and Past Chairs of the Board Seating”

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

Action: The Council Standing Rules were updated.

Resolution 18 ACEP Wellness Center Services

RESOLVED, That ACEP explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Annual Conference Wellness Center; and be it further

RESOLVED, That ACEP explore ways to better promote available resources for the wellness center at the Annual Conference and in general throughout the year.

Action: Assigned to the Well-Being Committee, Corporate Development staff, and Member Communications & Marketing staff. Several changes were made for the 2018 Wellness Center and publicized on the ACEP website and other ACEP communications:

- Reinstated blood draws for 2018 and increased the fee to cover the cost.
- Reviewed the burnout survey and added online capability or iPad on site.
- Moved the pet therapy booth next to the wellness pod.
- Individual tasked with a hand clicker, scanner, wall-based scanned (how to incentivize attendees to scan their own badge on a wall) have giveaways of wellness t-shirt etc. to incentivize people to scan in be counted as a visitor.
- Wellness Center backdrop with hashtag to encourage group photos.
- Increase the speaker volume and add TED talk signage.
- Allow freelance drawing instead of an artist’s mural.
- Additional signage to promote the Story Booth.
- Additional seating, background music, and charging stations.
- Promoted the Wellness Center on social media.
- Provided fun photo opportunities.
- Distributed buttons, t-shirts, and a water bottle with the wellness logo or #Wellness.
- Asked Wellness Champions to announce speakers.

In April 2019, the Board reviewed the results of the lab services offered in the Wellness Center during ACEP18. Only 44 individuals took advantage of the lab services. The direct costs for offering lab services totaled $26,320 resulting in a loss of $17,520 to provide lab services. The Board approved discontinuing offering lab services in the wellness center at ACEP19 and focus on other year-round wellness programs led by the Well-Being Committee and the Wellness Section.

Resolution 22 Funding of Emergency Medicine Training (as amended)

RESOLVED, That ACEP work with the appropriate organizations to optimize GME funding for all formats of emergency medicine training.

Action: Assigned to the ACEP-SAEM GME Work Group and to the Public Affairs staff for federal advocacy initiatives. ACEP’s Legislative & Regulatory Priorities for the First and Second Sessions of the 116th Congress include: 1) work with Members of Congress to increase the overall number of federally funded GME slots; 2) work with CMS to ensure that emergency medicine 3-year and 4-year residency training programs are appropriately funded; 3) monitor the expansion of the overall number of emergency medicine residency slots; and 4) monitor diversion of GME funds/resources from physicians to other types of providers.
Resolution 23 Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships (as amended)

RESOLVED, That ACEP work with state chapters to identify, develop, and implement processes that enhance the relationship, optimizing appropriate and timely information sharing; and be it further
RESOLVED, That individual Board members and an appropriate staff member participate in regular contact with state chapters and report back to the Council in 2018.

Action: Assigned to the National/Chapter Relations Committee and Chapter & State Relations staff. The following strategies were implemented:
1. Basecamp as a collaboration tool for sharing information and resources between chapter executives.
2. Regular communication from national to the chapters with information about Board meetings, communications from the president, and ACEP Leadership Updates.
3. Regular communication about national activities, programs, partnerships, opportunities, etc. to chapter executives and chapter presidents with encouragement to include relevant notifications in communications to chapter members as appropriate.
4. Continue holding bi-annual all-chapter audio conferences.
5. Continue providing funding for the Chapter Leader Visit Rotation Program (national ACEP provides funding for national leaders to visit up to 20 chapters each year).
6. Sent “Welcome” letters to newly installed/elected chapter presidents (with copy to the chapter executive director). The letter highlights the resources and support provided by national ACEP to chapters.
7. Held Chapter Leadership sessions at LAC18 and LAC19 for current or aspiring chapter leaders and provides strategies for effectiveness in their role. Topics included state advocacy, chapter finances, how to be an effective chapter leader, how to create an effective and diverse Board, and succession planning. Session leaders included national ACEP Board members and staff as well as chapter leaders and staff.
8. Launched the chapter engagED online community. Additional community groups can be created for many topic areas or groups, such as Chapter Officers (to discuss issues, share resources, ask questions) and Chapter Membership Chairs (to share best practices, challenges on membership recruitment, retention, and engagement).

These communication efforts are ongoing. Chapter Executives Leadership Summits were held at ACEP in November 2018 and November 2019. The summits provide valuable information and communications between chapter executives and staff.

Resolution 25 Resolution Co-Sponsorship Memo

RESOLVED, That the Council Steering Committee develop and promote a standardized format for a “co-sponsorship memo” that can be distributed through the Council listserv or other platform so that councillors may collaborate and further refine resolutions prior to submission.

Action: The Council Steering Committee discussed the resolution at their February 2018 meeting. The new engagED community platform was launched. This platform provides the means for collaboration and information sharing. Resolution topics and resolutions in development can be shared in this forum and cosponsors can be identified. A “Resolution Preparation Checklist” was also created. The “Guidelines for Writing Resolutions” document was updated to reference the checklist. A Council Forum session was held at LAC19 that focused on resolution development. Another Council Forum was scheduled for LAC20 but it was cancelled when all spring meetings were cancelled because of COVID-19.

Resolution 26 Study of Locums Physicians Representation (as amended)

RESOLVED, That the ACEP Board study the impact and potential membership benefit of a new chapter or section representing locums physicians and report back to the Council at the 2018 meeting.

Action: The Board approved formation of the section in February 2018. The Steering Committee discussed the resolution at their February 2018 meeting and interpreted that formation of the section met the intent of the resolution. Authors of the original resolution clarified that the intent of the resolution was to conduct a study because the section may not meet be sufficient to meet the needs of locums physicians. The Membership Committee was assigned an objective for 2018-19 to conduct the study.

The section met the minimum requirements for membership and was allocated a councillor for the 2019 Council meeting. The Membership Committee completed the study and shared their findings with the Board of Directors in October 2019. The Board approved the committee’s recommendation to take no further action to create a chapter representing locums tenens emergency physicians.
Resolution 27 9-1-1 Number Access and Prearrival Instructions
RESOLVED, That ACEP create a policy statement supporting 9-1-1 number access to a Public Safety Answering Points for 100% of the U.S. population at next generation 9-1-1 level; and be it further
RESOLVED, That ACEP create and advocate for broad recognition of a policy statement supporting every Public Safety Answering Point or EMS dispatch point be able to give appropriate medical prearrival instruction for bystander aid, including CPR and hemorrhage control, and include EMS physician involvement in their creation, implementation, and quality improvement activities; and be it further
RESOLVED, That ACEP work with appropriate stakeholders to inventory and summarize models for 9-1-1 and Public Safety Answering Point funding as a resource for areas in need of increased service levels; and be it further
RESOLVED, That ACEP work with appropriate stakeholders to engage in development of model legislation incorporating enduring funding streams for 9-1-1 call centers/Public Safety Answering Points incorporating key elements including: bringing systems to at least the next generation 9-1-1 level, providing medically appropriate prearrival instructions, and incorporating EMS physician involvement in quality oversight, response profiles, and prearrival instructions.
Action: Assigned to the EMS Committee with input from the State Legislative/Regulatory Committee and Chapter & State Relations staff.
In December 2017, ACEP was invited by the National Highway Traffic Safety Administration (NHTSA) to participate as a stakeholder in the Next Generation 911 (NG911) project. The primary author of this resolution was appointed to serve as ACEP’s representative on the project.

Resolution 28 Coverage for Patient Home Medication While Under Observation Status (as amended)
RESOLVED, That ACEP support the coverage of all administered medications for patients under observation status without having to apply for reimbursement; and be it further
RESOLVED, That ACEP support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.
Action: This resolution is a policy statement. Assigned to the Reimbursement Committee to review and determine if additional language was needed in the policy statement. Assigned to Public Affairs staff for federal advocacy initiatives.
The Board approved the policy statement “Coverage for Patient Home Medication While Under Observation Status” in June 2018. ACEP’s Legislative & Regulatory Priorities include “Monitor CMS/OIG reports and public-understanding on use of observation units that are protocol driven.”

Resolution 29 CPR Training (as amended)
RESOLVED, That ACEP draft model state legislation and assist chapters in advocating for CPR training in schools; and be it further
RESOLVED, That ACEP work with other stakeholder organizations to advocate for legislation to support CPR training in schools; and be it further
RESOLVED, That ACEP work with other stakeholder organizations to advocate for increased CPR training for laypersons.
Action: Assigned to the State Legislative/Regulatory Committee and Chapter & State Relations staff with input from the EMS Committee. The committee collaborated with the EMS Committee and obtained material from outside resources to develop a toolkit of resources that are available on the ACEP website.
ACEP has taken an active role in supporting and sponsoring layperson CPR training through partnering with the Texas College of Emergency Physicians for the Texas Two-Step Hands-Only CPR training. In 2017, 6,500 were trained across the state. During EMS Week 2017, ACEP partnered with the International Association of Fire Chiefs (IAFC) and American Medical Response (AMR) to sponsor the World CPR Challenge where more than 68,000 bystanders were trained nationwide.
In June 2018, the Board approved ACEP pursuing development of a program for laypersons to stop bleeding and render CPR. A business plan was developed and in June 2019, the Board approved the “Until Help Arrives” program. This program is designed for ACEP members to offer resources to their home communities. The campaign has broad appeal and presents an opportunity to partner with a variety of other healthcare provider groups on its training delivery. ACEP is also reaching out to other medical partners, emergency medicine organizations, the EMS community, and other medical associations to create partnerships for course delivery.
EMS Week 2019 featured the Stop the Bleed/CPR Challenge. In January 2019, ACEP was invited by the National Academies of Sciences, Engineering, and Medicine to participate as a stakeholder in their development of a Stop the
Bleed Action Collaborative. The collaborative was organized under the existing National Academies’ Forum on Medical and Public Health Preparedness for Disasters and Emergencies of which ACEP has been a member for several years.

**Resolution 30 Demonstrating the Value of Emergency Medicine to Policy Makers and the Public (as amended)**

RESOLVED, That a repository of public relations materials demonstrating the value of emergency medicine, including printed, video, and other information including emergency medicine economic research be assembled on the ACEP web site and such materials would be accessible to all members of ACEP who wish to reach specific target markets; and be it further

RESOLVED, That specific public relations materials regarding the value of emergency medicine be developed for legislators, which would include printed material and materials in various electronic formats; and be it further

RESOLVED, That the ACEP Board of Directors provide a report to the 2018 Council on the development and distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the public.

**Action:** Assigned to the Public Relations Committee and Public Relations staff. The Board of Directors approved funding of up to $100,000 in October 2017 to fund a study on the value and cost effectiveness of emergency care.

A repository of materials was developed demonstrating the value of emergency medicine and is available on the ACEP website. Additionally:

- Developed a new fact sheet about the value of emergency medicine.
- As part of promoting ACEP’s 50th anniversary, filmed and posted dozens of one-minute videos of members telling their stories about the value of emergency medicine.
- Developed and promoted a public opinion poll about the value of emergency medicine. The poll results found high trust and high satisfaction for emergency care.
- Continued to promote the Saving Millions campaign to policymakers and the general public. Campaign tools included web and print advertising in Washington, DC, policymaker publications and included a link to ACEP’s website [www.SavingMillions.org](http://www.SavingMillions.org).
- As insurance company giant Anthem Blue Cross Blue Shield began implementing a policy that devalued emergency care and denied coverage for patients, ACEP conducted its Fair Coverage campaign. Three viral videos were released in 2018 pushing back and promoting messages about the need to protect emergency care and emergency patients. ACEP promoted the videos through the news media and through Facebook ads, generating more than 600,000 views.
- Conducted a marketing campaign in 2018 to the general public to promote the value of emergency medicine and to promote emergency physicians as experts and as leaders in finding solutions to the opioid crisis. The campaign tools included a press release, a flyer, website and web banner ads on Facebook, generating results that exceeded estimates with a click-through rate of 3.15%, which is four times Facebook’s benchmark for health care campaigns. The ad campaign generated more than 20,000 click-throughs to ACEP’s FairCoverage.org site.
- Promoted ACEP’s consumer website, which promotes the value of emergency medicine to the general public. ACEP refreshes and promotes content on this site, and at least monthly develops and distributes a press release about a consumer health and safety topic, such as flu, hot cars and carbon monoxide poisoning. These statements promote emergency physicians as medical experts and help create a white-hat environment in which ACEP can advocate.
- ACEP’s external Twitter feed, @EmergencyDocs, has grown to more than 15,000 followers and includes policymakers and national health policy reporters. Relevant news stories that promote the value of emergency medicine (such as life-saving stories) are tweeted every day.
- The Value of Emergency Medicine study was completed in August 2019. The results of the study are pending publication.

In 2019, the Council and the Board of Directors adopted Amended Resolution 18(19) Promoting Emergency Physicians. The resolution directs ACEP to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of emergency physicians and to partner with the American Medical Association and other national medical societies on a campaign to promote the unique skill set, knowledge base, and value of residency-trained and board certified physicians. ACEP’s Strategic Plan includes developing and promoting resources that demonstrate the value of emergency medicine.

**Resolution 31 Development and Study of Supervised Injection Facilities (as amended)**

RESOLVED, That ACEP join their partner organization, the American Medical Association, in supporting the development and study of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities for their feasibility, effectiveness, and legal aspects as a potential public health intervention in areas and communities heavily impacted by IV drug use.
**Action:** Assigned to the Public Health & Injury Prevention Committee. The committee developed the information paper “After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use.”

**Resolution 32 Essential Medicines (as amended)**
RESOLVED, That ACEP collaborate with other medical organizations to speak with a unified voice to government agencies and elected officials as to the urgent need for resolution of the on-going crisis of lack of access to emergency drugs; and be it further
RESOLVED, That the ACEP Board of Directors make developing and promoting federal legislation to ensure adequate drug supply of critical medications a priority for ACEP’s legislative agenda;

**Action:** Assigned to the Federal Government Affairs Committee to include in ACEP’s legislative priorities and to Public Affairs staff to include in federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress and for the First Session of the 116th Congress.

ACEP staff developed and led a successful effort to urge the FDA to convene a Drug Shortages Task Force to identify the root causes of drug shortages. ACEP drafted a bipartisan congressional sign-on letter, and secured lead Congressional sponsors for it of Reps. Brett Guthrie (R-KY) and Mike Doyle (D-PA) in the House, and Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), that garnered 107 and 31 signatories, respectively. ACEP arranged to have members advocate for the letter as part of the 2018 Legislative & Advocacy Conference and through the 911 Network. These efforts were supplemented by ACEP staff and several other physician specialties affected by drug shortages that ACEP contacted to strengthen its efforts. The letter was successful in that just several weeks later, FDA Commissioner Gottlieb announced the creation of a new Drug Shortages Task Force to identify and address the root causes of drug shortages. His statement used verbatim language from the ACEP-led Congressional letter in describing the task force and its charge. ACEP staff maintained direct contact with the FDA’s lead staff of the task force to ensure ACEP was represented in this effort. Details about ACEP’s efforts are available on ACEP’s website.

On September 20, 2018, ACEP President Paul Kivela, MD, MBA, FACEP, participated in a drug shortage summit hosted by the American Society of Anesthesiologists, the American Hospital Association, and the American Society of Health-System Pharmacies. The summit focused on the national security aspect of drug shortages and ways to improve the resilience of the nation’s health care infrastructure. Many of the speakers were federal employees representing HHS, ASPR, FDA, CDC, and the Defense Logistics Agency (DLA) who engaged the attendees in discussions on how their programs could work better to facilitate patient care, improve transparency and communications, and more effectively utilize the supply chain capacity.

ACEP’s Legislative & Regulatory Priorities for the First Session of the 116th Congress included: “Work with Congress to enact recommendations of the FDA Drug Shortage Task Force” and “Work with the FDA to reduce drug shortages and opioid abuse.” On January 10, 2019, ACEP submitted an official response to the Drug Shortages Task Force that was convened by the FDA. On September 16, 2019, Reps. Brett Guthrie (R-KY) and Eliot Engel (D-NY), along with 92 other bi-partisan lawmakers, sent a letter to Acting FDA Commissioner Dr. Ned Sharpless urging the agency to prioritize the release of the interagency Drug Shortages Task Force report. ACEP and other interested parties participated in ongoing discussions with the FDA. The FDA released the long-anticipated report on October 29, 2019.

ACEP’s Legislative & Regulatory Priorities for the Second Session of the 116th Congress include “Work with the FDA to reduce drug shortages.”

**Resolution 34 Generic Injectable Drug Shortages (as amended)**
RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of the shortage of generic injectable drugs and educate our members, the general medical community, and the public on this critical issue and how to solve it; and be it further
RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to seek Congressional legislative repeal of the Group Purchasing Organizations’ safe-harbor protection.

**Action:** Assigned to Public Affairs staff to pursue this initiative through appropriate channels, such as continued involvement with the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the Campaign for Sustainable Rx Pricing.

ACEP met and consulted with other medical specialties and discussed potential strategy. Additionally, ACEP broached the topic of the potential role of GPOs with some congressional staff, though congressional staff and members of Congress are reticent to make any specific assertions or take action without clear, compelling, and evidence-based research to support any legislative efforts. Early in 2018, ACEP became aware that a member of Congress was looking into possible legislation to repeal the safe harbor repeal but ultimately declined to do so. ACEP worked with congressional appropriators in an attempt to secure language in H.R. 6470, the FY2019 Departments of Labor, Health and Human
“Shortages of critical drugs continue to impact the delivery of health care in the U.S. The committee requests that GAO build upon its existing examinations of the causes of drug shortages and specifically examine the role of group purchasing organizations (GPO) and their related safe harbor in shortages.”

This language was shared with House Appropriations Committee Chairman Tom Cole (R-OK), but unfortunately it was not included in the committee report accompanying the legislative text.

ACEP staff developed and led a successful effort to urge the FDA to convene a Drug Shortages Task Force to identify the root causes of drug shortages. ACEP drafted a bipartisan congressional sign-on letter, and secured lead Congressional sponsors for it of Reps. Brett Guthrie (R-KY) and Mike Doyle (D-PA) in the House, and Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), that garnered 107 and 31 signatories, respectively. ACEP then arranged to have members advocate for the letter as part of the 2018 Legislative & Advocacy Conference and through the 911 Network; these efforts were supplemented both by ACEP staff as well as several other physician specialties affected by drug shortages that ACEP contacted to strengthen its efforts. The letter was successful in that just several weeks later, FDA Commissioner Gottlieb announced the creation of a new Drug Shortages Task Force to identify and address the root causes of drug shortages.

His statement used verbatim language from the ACEP-led Congressional letter in describing the task force and its charge. ACEP staff maintained direct contact with the FDA’s lead staff of the task force to ensure ACEP was represented in this effort. Details about ACEP’s efforts are available on ACEP’s website.

ACEP has remained active in working with the Drug Shortages Task Force, including:

On September 20, 2018, ACEP President Paul Kivela, MD, MBA, FACEP, participated in a drug shortage summit hosted by the American Society of Anesthesiologists, the American Hospital Association, and the American Society of Health-System Pharmacies. The summit focused on the national security aspect of drug shortages and ways to improve the resilience of the nation’s health care infrastructure. Many of the speakers were federal employees representing HHS, ASPR, FDA, CDC, and the Defense Logistics Agency (DLA) who engaged the attendees in discussions on how their programs could work better to facilitate patient care, improve transparency and communications, and more effectively utilize the supply chain capacity. In October 2018, ACEP President Vidor Friedman, MD, FACEP, participated in an invitation-only FDA listening session on drug shortages and shared how drug shortages affect emergency patients in particular. In November 2018, ACEP DC staff attended the FDA Drug Shortages Task Force public meeting held in Washington, DC. In July 2019, ACEP DC staff spoke with Keagan Lenihan, Chief of Staff to FDA Commissioner Dr. Ned Sharpless about the status of the Drug Shortage Task Force report. The FDA is still trying to get the report out by the end of year.

ACEP’s Legislative & Regulatory Priorities for the First Session of the 116th Congress included: “Work with Congress to enact recommendations of the FDA Drug Shortage Task Force” and “Work with the FDA to reduce drug shortages and opioid abuse.” On January 10, 2019, ACEP submitted an official response to the Drug Shortages Task Force that was convened by the FDA. On September 16, 2019, Reps. Brett Guthrie (R-KY) and Eliot Engel (D-NY), along with 92 other bi-partisan lawmakers, sent a letter to Acting FDA Commissioner Dr. Ned Sharpless urging the agency to prioritize the release of the interagency Drug Shortages Task Force report. ACEP and other interested parties have participated in ongoing discussions with the FDA, but we have been awaiting the release of the report.

A similar resolution was submitted to the 2018 Council. Resolution 27(18) Generic Injectable Drug Shortages called for ACEP to prepare a press release calling for repeal of the group purchasing organization (GPO) safe harbor. It was referred to the Board of Directors. In October 2019, ACEP staff provided information to the Board about actions that have been taken to address drug shortages, including ACEP’s work with the Drug Shortages Task Force. The Board approved taking no further action on the resolution. The FDA released the task force’s report on October 29, 2019.

ACEP’s Legislative & Regulatory Priorities for the Second Session of the 116th Congress include “Work with the FDA to reduce drug shortages.”

Resolution 36 Maternity and Paternity Leave (as amended)

RESOLVED, That ACEP advocate for paid parental leave for emergency physicians; and be it further
RESOLVED, That ACEP develop an information paper on best practices regarding paid parental leave for emergency physicians; and be it further
RESOLVED, That ACEP’s Board of Directors report their findings at the 2018 ACEP Council.

Action: Assigned to the Well-Being Committee. The committee revised the “Family Leave of Absence” policy statement to include the tenets of the resolution and it was approved by the Board in June 2019. The committee continues to work on developing an information paper or Policy Resource & Education Paper (PREP) as an adjunct to the policy statement.

Resolution 39 ACEP Involvement in State Legislative Activities (as amended)

RESOLVED, That ACEP develop policy that addresses ACEP involvement in state level regulatory and legislative
agendas, including direct lobbying efforts, by in coordination with the state chapter and consistent with ACEP policy; and be it further

RESOLVED, That ACEP present a policy that addresses ACEP involvement in state level regulatory and legislative activities for consideration and comment at the 2018 Council meeting.

Action: Assigned to the State Legislative/Regulatory Committee. In May 2018, the Board approved the following policy:

If a conflict arises between a chapter and national ACEP regarding a state legislative issue, national ACEP leadership must consider whether the disagreement is a matter of strategy or a matter of policy. on issues of strategy, national should defer to the chapter, given the chapter’s better understanding of local political dynamics. on issues of policy, national should intervene if the issue is material to the specialty or counter to existing ACEP policy. First, national ACEP should take action to find a position that is in the best interests of the specialty and the chapter by reaching out to the chapter leadership. if no compromise can be reached, then national ACEP may choose to take a position that differs from the chapter position and would become the official position of the specialty.”

Additionally, the Board approved the following actions: 1) increase frequency and improve quality of communication between chapters and the national ACEP Board and staff on important state legislative issues to help prevent disagreements from arising; 2) direct the State Legislative/Regulatory Committee and the National/Chapter Relations Committee to investigate alternate methods to convene representatives from a chapter or multiple chapters for consultation between Council meetings in the case of important state legislative issues requiring further urgent discussion.

Resolution 40 Reimbursement for Emergency Services (as amended)

RESOLVED, That the policy of many third party payers of denying payment for Emergency Medical Services is in opposition to the prudent layperson definition of an emergency and federal EMTALA laws; and be it further

RESOLVED, That ACEP work with third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care; and be it further

RESOLVED, That ACEP, in order to promote public health and patient safety, continue to uphold federal EMTALA laws by providing a medical screening examination and appropriate medical care to all patients who request emergency services and ACEP will advocate for subsequent reimbursement for such services; and be it further

RESOLVED, That ACEP continue to advocate for our patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services; and be it further

RESOLVED, That ACEP partner with affected states and the American Medical Association to oppose this harmful policy and the denial of payment for emergency services.

Action: This resolution has been addressed through the work of the Reimbursement Committee, the ACEP/EDPMA Joint Task Force on Reimbursement Issues, and federal advocacy initiatives by ACEP’s Public Affairs staff.

The AMA adopted a resolution in June 2017 that addresses these issues and also sent a letter to Anthem on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage. ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem’s assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem’s denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA developed model legislation, “Patient Protections from Unanticipated Out-of-Network Care Act,” that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) has formally adopted a “skinny version” of the original AMA model with the network adequacy and assignment of benefits provisions removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician’s actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors discussed the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). On July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem’s Blue Cross Blue Shield of Georgia in federal court in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies...
Following five years of meetings and attempts by ACEP staff to obtain an explanation from the United States Center for Consumer Information and Insurance Oversight (CCIIO) regarding the methodology used in the 2010 Interim Final Rule governing payments of out-of-network emergency services, ACEP filed suit on May 12, 2016, against the Departments of Health & Human Services, Labor, and Treasury (“the Departments”) challenging the Greatest-of-Three (“GOT”) regulation. On August 31, 2017, the U.S. District Court for the District of Columbia (the “Court”) partially granted ACEP’s Motion for Summary Judgment and denied the Government’s Cross Motion for Summary Judgment, finding that the Departments failed to seriously respond to comments and proposed alternatives submitted by ACEP and others regarding perceived problems with the GOT regulation. On April 30, 2018, the Departments published in the Federal Register the “Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Recissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act”. In this final regulation, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP’s proposal to use an independent database to set payment rates. On May 19, 2018, the Board of Directors approved dismissing the lawsuit based upon recommendation of legal counsel, noting that the suit was successful in providing the College with valuable information, such as the “NORC Report,” and sent a strong message that ACEP will fight on behalf of the rights of its members; however, the likelihood of ultimately prevailing was low and ACEP’s legal resources could be best utilized in other arenas. Based upon a Joint Stipulation of Dismissal filed with the Court on May 23, 2018, Judge Colleen Kollar-Kotelly signed the Order dismissing the case. In June 2018, the Board discussed legislative and regulatory strategies and next steps for pursuing the Greatest-of-Three methodology governing payments for out-of-network emergency services with CCIIO.

ACEP continues to work on this issue and assist chapters in their efforts. State public policy grants have been provided to several chapters to support efforts on out-of-network/balance billing legislation.

**Resolution 43 Expanding ACEP Policy on Workforce Diversity in Health Care Settings (as amended)**

RESOLVED, That ACEP expand its policy statement “Workforce Diversity in Health Care Settings” to help identify and promote inclusion of qualified individuals with additional diverse characteristics (including racial and ethnic diversity, as per existing policy) and amend it to read:

The American College of Emergency Physicians believes that:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, and other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care; and
- Attaining diversity with well-qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal.

*Action:* The “Workforce Diversity in Health Care Settings” policy statement was revised in November 2017.

**Resolution 44 Guidelines for Opioid Prescribing in the ED**

RESOLVED, That ACEP encourage electronic medical record providers to incorporate easy-to-use Prescription Monitoring Programs functionality into their products; and be it further

RESOLVED, That ACEP strongly discourage mandates for screening all emergency department patients for opioid use; and be it further

RESOLVED, That ACEP promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

*Action:* Assigned to the Emergency Medicine Practice Committee to review ACEP’s current policy statements to determine if revisions are needed and review the current resources available to determine if additional resources are needed. ACEP’s clinical policy “Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department” is currently under review by the Clinical Policies Committee.

The Emergency Medicine Practice Committee reviewed the policy statement “Ensuring Emergency Department Patient Access to Appropriate Pain Treatment.” The policy statement supports ACEP chapter autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control with physician clinical judgement. The EQUAL Network has also developed guidelines in association with the EQUAL Opioid Management focus area.

On June 12, 2018, two bills were passed in the House of Representatives that were championed by ACEP:

- The Alternatives to Opioids (ALTO) in the Emergency Department Act (H.R. 5197 – Pascrell/McKinley; S. 2516 – Booker/Capito)
- Provides grants to help emergency departments and hospitals implement non-opioid, evidence-based pain management protocols, based on the successful and proven ALTO program developed at St. Joseph’s in Paterson, New Jersey.
- In New Jersey, the ALTO program at St. Joseph’s Hospital saw opioid prescriptions drop by 82 percent over two years. These results were recently replicated at 10 hospitals in Colorado, where hospital systems noted a 36 percent drop in opioid prescriptions in the first six months of the program.

The Preventing Overdoses While in Emergency Rooms (POWER) Act

(H.R. 5176 – McKinley/Doyle; S. 2610 – Capito/Murphy)
- Provides grants to establish policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department, and to develop best practices to provide a “warm handoff” to appropriate community resources and providers to keep patients engaged in treatment. MAT is a proven medical treatment that can relieve withdrawal symptoms and psychological cravings of opioid use disorder.
- Studies show success for this model – after one month, 78 percent of patients remained in addiction treatment programs with ED-initiated MAT, compared to 37 percent when given only a simple referral in the ED to treatment in the community.

On June 13, 2019, the House of Representatives approved a bipartisan amendment to provide $10 million for the Alternatives to Opioids (ALTO) in the Emergency Department program that was authorized in the 2018 opioids bill, the SUPPORT for Patients and Communities Act (P.L. 115-271). The amendment was offered to the Fiscal Year 2020 Labor/Health and Human Services (L/HHS) appropriations bill. ACEP DC staff worked with Rep. Pascarell's office to ensure the amendment was made in order and passed successfully. ACEP submitted a letter of support from and Rep. Pascarell's office informed submitted ACEP's letter of support for the amendment into the Congressional Record.

The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine. ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources. The Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committees have developed opioid resources that are available on the ACEP website.

Resolution 49 Participation in ED Information Exchange and Prescription Drug Monitoring Systems

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate their participation in state prescription drug monitoring programs; and be it further

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures, to encourage and facilitate their participation, to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits and hospital care plans for frequent users of emergency departments.

Action: Assigned to Public Affairs staff to work with the cited agencies and to Chapter & State Relations staff to support chapter advocacy efforts for adoption of EDIE programs and implementation of effective state prescription drug monitoring programs. ACEP’s Legislative and Regulatory Priorities for the Second Session of the 115th Congress included “support funding for voluntary, interstate prescription drug monitoring programs” and “promote DoD, VA, and HIS prescription data sharing with state PDMPs.”

An ACEP-developed provision that requires the Department of Defense to share controlled substance prescribing information of TRICARE beneficiaries with State Prescription Drug Monitoring Programs was successfully passed into law as part of H.R.5515, the John S. McCain National Defense Authorization Act for Fiscal Year 2019. ACEP staff worked closely with Representative Mike Turner (D-OH) to develop this legislative effort and ensure its inclusion in the defense authorization bill. A month later, Rep. Turner and Rep. Seth Moulton (MA) sent a letter to the Secretary of Defense advancing this initiative. The “Sharing Health Information to Ensure Lifesaving Drug Safety” (SHIELDS) Act (2018 H.R. 5591) was introduced in April 2018 and passed into law in August 2018. In January 2019, Virginia became the first state to systematically integrate its PDMP with those of the DoD Medical Treatment Facilities.

ACEP’s Legislative & Regulatory Priorities for the First Session of the 116th Congress included: “support funding for voluntary, interstate prescription drug monitoring programs” and “seek Indian Health Service submission of prescription records to state PDMPs.” Unfortunately, there is no central authority that can mandate HIS action. Each tribe/nation makes their own determination and most tribes have very little resources.

In May 2019, ACEP met with IHS to discuss ways to work together to improve care for Native Americans. A two-year non-financial memorandum of understanding (MOU) was developed in September 2019 between ACEP and IHS to explore opportunities for collaboration in the following areas: emergency physician recruitment and retention; emergency physician resident training at IHS sites; provider training/knowledge transfer in key topic areas to be identified; clinical guidelines and best practices in key topic areas to be identified; technical assistance in key topic areas to be identified; collaboration with ACEP on IHS-related or American Indians/Alaska Natives-related topics as well as fellowship projects.
or rotations; practice-based research to improve quality; and achieving health equity for the American Indian/Alaska Native population.

Resolution 51 Retirement or Interruption of Clinical Emergency Medicine Practice

RESOLVED, ACEP study and evaluate mechanisms to support practicing emergency physicians to help recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement; and be it further

RESOLVED, That ACEP actively engage in developing resources and communication of career transition opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

Action: Assigned to the Well-Being Committee to review ACEP’s current resources, including the report developed by the ACEP/ABEM Aging Physician Task Force, and develop additional resources as needed, specifically to address interruption of clinical emergency medicine practice. The committee continues to work on developing resources.

Resolution 52 Support for Harm Reduction and Syringe Services Programs

RESOLVED, That ACEP endorse Syringe Services Programs for those who use injection drugs; and be it further

RESOLVED, That ACEP promote the access of Syringe Services Programs to people who inject drugs; and be it further

RESOLVED, That ACEP invest in educating its members on harm reduction techniques and the importance of Emergency Departments to partner with local Syringe Services Programs to advance the care of people who inject drugs.

Action: Assigned to the Public Health & Injury Prevention Committee. The committee developed the information paper “After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use.”

Resolution 55 Workplace Violence (as amended)

RESOLVED, That ACEP move past policy creation and simple awareness campaigns with state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling provided), to ensure safety in the Emergency Department for patients and staff; and be it further

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters and hospitals addressing workplace violence.

Action: Assigned to the State Legislative/Regulatory Committee and to Public Affairs staff for federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress and the First Session of the 116th Congress. The State Legislative/Regulatory Committee compiled information and resources to develop a toolkit for chapters.

In March 2019, ACEP sent a letter of support for H.R. 1309: The Workplace Violence Prevention for Health Care and Social Service Workers Act, asking Congress to consider how EDs are staffed to ensure the important provisions of this legislation are implemented appropriately. ACEP's letter requested additional clarity of the legislation's wording to ensure any new federal requirements do not create any unintentional burdens for entities that do not control the health care workplace. The House has approved the legislation, but as of January 2020, the Senate has not yet acted. Some senators have expressed interest in the issue and ACEP is continuing to work on a Senate strategy.

Resources on workplace violence are available on the ACEP website.

ACEP has partnered with ENA to launch a joint campaign, “No Silence on ED Violence,” to combat violence in the emergency department. The campaign launched at ENA’s annual conference in September 2019 and at ACEP19. Elements of the campaign include a standalone website with resources to help members address the problem in their hospitals and advocate for change at the hospital, state, and federal level. Advocacy resources include materials to support state legislative efforts for chapters and a social media campaign to engage ACEP and ENA members in sharing their stories to help highlight the extent of the problem. A public relations campaign launched in November 2019 to increase public and media awareness of the issue.
Resolution 56 In Memory of Robert E. Blake, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Eugene Blake, MD, FACEP, as one of the leaders in the medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Robert Eugene Blake, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of West Virginia and the United States.

Action: A framed resolution was prepared for Dr. Blake’s family.

Resolution 57 In Memory of James H. Creel, Jr., MD, FACEP
RESOLVED, That the American College of Emergency Physicians fondly remembers and honors the many contributions of James H. Creel, Jr., MD, FACEP, one of the truest pioneers and leaders in emergency medicine and emergency medical services; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of James H. Creel, Jr., MD, FACEP, his colleagues, friends, residents, staff, and students our heartfelt condolences and gratitude for his tremendous accomplishments, devotion, and service to the specialty of emergency medicine, the State of Tennessee, and the United States of America.

Action: A framed resolution was prepared for Dr. Creel’s family.

Resolution 58 In Memory of Paul Berger, Jr., MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions by Paul Berger, Jr, MD, FACEP, as one of the leaders in emergency medicine, EMS, and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to his wife Lanie Berger, his son Paul Berger, III, DO, his friends, and his colleagues our deepest sympathy and our gratitude for having been able to learn so much from a kind, gentle, caring leader in emergency medicine and gratitude for his tremendous service to the specialty of emergency medicine and the State of Iowa.

Action: A framed resolution was prepared for Dr. Berger’s family.

Resolution 59 In Memory of William Wilkerson, Jr., MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by William Wilkerson, Jr, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of William Wilkerson, Jr, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Michigan and the United States.

Action: A framed resolution was prepared for Dr. Wilkerson’s family.

Resolution 60 Commendation for First Responders to 2017 Hurricanes
RESOLVED, That ACEP recognizes all ACEP members, staff, and their families that were involved in the response to Hurricanes Harvey, Irma, and Maria and commends the significant commitment they have made to the ideals of emergency medicine and the service provided to the people in the States of Texas, Louisiana, and Florida and the territories of Puerto Rico and the United States Virgin Islands.

Action: The resolution was read aloud at the Council Awards Luncheon and all first responders were thanked for their service.

Resolution 61 In Memory of Michael G. Guttenberg, DO, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, as one of the leaders in emergency medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of New York State and the United States.

Action: A framed resolution was prepared for Dr. Guttenberg’s family.
Referred Resolutions

Resolution 20  Campaign Financial Reform – to the Steering Committee (as amended)
RESOLVED, That the Council Steering Committee create expenditure limitations to allow younger encourage additional members to consider candidacy for leadership positions without the concern for financial means, and be it further
RESOLVED, That the Candidate Campaign Rules be amended by adding: “Candidates will not attend annual chapter meetings unless officially invited, on the meeting’s agenda for a planned educational endeavor, and accept reimbursement of travel expenses in accordance with the chapter’s policies;” and be it further
— RESOLVED, That the Council Steering Committee consider changes in the election process such as:
  • requiring candidates to disclose financial expenditures on their candidacy;
  • capping the monetary amount that can be used on all candidate-related expenditures, including travel, “coaches,” videos, etc.;
  • prohibit ACEP residency and ACEP chapter visits for each candidate during the period of declared candidacy;
  • restricting publication of non-scholarly work in non-peer reviewed journals such as ACEP Now and other Emergency Medicine open subscription media; and
  • restricting social media “public service announcements.”

Action: Assigned to the Council Steering Committee for discussion at the February 2018, meeting. The Steering Committee approved adding the following information to the Candidate Campaign Rules #13:

Resolution 21  Creation of an Electronic Council Forum – to the Steering Committee
RESOLVED, That the Board of Directors task the appropriate committees to create a year round forum for councillors to introduce, debate, and vote on resolutions; and be it further
RESOLVED, That the results of the votes in the electronic Council forum be nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues; and be it further
RESOLVED, That the electronic Council forum product feature include a user experience that can be used during the annual Council meeting to receive and display proposed amendments in real time during discussion and voting.

Action: Assigned to the Council Steering Committee for discussion at the February 2018, meeting. There was consensus that the current process for conducting the annual Council meeting meets the Council’s needs, but additional communication is needed to the Council about the features of the current Council meeting website that is used to distribute all Council meeting materials. The website has a “chat” feature to discuss resolutions in advance of the Council meeting, in addition to using the Council engagED community platform for discussion purposes.

Resolution 24  Maintenance of Competence for Practicing Emergency Physicians (as amended)
RESOLVED, That ACEP study the needs, and cost-effective evidence-based requirements that would support practicing board-certified emergency physicians to legitimately demonstrate their ongoing competence and skills necessary for their own practice settings and develop appropriate minimum guidelines for appropriate “maintenance of competence” with minimum and legitimate barriers to continued practice, and present a report for consideration at the 2018 Council meeting.

Action: The Board of Directors continued to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM held a Summit on October 2-3, 2017, to discuss modifications and alternatives to the ConCert exam. Representatives from ACEP attended the Summit.

An article appeared in the July 2018 issue of ACEP Now highlighting ABEMS’s efforts to create a new process for continuing certification by offering an alternative to the ConCert Examination. ABEM pursued several critical activities including redefining the purpose of continuing certification for ABEM and developing success metrics. All diplomates were invited to complete a survey to confirm and further explore the information ABEM received during the calls with 25
state chapters in 2017. Additional surveys were used to refine the design. The ACEP Board of Directors continued to
dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM updated the Council on
their efforts at the 2017 and 2018 annual meetings. In December 2018, ABEM released the draft report “Continuing
Board Certification: Vision for the Future” (developed by an independent commission) for comments by January 15,
2019. ACEP’s comments were provided to ABEM.

ABEM will no longer offer ConCert after 2022. Starting in 2021, ABEM will move to a 5-year certification period.
Physicians will now use MyEMCert to certify starting in 2021 instead of 2022 as originally scheduled.

Resolution 33 Immigrant and Non-Citizen Access to Care
RESOLVED, That ACEP develop model hospital policy language similar to the “Delivery of Care to Undocumented
Persons” policy that physicians can access and present to their hospital systems for implementation; and be it further
RESOLVED, That ACEP make available online for public use, in multiple languages, a “Safe Zone” statement that
notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physicians
can ensure the policy is communicated in the languages most relevant to their patient populations.

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

The committee reviewed the current policy statement “Delivery of Care to Undocumented Persons.” Revisions were
recommended to include reference to safe zones. The revised policy statement was approved by the Board in June 2018.

Resolution 35 Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment
RESOLVED, That ACEP work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea &
Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to
receive federal payment.

Action: The Undersea & Hyperbaric Medicine Society drafted a letter to CMS outlining the rationale for requiring facility
accreditation and requested ACEP to sign on to the letter. Leaders of ACEP’s Undersea and Hyperbaric Medicine Section
reviewed and revised the letter and recommended ACEP’s endorsement. In February 2018, the Board of Directors
approved sending the letter to CMS.

Resolution 38 Prescription Drug Pricing
RESOLVED, That ACEP create a policy statement that:
• recognizes the threat that unaffordable prices of medications used to treat acute and chronic diseases poses to our
  patients and the challenges this imposes upon the emergency medical system;
• supports the negotiation of drug prices under Medicare Part D;
• supports the importation of prescription drugs; and
• supports value-based pharmaceutical pricing; and be it further
RESOLVED, That ACEP work with the American Medical Association and other stakeholders to support regulatory
and legislative efforts to address these issues.

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

ACEP is a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care,
consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the
Campaign for Sustainable Rx Pricing.

ACEP’s Legislative and Regulatory Priorities for the Second Session of the 115th Congress and the First and Second
Sessions of the 116th Congress included “promote access to affordable medications for emergency patients and monitor
legislative activities regarding excessive drug pricing” and “monitor efforts by the Administration to reduce prescription
drug prices.

The Emergency Medicine Practice Committee developed the policy statement “Prescription Drug Pricing” that was
approved by the Board in June 2018.

Resolution 41 Reimbursement for Hepatitis C Virus Testing in the ED
RESOLVED, That ACEP encourage the adoption of state laws that allow for reimbursement for HCV testing in
settings beyond the primary care setting including the Emergency Department.

Action: Assigned to the Reimbursement Committee to review and provide a recommendation to the Board regarding
further action on the resolution.

A Reimbursement Committee member, who is a former regional medical director for CMS, investigated the options
ACEP could use to encourage reimbursement by payers for Hepatitis C testing in the ED. In June 2019, based on the analysis, the committee recommended to the Board that ACEP petition the Office of Coverage and Analysis Group at CMS to reconsider the addition of the ED as the place of service for Hepatitis C testing as a next step since state Medicaid plans largely follow precedence set by CMS. CMS defines coverage for Hepatitis C testing for Medicare beneficiaries in Decision Memo CAG-00436N as taking place in primary care settings. State Medicaid programs have largely followed suit with similar criteria for reimbursement. Furthermore, testing would need to be billed to the facility, not the professional or physician. Emergency physicians would also be required to follow up with results and provide counseling, which exceeds their scope of practice. Thus, it is imperative to seek CMS clarification of the addition of POS 23 (Hospital ED) for Hepatitis C testing before seeking individual state Medicaid program approval. The Board approved the committee’s recommendation and a letter was sent on August 13, 2019, to the Office of Coverage and Analysis Group at CMS.

Resolution 45 Group Contract Negotiation to End-of-Term Timeframes
RESOLVED, That ACEP establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage; and be it further
RESOLVED, That ACEP oppose not support sudden, abrupt changes in contract groups without time for adequate transition and training.

Action: Assigned to the Contracts Transitions Task Force. The task force developed the information paper “Emergency Department Physician Group Staffing Contract Transition.” The ACEP website includes additional resources on contracts.

Resolution 46 Impact of Climate Change on Patient Health and Implications for Emergency Physicians
RESOLVED, That ACEP research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy statement to guide future research, training, advocacy preparedness, mitigation practices, and patient care.

Action: Assigned to the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the resolution. The committee developed the policy statement “Impact of Climate Change on Public Health and Implications for Emergency Medicine” that was approved by the Board of Directors in June 2018.

Resolution 47 Improving Patient Safety Through Transparency in Medical Malpractice Settlements
RESOLVED, That ACEP develop a policy to reduce medical error and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate; actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits; and report progress on this objective at the ACEP annual meeting in 2018.

Action: Assigned to the Medical-Legal Committee to review and provide a recommendation to the Board regarding further action on the resolution. In June 2018, the Board of Directors approved the committee’s recommendation to not pursue the recommendations contained in the resolution at this time. An objective was assigned to the committee for 2018-19 to explore opportunities to use information from the National Practitioner Data Bank (NPDB) or related closed claims materials that might provide teachable information that may help reduce medical errors and improve patient safety.

In June 2019, the Board approved the committee’s recommendation to not seek to access malpractice data from the NPDB directly but review any relevant aggregate data that may be made available. The committee believes that trying to access and review some portion of the 1.4 million records in the NPDB is a high-effort, low-yield exercise. As a membership association, the amount of access ACEP would have to the data would be limited by the NPDB and there would be no ability to drill into specifics of individual cases that would be needed to yield information that could be most helpful in identifying concerning trends. Much of the data that would be critical for this type of review and analysis, such as charts, are not included in the NPDB. It was also noted that much easier access to useful information on high-risk practices is already available through a plethora of published sources.

Resolution 48 Non-Fatal Strangulation
RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders, to provide educational and clinical resources as well as in person and enduring educational programs for emergency providers on the evaluation, radiographic investigation, and management of non-fatal strangulation; and be it further
RESOLVED, That ACEP create a policy statement on the seriousness of non-fatal strangulation and develop a clinical practice guideline for the emergency department evaluation, treatment, and management of non-fatal
strangulation.

**Action:** Assigned to the Clinical Policies Committee to review and provide a recommendation to the Board regarding further action on this resolution. The committee conducted an initial literature review and concluded there is not enough evidence to develop a clinical policy on the topic. The committee determined that a policy statement is not the ideal means of disseminating educational content on non-fatal strangulations. There are currently multiple sources of information,

- As an adjunct to the ACEP policy statement, “Management of the Patient with the Complaint of Sexual Assault,” ACEP’s Forensic Medicine Section prepared a handbook, “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” that is available on the ACEP website. Chapter 16 of the handbook is titled “Strangulation.” This chapter addresses the challenges, physiology, mechanisms, definitions, pathophysiology, clinical symptoms and caveats, clinical findings, clinical evaluation, management, and documentation related to strangulation. There are also examples of a documentation chart for non-fatal strangulation cases, medical release form, and questions to ask the victim.
- The International Association of Forensic Nurses has developed a position statement on non-fatal strangulation and a [documentation toolkit](#), both available online on their website.
- The Emergency Nurses Association has a Topic Brief, “An Overview of Strangulation Injuries and Nursing Implications,” also available on their website.
- The Training Institute on Strangulation Prevention has various resources (e.g., brochures, training DVD, webinars) on the topic, available on their Web site. The goals of the Institute are to: enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled; improve policy and practice among the legal, medical, and advocacy communities; maximize capacity and expertise; increase offender accountability; and ultimately enhance victim safety.

The committee agreed that further dissemination of existing educational materials on the topic could be done. The Forensic Medicine Section could provide links to additional resources on their ACEP microsite or could submit a course proposal for an ACEP meeting on the topic.

**Resolution 50  Promoting Clinical Effectiveness in Emergency Medicine**

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

**Action:** This resolution is addressed through ACEP’s clinical policies process and E-QUAL Network.

Clinical policies are created by an expert panel that reviews and grades the literature and answer specific question regarding preferred practice guidelines. These reviews may cover effectiveness, but rarely consider cost as a variable.

Though not a formal cost effectiveness program, the [Emergency Quality Network (E-QUAL)](https://www.acep.org/quality/e-qual) offers analysis and recommendations for cost effective treatment. E-QUAL offers learning collaboratives in four main areas: sepsis, avoidable imaging (low back pain, minor head injury, pulmonary embolism, and renal colic), low risk chest pain, and opioid management. The network offers a toolkit with best practices and sample guidelines, as well as access to benchmarking data. It provides free CME and meets the CMS Improvement Activity requirements of the CMS Quality Payment Program (MIPS). Any ACEP member may join the network at no cost.

**Resolution 62  Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States (as amended)**

RESOLVED, That ACEP lobby Congress to give [advocate giving](#) CMS the authority to recognize independent Freestanding Emergency Centers as Medicare Certifiable locations of acute unscheduled healthcare in the United States in Federally Declared Disaster areas.

RESOLVED: That ACEP lobby Congress to give CMS the authority to create Critical Access Emergency Center Designation where Critical Access Hospitals no longer exist due to catastrophic destruction from natural disasters or where Critical Access Hospitals cannot be feasibly maintained leaving areas of the Country without access to Emergency Medical care.

**Action:** Assigned to the Federal Government Affairs Committee to review and provide a recommendation regarding further action on this resolution.
The Board of Directors discussed this resolution at their December 2017 retreat. On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcommittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP’s Legislative & Regulatory Priorities for the Second Session of the 115th Congress and the First Session of the 116th Congress included:

- monitor legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers;
- acknowledge the role of freestanding emergency centers and other health care delivery models as crucial to encourage coverage innovation;
- enact legislation allowing critical access hospitals to convert to rural emergency hospitals by eliminating inpatient services.

In August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.
President-Elect Candidates
2020 President-Elect Candidates

Christopher S. Kang, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Gillian R. Schmitz, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV
2020 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Christopher S. Kang, MD, FACEP, FAWM

**Question #1:** What is your view on the positive and negative impacts of market forces, such as hospital consolidation and the involvement of private equity, on the practice of emergency medicine?

The impacts of market forces on healthcare have been the subject of research as well as continual public and private debates for decades. Although they constitute a complicated and especially vexing challenge for emergency medicine, changing annually at multiple levels as some forces rise and others ebb, I view their drivers and effects to be shaped by three factors: the stakeholders, industry landscape, and timing.

There were two initial stakeholders in healthcare, the patient and the physician. As the number of stakeholders drastically increased, to now include hospitals, insurers, communities, regulators, and both state and federal governments, the standing and authority of physicians depreciated.

Over the past decade, the emergency medicine landscape has been significantly affected by government policy, employer and hospital consolidation, and the rise of private equity. The Patient Protection and Affordable Care Act obligated fundamental changes in reporting (including metrics), reimbursement, and coordination of care while insurers and various states continue to attempt to refuse to pay for some emergency department care and EMTALA remains an “unfunded mandate”. These changes helped prompt the on-going wave of employer, hospital, and healthcare system consolidations and the beliefs in larger market shares, networks, and greater operational efficiency. These changes also precipitated the rise of private equity in emergency medicine, which offered another source of financial shelter but also introduced another stakeholder.

As emergency medicine evolved, various stakeholders would align with each other. However, over the past decade and until this year, it has often seemed that all of the other stakeholders, including patients, were aligned against emergency physicians.

Over the past six months, COVID-19 has served as a stress test for emergency medicine, disrupting all of the market forces and challenging each stakeholder’s standing. While some beliefs and practices have held up, others have been revealed to be more promissory or unlikely to be realized. As severely as COVID-19 has affected you, your colleagues, and your practice, it also allows us to regroup, reaffirm and regain our standing. Patients, communities, and some government agencies are now more aligned with us, and recognize and value our leadership and commitment to high quality patient care.

Your College has been assessing these market forces and their effects. Two years ago, I requested that one of the objectives for the Ethics Committee was to explore the impact of the business of emergency medicine on the patient-physician relationship. Last year, I supported the introduction and adoption of Resolution 58, The Role of Private Equity in Emergency Medicine, to encourage an open and frank discussion. As your Treasurer, I am knowledgeable about the College’s finances and their current limitations, and encouraged staff to reassess and refine some operations to better position the College once COVID-19 subsides.

If elected, I will continue to utilize these views to facilitate discussion, advocacy, and action so that the College may take advantage of this opportunity to rebuild and sustain our professional standing and leading roles in the definition, management, evaluation, and improvement of quality emergency care for our patients and communities.

**Question #2:** Different emergency medicine organizations may have contrasting views on emergency medicine practice and policy. How would you help ACEP create a unified message to guide policy leaders while preserving ACEP’s vision?

Although emergency medicine (EM) organizations may have contrasting views on various practices and policies, they all advocate that patients seeking emergency care should have access to the highest quality care available by those trained and specialized in EM. While respecting differing operational philosophies, it is this shared belief, encapsulated by ACEP’s vision statement, that provides the foundation for optimism, leadership, and advancing ACEP’s mission.

As President, to preserve ACEP’s vision, I will create a unified message to guide policy leaders by setting the tone, reaffirming this belief and common values, and leading by example.
The President sets the tone for the College as you do on shift with your clinical team. I believe that EM organizations must act like a family. Family members may share rivalries and occasionally disagree, but, ultimately, we should remain true to our family so that it can flourish.

In order for the College to more effectively collaborate with the other EM organizations, we must first reassess and reaffirm ACEP’s vision. Since 2003, a great deal has changed. Mirroring today’s society, our College has accumulated an ever-growing list of issues and priorities. Similarly, as we have pursued more diverse personal, professional, and social interests, divisiveness within the College has also grown as some interests compete and conflict with each other. These differences should enrich, not eclipse our shared belief and values. Once we reaffirm these commonalities and acknowledge that diversity and divisiveness are not mutually exclusive, ACEP can advance and lead the other EM organizations with greater clarity, integrity, and resolve.

I am committed to the College’s mission and vision, and will continue to lead by,
- welcoming difficult conversations and sound, objective criticism;
- encouraging representation and discourse at Board of Directors meetings;
- facilitating and recognizing cooperation as exemplified by the five most recent Council Teamwork Award recipients;
- collaborating with other member organizations of the emergency physician-led team; and
- maintaining membership in other EM organizations to foster mutual respect and initiatives to advance our shared belief in emergency physicians and their training, employment, scope of practice, rights, and well-being.

**Question #3:** What additional opportunities and strategies does ACEP need to address during the COVID era?

COVID-19 has served as a stress test for all of you, emergency medicine, and ACEP and unsettled every aspect of your professional identity. By exposing needed changes, it also presents the opportunity to regroup and emerge stronger and more vibrant. While recognizing the exceptional job the College staff, leaders, and President have done under unprecedented and surreal conditions, my plan to immediately implement during the COVID-19 era has three parts: COVID-19 and future outbreaks, on-going College priorities eclipsed by COVID-19, and the modernization of the College.

ACEP must continue to advocate for sufficient resources and a safer, supportive environment for you and all patients seeking emergency care. The College should also continue to disseminate lessons learned about the availability and adequacy of PPE and medical supplies, screening and diagnosis, testing, treatments, regional coordination of care, and practice innovations for COVID-19 and future infectious disease outbreaks. For example, I was involved with Seattle’s regional response to the first domestic COVID-19 outbreak. I advocated for the EngagED COVID-19 platform, coordinated responses to state and Congressional inquiries, facilitated meetings with industry leaders like Microsoft, and shared information with other chapters, the Epidemic Expert Panel, the Supply Chain Task Force, and ASPR and the CDC.

As COVID-19 persists, we cannot neglect other clinical, professional, and membership priorities or overlook evolving opportunities. Millions are still affected by substance use disorders and lack access to mental health resources. Employer and hospital consolidations have diminished the value of emergency physicians and constrained your rights and benefits. Insurers and states try to evade paying for some emergency department care. Your employment and scope of practice are being challenged. COVID-19 has afflicted the current workforce and indelibly affected the next generation of emergency physicians. Yet, there have been advances with liability protection, video conferencing, telehealth, and information sharing. ACEP must harness and sustain the renewed respect and support by the public, patients, other specialties, administrators, and government leaders.

The College itself, which unites us and is our critical professional and advocacy resource, requires immediate attention if ACEP is to emerge stronger and more vibrant. Drawing on my experiences as Treasurer and as I start my final year on the Board, I will, if elected, facilitate the College’s modernization by,
- working closely with the current President,
- collaborating with the new Executive Director during this formative time as she instills her vision & leadership,
- safeguarding the College’s finances by reassessing legacy practices and incorporating new initiatives,
- fostering improved communication between chapters and the College as well as members and past leaders with the Board,
- cultivating a more collaborative leadership culture at the Board level, and
- reaffirming the College’s mission that members are recognized, valued, and duly employed as the leaders of their ED teams.

I remain committed to ACEP, my family. I have a plan, and the time to implement it is now. I will continue to lead with integrity, accountability, and unwavering belief in and fidelity to emergency physicians. Under my leadership, the College will apply the lessons learned so that we are better prepared and will, above all, emerge with renewed focus and dedication, an increasingly stronger and efficient College, and more effectual leadership that will foster continued and greater successes for the next decade.
CANDIDATE DATA SHEET

Christopher Scott Kang, MD, FACEP

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Current and Past Professional Position(s)

Clinical/Academic
Attending Physician, Core EM Residency Faculty, 2001-Current
Madigan Army Medical Center
Joint Base Lewis-McChord, WA

Attending Physician, 2007-Current
Olympia Emergency Physicians, PLLC
Providence St. Peter Hospital
Olympia, WA

Assistant Professor, Adjunct, 2008-Current
Military and Emergency Medicine
Uniformed Services University of the Health Sciences

Assistant Professor, Clinical, 2006-Current
Department of Emergency Medicine
University of Washington

Associate Professor, 2018-Current
Physician Assistant Program
Baylor University

Attending Physician, 2004-2005
Mt. Rainier Emergency Physicians, PLLC
Good Samaritan Hospital
Puyallup, WA

Attending Physician, 2000-2001
Emergency Medical Services
121st General Hospital
U.S. Army Yongsan Garrison
Seoul, Republic of Korea

Military
52nd Medical Battalion
Battalion (Flight) Surgeon
U.S. Army Yongsan Garrison
Seoul, Republic of Korea

Joint Task Force Bravo
Flight Surgeon/Emergency Treatment Physician
Soto Cano Air Base, Honduras
U.S. Army’s First Stryker Brigade
296th Brigade Support Battalion, 1-14 Cavalry Squadron, 5-20 Battalion
Samarra and Tal ‘Afar, Iraq

Education (include internships and residency information)

Undergraduate: 1992, Northwestern University, Evanston, IL
Weinberg College of Arts and Sciences
Bachelor of Arts, History
Graduate: 1996, Northwestern University, Chicago, IL
Feinberg School of Medicine
Doctor of Medicine
Residency: 2000, Northwestern University, Chicago, IL
Emergency Medicine (PGY1-4)

Doctor of Medicine, 1996

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified


Professional Societies

American College of Emergency Physicians
- Washington Chapter
- Government Services Chapter
American Academy of Emergency Medicine
American Medical Association
- Washington State Medical Association
Society of Academic Emergency Medicine
United States Army Society of Flight Surgeons
Wilderness Medical Society

National ACEP Activities – List your most significant accomplishments

BOARD OF DIRECTORS (2015-Current)

Office Position(s)
- Treasurer, 2019-2020
- Social Media Communications Group, Board Liaison, 2017-2019

Task Force
- Emergency Medicine Residency Engagement, Member, 2018-2020
- Board of Directors Work Group, EM Workforces, Chair, 2018
- Nurse Practitioner/Physician Assistant Utilization, Liaison, 2018-2020
- Emergency Medicine Physician Workforce, Liaison, 2018-Current

Committee Liaison
- Audit Committee, 2019-2020
- Finance Committee, 2019-2020
- Disaster Preparedness and Response Committee, 2015-Current
- Ethics Committee, 2017-2019

Section Liaison
- Aerospace Medicine Section, 2019-Current
- Air Medical Transport Section, 2017-Current
- Disaster Medicine Section, 2015-Current
- Event Medicine Section, 2017-2019
- Undersea and Hyperbaric Medicine Section, 2017-19
- Wilderness Medicine Section, 2015-Current
Chapter Visits
- Coastal Conference (GA, NC, SC), EMerald Coast Conference (AL, AR, LA, MO, MS, TN), GS, HI, NM, Symposium by the Sea/FL, TX

Residency Visits
- IL, MI, NY

Other Organizations
- American College of Surgeons Committee on Trauma, Liaison, 2016-Current
- Emergency Medicine Foundation, Board of Trustees, 2020-Current
- National Trauma Institute, Board of Directors, 2018-Current

Other Activities
- Annals of Emergency Medicine, Manuscript Reviewer, 2013-Current
- Leadership and Advocacy, Faculty/Presenter, 2018
- ACEP16, Faculty/Presenter, 2016
- Code Black, InnovatED, 2015-2017
- National Chapter Relations Committee, Member, 2014-2015
- Disaster Preparedness and Response Committee, Chair, 2013-2015
- Disaster Medical Section, Chair Elect, 2013-2015
- Steering Committee, Member, 2013-2014
- Council Resolution Committee, Member, 2012
- Emergency Medicine Basic Research Skills Course, Advisor, 2012-Current
- Disaster Preparedness and Response Committee, Member, 2010-2015
- Project Medical Director/Site Survey Team/Faculty Moderator, Department of Homeland Security Community Healthcare Disaster Preparedness Assessment, 2006-2012

ACEP Chapter Activities – List your most significant accomplishments
Washington Chapter
- Officer: Secretary/Treasurer, President Elect, President, Immediate Past President (2011-2015)
- Board of Directors: 2010-Current
- Councillor: 2010-2015
- Education Committee: 2010-Current

Practice Profile
Total hours devoted to emergency medicine practice per year: 2040 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 70 % Research 5 % Teaching 20 % Administration 5 %
Other: _________________________

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Madigan Army Medical Center, Department of Emergency Medicine, Tacoma, WA
- Federal Employee, Staff Attending Physician
- Single Hospital – Defense Health Agency Medical Facility
- Tertiary/Regional Medical Center
- Washington State Level II Trauma Center
- STEMI Center
- Core Faculty Member, Residency in Emergency Medicine
- Faculty Advisor, Physician Assistant Fellowship Program in Emergency Medicine

Olympia Emergency Physicians, PLLC, Providence St. Peter Hospital, Olympia, WA
- Part-Time Employee, Attending Physician
- Single Emergency Department/Hospital Group
Washington State Level III Trauma Center
- Washington State STEMI Center
- Washington State Stroke Center

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Madigan Army Medical Center
Current Position(s)
- Core Faculty, Residency in Emergency Medicine
- Institutional Review Board
- ALS Instructor
- PALS Instructor

Past Position(s)
- Research Director, Residency in Emergency Medicine, 2006-2015
- Residency Order of Merit Selection Committee, 2006-2014
- Pandemic Influenza Committee, 2005-2007
- Patient Decontamination, Chair, 2003
- Assistant Chief of ED Operations, 2002-2003
- Physician, NBC Special Medical Augmentation Response Team, 2002-2003
- Safety/Environment of Care Committee, 2001-2003
- Patient Safety Committee, 2001-2003

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

| Defense Expert | 0 Cases | Plaintiff Expert | 0 Cases |
CANDIDATE DISCLOSURE STATEMENT

Christopher Scott Kang, MD, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: Department of the Army, Madigan Army Medical Center
   Address: 9040A Jackson Avenue
            Joint Base Lewis McChord, WA 98431
   Position Held: Attending Physician
   Type of Organization: Defense Health Agency / Regional Medical Center

   Employer: Olympia Emergency Physicians, PLLC
   Address: 415 Lilly Road NE
            Olympia, WA 98506
   Position Held: Attending Physician
   Type of Organization: PLLC, Single Emergency Department/Hospital Group

2. Board of Directors Positions Held – List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.

   Organization: American College of Emergency Physicians - Board of Directors
   Address: 4950 W. Royal Lane
            Irving, TX 75063-2524
   Type of Organization: Medical Specialty Professional Society/Organization
   Duration on the Board: 2015-Current

   Organization: Washington Chapter, ACEP – Board of Directors
   Address: 2001 6th Ave, Ste 7200
            Seattle, WA 98121
   Type of Organization: Medical Specialty Professional Society/Organization
   Duration on the Board: 2011-Current

   Organization: National Trauma Institute
   Address: 9901 IH West, Suite 720
            San Antonio, TX 78230
Type of Organization: 501(c)3 Nonprofit Corporation – Trauma Research
Duration on the Board: 2018-Current

Organization: Emergency Medicine Foundation
Address: 4950 W. Royal Lane
         Irving, TX 75063-2524

Type of Organization: 501(c)3 Nonprofit Corporation – Emergency Medicine Research
Duration on the Board: 2020

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Christopher S. Kang          Date          8 June 2020
August 14, 2020

RE: Endorsement for Christopher Scott Kang, MD, FACEP
President Elect

Dear Councillors:

The Washington Chapter of the American College of Emergency Physicians (WA-ACEP) and Disaster Medicine Section of ACEP would like to provide our wholehearted support of Christopher Scott Kang, MD, FACEP for the national ACEP President-Elect position. It is without reservation and with considerable enthusiasm that we endorse Dr. Kang’s candidacy because we know that his leadership skills, exceptional ability to collaborate, and extreme poise, will immensely benefit our college.

Dr. Kang’s career spans 20+ years ranging from bedside ED physician to a Flight Surgeon to an Associate Professor of Emergency Medicine. Dr. Kang is incredibly bright and has a gift of eloquent, calm speaking. He is very approachable and strives to find opportunities for all who yearn to achieve. In today’s climate of stress and uncertainty regarding the COVID-19 pandemic and the field of Emergency Medicine, Dr. Kang is a natural and much needed presence. Dr. Kang has demonstrated his keen leadership skills and innovation in multiple sections, committees and on the Board for ACEP.

Dr. Kang’s involvement in ACEP is nothing short of thorough. He has been the Chair of the Disaster Preparedness and Response Committee, served on the National Chapter Relations Committee, and was a member of the Disaster Medicine Section serving as Chair-Elect from 2013-2015, when he was elected to the ACEP Board of Directors. He also serves as the ACEP Board Liaison for the Disaster Committee, as well as sections of Disaster Medicine, Air Medical Transport, Wilderness Medicine, Event Medicine, and others. He was instrumental as a section leader in the success of the ACEP Disaster Section Code Black production in 2015-2017 and navigated financial storms first as WA-ACEP Treasurer, then as the Treasurer for National ACEP during COVID. Having accomplished so much in these roles, Dr. Kang is ready for more challenges.

Dr. Kang’s deep involvement in ACEP shows a strong enthusiasm for the college, and his success in these varied positions demonstrates an aptness for leadership. It is rare to find a combination of these attributes in an individual and it is what makes Dr. Kang uniquely qualified for President-Elect.
While he is dynamic in his qualifications, what elevates Dr. Kang as the epitome of valued leadership is team building. Throughout his involvement with ACEP, Dr. Kang has stood out in his ability to build and mentor amazing teams, thereby making those around him successful. Additionally, his one-on-one mentoring skills are par none. He has worked closely with six of the previous Horizon Award winners in their early years, as well as coordinated and nominated the last 3 winners of the ACEP Team award. He actively practices military medicine and is in the process of grooming its future leaders.

WA-ACEP’s rise in recent years in elevating National ACEP’s policies & esteem, is very much attributed to Dr. Kang’s ability to facilitate connection and communication amongst a team while establishing excellent morale. This quality made him an asset to the ACEP Workforce Task Force, where he was able to produce recommendations around controversial topics that could be successfully solved by motivating diverse groups to work together. To be led by Dr. Kang is to be empowered, motivated and unified.

We welcome the opportunity to talk with you at any time to discuss our enthusiastic support of Dr. Chis Kang to serve as the ACEP President-Elect. We are proud to stand behind him as he aims to advance Emergency Medicine through our valuable organization.

Sincerely,

Susan Stern, MD
WA-ACEP President

Kathy Lehman-Huskamp
Kathy Lehman-Huskamp, MD, FACEP, FAAP
Chair ACEP Disaster Section
Christopher S. Kang, MD, FACEP, FAWM

Dear Council,

You set the tone and advocate for issues that guide the College for the following year. This year, your voting will carry even greater historical significance because of a confluence of unique events that the College has never previously faced.

The following four concepts have been hallmarks of my service, and will attest to my presidency and priorities for the next three years.

Accountability. I value every idea and treat everyone with respect and in the manner I want to be treated. I will not ask others to complete a task without sufficient guidance and resources, and that I have not done or would not do myself. If successful, the team members receive the credit, recognition, and opportunity to grow. If not successful, it is my responsibility.

College. The College is our common and critical professional and advocacy resource. It unites us. It requires attention now if it is to emerge stronger and more vibrant.

- Our exceptional staffs have been stressed. Legacy practices require reassessment. Our new Executive Director should have the supportive environment and partner that will prioritize and collaborate with her during this formative time as she instills her vision and leadership.

- Communication and priorities amongst sections, chapters, and national offices as well as with other organizations have been challenging and, at times, increasingly discordant. Divisiveness has grown as some interests compete and conflict with each other.

Evolution. Both personally and professionally, I constantly seek to learn, improve, and share my lessons learned with others. I am continually mentored by past leaders, young physicians, and residents. I cherish and respect our heritage and past leaders while welcoming new practices and innovation, such as the EngagED COVID-19 hub.

Principles. I believe that fidelity to key principles can help better comprehend and navigate challenging issues as they grow in number and complexity.

- Integrity
- Due diligence
- Respecting perspective
- Understanding context
- Leaving a place in a better condition than when you started

What is right for emergency physicians?
Emergency physicians, current and the next generation, face unprecedented uncertainty. However, with this adversity comes the opportunity to reaffirm our common belief in each other, reassess our College’s mission and priorities, and rededicate ourselves to advancing our profession. Who has the integrity and equanimity, service record, knows the staff, understands the College’s finances and operations, and recognizes that the College itself must be a priority?
Over the past five years, and especially these last six months, I have observed and studied what culture and operations worked well and those that could be improved. I have a plan, and the time to implement it is now.

With your vote and my leadership, the College will evolve and become better prepared to face new, even unforeseen, challenges, and will, above all, emerge with renewed focus and dedication, an increasingly stronger and efficient operations, and more effectual leadership that will foster continued and greater successes for the next decade.

Sincerely,

Christopher Kang, MD, FACEP, FAWM
DY N A M I C.  H I S T O R I C.  I N T E G R I T Y.

SHAPING THE NEXT DECADE

CHRISTOPHER KANG
MD, FACEP, FAWM

for President-Elect
2020 ACEP Board of Directors
CHAPTER-NATIONAL RELATIONSHIP

- Limited Chapter Resources Workgroup Member
- Monitoring Impact of COVID-19 on Chapter Operations
- Improve Communication and Coordination

COLLEGE

- Member of 12 Sections/5 Committees
- Treasurer and Reevaluating Financial Practices and Programs
- Collaborate with the Executive Director to advance staffing and operations

COLLABORATION

- Supported Past Five Council Teamwork Award Recipients
- Liaison to ACS COT and Partner with ENA
- Strengthen Partnerships with AMA, ENA, and EM Organizations

CULTURE

- Counseled by Past Leaders, Young Physicians, and Residents
- Liaison to NP/PA Utilization and EP Workforce Task Forces
- Foster and Synergize Leadership at Section, Chapter, and Board Levels

KEY // = PAST  = PRESENT  = FUTURE
CHRISTOPHER S. KANG

EDUCATION

2001, 2011 American Board of Emergency Medicine
Board Certification in Emergency Medicine

1996 – 2000 Northwestern University Medical School Chicago, IL
Accredited Residency in Emergency Medicine

1992-1996 Northwestern University Medical School Chicago, IL
Accredited Medical School, Doctor of Medicine

1989-1996 Northwestern University Evanston & Chicago, IL
Honors Program In Medical Education, Bachelor of Arts

LICENSE AND CERTIFICATIONS

Medical License, Washington 2003 – Pres
Medical License, Illinois 1996 - Pres
Basic / Advanced Disaster Life Support (Instructor) 2008 - 2010
Advanced Wilderness Life Support (Instructor since 2008) 2007 – Pres
Advanced Cardiac Life Support (ACLS Instructor since 2000) 1996 – Pres
Advanced Pediatric Life Support (Instructor since 2000) 1996 – Pres

PROFESSIONAL EXPERIENCE

Current Employment (Military)
Madigan Army Medical Center (MAMC) 2001 – Pres
Department of Emergency Medicine, Attending Physician
Tacoma, Washington

Positions and Responsibilities
• Residency Core Faculty/Attending and Resident Advisor 2001 – Pres
• Residency Research Director 2006 - 2015
• Institutional Review Board 2006 – Pres
• Residency Order of Merit Selection Committee 2006 – 2014
• Institution Pandemic Influenza Committee, Member 2005 – 2007
• Institution, Patient Decontamination Subcommittee, Chair 2003
• Assistant Chief, ED Operations 2002 - 2003
• Acute Care Physician, Western Regional Medical Command NBC Special Medical Augmentation Response Team
• MAMC Safety/Environment of Care Committee 2001 - 2003
• MAMC Patient Safety Committee 2001 – 2003

Current Employment (Civilian)
Providence St Peter Hospital, Attending Physician 2007 – Pres
Olympia, Washington

Current Faculty Appointments
Associate Professor, Physician Assistant Program 2018 – Pres
Baylor University

Assistant Professor, Adjunct, Military and Emergency Medicine 2008 - Pres
Uniformed Services University of the Health Sciences

Assistant Professor, Clinical, Emergency Medicine 2006 – Pres
University of Washington

Previous Faculty Appointments
Assistant Professor, Physician Assistant Program, Baylor 2008 - 2018
Baylor University

Clinical Instructor, Military and Emergency Medicine 2002 - 2006

Previous Employment (Civilian)
Good Samaritan Hospital, Attending Physician 2004 - 2005
Puyallup, Washington

Other Employment (Military)
U.S. Army’s First Stryker Brigade 2003 - 2004
296th Brigade Support Battalion, 1-14 Cavalry Squadron, 5-20 Battalion
Samarra & Tal’Afar, Iraq - Operation Iraqi Freedom

Joint Task Force-Bravo 2002
Flight Surgeon, Emergency Treatment Physician
Soto Cano Air Base, Honduras

121st General Hospital 2000 - 2001
Emergency Medical Services Attending Physician
Yongsan Garrison, Seoul, Republic of Korea

52nd Medical Battalion 2000 - 2001
Battalion (Flight) Surgeon
Yongsan Garrison, Seoul, Republic of Korea
ADDITIONAL PROFESSIONAL AND LEADERSHIP POSITIONS AND ACTIVITIES

Leadership

American College of Emergency Physicians (ACEP)
- Board of Directors 2015 - Pres
- Board of Directors, Secretary/Treasurer 2019 – Pres
- Board of Directors, Liaison, Audit Committee 2019 - Pres
- Board of Directors, Liaison, Finance Committee 2019 - Pres
- American College of Surgeons Committee on Trauma, Liaison 2016 - Pres
- Board of Directors Liaison, Disaster Preparedness and Response 2015 - Pres
- Board of Directors Liaison to Ethics Committee 2017 - 2019
- Council Steering Committee 2013 - 2014
- Disaster Preparedness and Response Committee, Chair 2013 - 2015
- Disaster Preparedness and Response Committee 2010 – 2015
- National Chapter Relations Committee 2014 - 2015
- Disaster Medicine Section, Chair Elect 2013 - 2015
- Council Resolution Committee C 2012
- Disaster Medicine Section, Secretary 2011 - 2013
- Advisor, Emergency Medicine Basic Research Skills Course 2009 – Pres
- Site Survey Team, Faculty Moderator, Project Medicine Director Department of Homeland Security (DHS) Community Healthcare Disaster Preparedness Assessment (CHDPA)
- Emergency Medicine Basic Research Skills Course, Graduate 2008 – 2009
- Teaching Fellowship, Graduate 2007

Washington Chapter, American College of Emergency Physicians (WA ACEP)
- Immediate Past President 2014 - 2015
- President 2013 - 2014
- President-Elect 2012 - 2013
- Secretary-Treasurer 2011 – 2012
- Board of Directors 2010 – Pres
- Education Committee – Summit to Sound Northwest Emergency Medicine Assembly (S2S NEMA)
- Education Committee, Chair – S2S NEMA 2011 - 2012

Northwest Regional Healthcare Response Network
- Disaster Clinical Advisory Council 2013 – Pres

National Trauma Institute
- Board of Directors 2018 - Pres

Emergency Medicine Foundation
- Board of Trustees 2020
## Additional Professional and Leadership Positions and Activities

### Activities

**American College of Emergency Physicians (ACEP)**
- Disaster Medicine Forum, Leadership and Advocacy Faculty 2014
  - Washington, D.C.
- ACEP-DHS Hospital Evacuation Workgroup 2009
  - Dallas, Texas
- CDC-ACEP In A Moment’s Notice: Surge Capacity for Terrorist Use of Explosives Workgroup 2009
  - Boston, Massachusetts
  - Dallas, Texas

**Annals of Emergency Medicine**
- Manuscript Reviewer 2013 – Pres

**Journal of Wilderness and Environmental Medicine (JWEM)**
- Manuscript Reviewer 2008 – Pres

**Western Journal of Emergency Medicine (WJEM)**
- Section Co-Editor, Disaster Medicine 2007 – Pres
- Manuscript Reviewer 2007 – Pres

**Wilderness Medical Society (WMS)**
- Advanced Wilderness Life Support, Faculty 2007 - 2014
  - Moab/Park City, UT; Chehalis/Mt. Rainier, WA; Whistler, Canada
- Advanced Wilderness Life Support, Course Director 2009
  - Park City, UT

**Department of Army (DA)**
- Advanced Officer Course 2004
- US Army Safety Center Accident Investigation Board, Iraq 2004
- Flight Surgeon Primary Course Critical Task Selection Board 2003
- Medical Management of Chemical and Biological Casualties Course 2003
- Medical Effects of Ionizing Radiation 2003
- Primary Flight Surgeon Course 2000
- Officer Basic Course, Commander’s List Graduate 1993

**Department of Defense/Veterans Affairs (DoD/VA)**
- Clinical Practice Guidelines Workgroup, Acute Stroke/TIA 2006
- Clinical Practice Guidelines Workgroup, COPD 2005
HONORS AND AWARDS

American Medical Association (AMA)

Annals of Emergency Medicine
- Top Manuscript Reviewer 2018, 2019

Department of the Army (DA)
- Civilian Achievement Award 2010
- Meritorious Service Medal 2004
- Army Commendation Award 2001, 2003, 2004
- Army Achievement Award 2001, 2002 x 3
- Global War on Terrorism Expeditionary Medal 2003
- Korean Defense Service Medal 2001
- Global War on Terrorism Service Medal 2001
- Combat Medical Badge 2004
- Flight Surgeon Badge 2000

Madigan Army Medical Center (MAMC)
- F.M. Burke Award – Outstanding Teacher Emergency Medicine Residency 2002, 2015, 2018

Western Journal of Emergency Medicine (WJEM)
- Top Section Editor 2010
- Top Manuscript Reviewer 2009, 2010

Wilderness Medicine Society
- Academy of Wilderness Medicine, Fellow
PUBLICATIONS AND PRESENTATIONS

PEER REVIEWED


                      Moffett PM, Cartwright L, Grossart EA, O'Keefe D, Kang CS. Intravenous Ondansetron and the QT Interval in Adult Emergency Department Patients: An Observational Study. Acad Emerg Med. (Study)


Matlock AG, Cashin B, Reynolds P, Wills BK, Kang CS. Effect of Hydroxocobalamin on Surface Oximetry. Prehospital and Disaster Medicine. (Study)


Simmons J, Cookman L, Kang C, Skinner C. Three Cases of “Spice” Exposure. Clinical Toxicology. (Case Series)


Cashin BV, Matlock AG, Kang CS, Reynolds PS, Wills BK. Effect of Hydroxocobalamin on Surface Oximetry in Non-Exposed Humans.
Annals of Emergency Medicine, Research Supplement. (Abstract)


2007


NON-PEER REVIEWED

2019 Bulger EM, Perina DG, Qasim Z, Beldowicz B, Brenner M, Guyette F, Rowe D, Kang CS, Gurney J, DuBose J, Joseph B, Lyon R, Kaups K, Friedman VE, Eastridge B, Stewart R. Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) in Civilian Trauma Systems in the USA, 2019: A Joint Statement from the American College of Surgeons Committee on Trauma, the American College of Emergency Physicians, the National Association of Emergency Medical Services Physicians and the National Association of Emergency Medical Technicians. Trauma Surg Acute Care (Clinical Statement)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2018 Perina DG, Kang CS, Bulger EM, Stewart RM, Winchell RJ, Brenner M, Henry S, Weieter IJ, Chang MC, Rotondo MF. Authors' Response to Letter to the Editor by Allen et al regarding Joint statement from the American College of Surgeons Committee on Trauma (ACS COT) and
the American College of Emergency Physicians (ACEP) regarding the clinical use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) by Brenner et al. Trauma Surgery & Acute Care. (Clinical Statement)

Brenner M, Bulger EM, Perina DG, Henry S, Kang CS, Rotondo MF, Chang MC, Weireter LJ, Coburn M, Winchell RJ, Steward RM. Joint Statement from the American College of Surgeons Committee on Trauma (ACS COT) and the American College of Emergency Physicians (ACEP) Regarding the Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA). Trauma Surgery & Acute Care. (Clinical Statement)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2017 Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)


Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)


Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)


Moffett P, Kang CS. The Impaired Physician. Ethical Problems in Emergency Medicine. (Book Chapter)

Kang CS, Harrison BP. Anxiety and Panic Disorders, Adams’ Emergency Medicine, 2nd Ed. (Textbook Chapter)

Kang CS, Wedmore IS. Chemical and Radiologic/Nuclear Agents. Adams’ Emergency Medicine, 2nd Ed. (Textbook Chapter)

Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)


Advanced Wilderness Life Support, 7th Ed. (Textbook Chapter)

2009  Tomich EB, Merchant EE, Kang CS. Cardiomyopathy, Takotsubo. eMedicine.com. (Article)

2008  Kang CS, Harrison BP. Anxiety and Panic Disorders, Adams’ Emergency Medicine, 1st Ed. (Textbook Chapter)


Contributor to PEER VII (Board Review Book)

2003  Vandenber V, Kang CS. Pemphigus, Rosen and Barkin’s 5-Minute Emergency Medicine Consult, 2nd Ed. (Textbook Chapter)

2000  Contributor to Questions of the Day and Cases of the Month for the National Center for Emergency Medicine Informatics website http://www.ncemi.org

ORAL PRESENTATION


Kang C. Atypical Headaches. Michigan State University Management and Education Center Emergency Medicine Residency Education Day, Troy, MI.


Anderson S, Kang C. Update on Emergency Medicine Issues and ACEP Activities, WA ACEP Summit to South Northwest Emergency Medicine Assembly, Seattle, WA


Kang C. Credentialing, Clinical Privileges, Certification, and Continuing Education. 2018 EMSAPS, Ocean Shores, WA.

Anderson S, Kang C. Update on Emergency Medicine Issues and ACEP
Activities, WA ACEP Summit to South Northwest Emergency Medicine Assembly, Seattle, WA


Kang C. Personal Wellness and Resiliency. ACEP17 Wellness Center. Washington, D.C.

Kang C. Introduction to Disaster Medicine. HI ACEP Annual Meeting. Honolulu, HI.

Kang C. Update on Emergency Medicine Issues and ACEP Activities. HI ACEP Annual Meeting. Honolulu, HI.


2015 Moffett PM, Cartwright L, Grossart EA, O'Keefe D, Kang CS. Intravenous Ondansetron and the QT Interval in Adult Emergency Department Patients: An Observational Study. ACEP15 Research Forum, Boston, MA.


Murray RA, Kang CS. Updated: In A Moment’s Notice – Patient Surge Response to Terrorism Event. Hospital Preparedness for Bombings and Mass Casualty Events Expert Panel Meeting. CDC, Atlanta, GA.

Course Instructor/Presenter: HEENT Injuries, Medical Cases and Infectious Disease Cases in the Wilderness, AWLS, Mt. Rainier, WA.

Meyers M, Bothwell JD, Skinner CG, Della-Giustina DA, Kang CS. Impact of Gastric Decontamination of Ultrasound Visualization of Ingested Pills. Society for Academic Emergency Medicine, Atlanta, GA.

Course Instructor/Presenter: Animal Attacks/Bites, Medical Cases and Infections Disease Cases in the Wilderness. AWLS, Mt. Rainier, WA.

Course Instructor/Presenter: Medical Cases and Infectious Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Whistler, British Columbia, Canada.

2011 Course Instructor/Presenter: Water Purification, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Mt. Rainier, WA.

2010 Course Instructor/Presenter: Water Purification, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Patient Packaging, Practical Exercises. AWLS, Chehalis, WA.


Presenter: Patient Evacuation, Unified Command; Community Tabletop Exercise Moderator. ACEP and DHS/FEMA Community Healthcare Disaster Preparedness Assessment Training, Baton Rouge, LA.

Course Instructor/Presenter: Primary Patient Assessment, Patient Packaging, Practical Exercises. AWLS, Park City, UT.

Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Wound and Burn Management, Practical Exercises. AWLS, Moab, UT; Mt. Rainier, WA.

2008 Presenter: Regional Agreements, Memorandum of Agreements; Community Tabletop Exercise Moderator. ACEP and DHS/FEMA Community Healthcare Disaster Preparedness Assessment Training, Las Vegas, NV.

Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Wound and Burn Management, Practical Exercises. AWLS, Moab, UT; Mt. Rainier, WA.

2007 Course Instructor/Presenter: HEENT Emergencies in the Backcountry, Dermatological Problems in the Wilderness, Medical Kits, Medical Cases and Infectious Disease Cases in the Wilderness, Practical Exercises. AWLS, Moab, UT.

2002 Faculty and Presenter, Advances in Wound Management. ACEP Scientific Assembly, Seattle, WA.

POSTER PRESENTATION


Cashin BV, Matlock AG, Kang CS, Reynolds PS, Wills BK. Effect of Hydroxocobalamin on Surface Oximetry in Non-Exposed Humans. ACEP SA Research Forum, Las Vegas, NV.


Smith S, Kang CS, Wedmore IS. Effectiveness of Water Filter Pump for Wound Irrigation. Wilderness Medicine Society Summer Meeting, Snowmass, CO.


Jones RA, Kang CS, Wills BK. Chlorine Blast Exposure. ACEP DHS-FEMA Clinical Applications of Disaster Planning, Dallas, TX.

PROFESSIONAL MEMBERSHIPS

American College of Emergency Physicians

American Academy of Emergency Medicine

Society for Academic Emergency Medicine

Wilderness of Medical Society, Academy of Wilderness Medicine, Fellow

American Medical Association

Washington State Medical Association

U.S. Army Society of Flight Surgeons, Lifetime Member

Boy Scouts of America, Eagle Scout and Order of the Arrow
Question #1: What is your view on the positive and negative impacts of market forces, such as hospital consolidation and the involvement of private equity, on the practice of emergency medicine?

There have been dramatic market forces in the healthcare sector that have promoted consolidation of hospitals, insurance companies, and physician practice groups. Markets are driven by reimbursement, which is shifting over time from traditional fee for service to payment based on value. The industry’s response is to consolidate in an effort to increase market share and capture economies of scale. The positive effects of consolidation to date are an enhanced focus on care coordination, information technology, and integrated healthcare delivery in an effort to improve outcomes while reducing costs. Conversely, the negative effects of consolidation include unchecked growth, with subsequent concentration of influence and decision-making into the hands of a shrinking number of business leaders. These business leaders, often non-physicians, may allow disparate priorities to displace the best interests of emergency department patients and emergency physicians.

I believe our patients’ interests are best served through physician leadership within every employer and ownership model. ACEP must ensure that our employment models prioritize high quality care, safe clinical practice environments, fair and equitable compensation, due process rights, and most importantly, a physician voice to lead the business operations and strategic direction of our practices.

Decreased reimbursement and inability to obtain reasonable in-network rates coupled with higher operational costs for quality reporting and technology upgrades forced many smaller practices to close or sell to larger groups. Smaller hospitals lack the economies of scale and physician networks required to achieve care coordination at a lower cost. Many rural hospitals are on the verge of collapse due to lower patient volumes, poor payor mixes, and high deductible plans that create uncollectable bad debt. The number of hospital administrators and managers has grown almost exponentially as have the number of regulations that mandate measurement and reporting of quality, safety, and patient experience metrics. Less and less of the healthcare dollar is spent on actual patient care. Many counties in the US are now monopolized by 1 or 2 insurance companies and health systems - leaving less competition, less choice, and potentially higher costs.

The role of private equity in physician practice is a complex topic that is controversial and potentially divisive. The evolution and maturation of large, clinically-integrated physician staffing models was a predictable response to recent market forces and large-scale consolidation across the entire healthcare industry. The extent to which emergency physician group leadership is being supplanted by non-clinical corporate executive leadership varies across groups. We need to ask the tough questions and study the impact that different employment and leadership models have on our practice, autonomy, and health of our patients. We need to ensure that our employers and other business entities that maintain ownership in our practices prioritize patient care and physician independent decision-making. Whether we are employed by a hospital, small group, or larger physician organization, there will be increasing financial pressures that will impact us all.

I believe it is the job of the ACEP President to represent, and advocate for all emergency physicians, regardless of whom they work for. We all practice under the same tent of emergency medicine, and we have real enemies that will use to their advantage any divisiveness and rancor among our ranks. ACEP must focus on goals that enhance the practice environment of all emergency physicians. We need protections in all practice settings and ACEP is well positioned to be a champion for each of us.
**Question #2: Different emergency medicine organizations may have contrasting views on emergency medicine practice and policy. How would you help ACEP create a unified message to guide policy leaders while preserving ACEP’s vision?**

As a member of several different emergency medicine organizations, I believe we generally agree on most issues impacting our specialty. I also believe that having different perspectives and diversity of thought is often healthy as long as the debate is respectful. At the end of the day, we all have different backgrounds, experiences, employer models, and work environments, yet we are all emergency physicians. We must collaborate, listen intently, and discover unifying principles that strengthen our voice rather than allowing politics or personal agendas to divide us.

I have never been afraid to stand up for the things I believe in. I have successfully collaborated with other EM organizations on a variety of issues including protecting core faculty time, improving the distribution of PPE, developing accreditation standards for free-standing EDs, challenging BLS certification requirements for emergency physicians, and creating guidelines for medical student rotations in the midst of COVID-19. Additionally, I helped find consensus on controversial topics that informed our position within the Board.

During my tenure on the Board, we have repeatedly reached out to other organizations, specialties, and our own members to seek consensus on controversial topics such as scope of practice, gun violence, and strategies for funding health care. We cannot always agree with other organizations on matters of importance, and I do not believe that full consensus with other organizations should always be the goal. As leaders, we represent a diverse membership, but we need to work together to strengthen our messaging, unite our specialty, and effectively advocate for the interest of our members, our patients, and the public. You can trust that I will collaborate, actively listen, and work respectfully with other organizations while preserving the mission and vision of the American College of Emergency Physicians.

**Question #3: What additional opportunities and strategies does ACEP need to address during the COVID era?**

COVID has fundamentally disrupted the health care sector, impacting public health and the economy. ACEP has been at the forefront of this pandemic educating our members and the public, collaborating with the CDC, FDA, U.S. Congress and the White House, and advocating for physicians to have sufficient PPE, liability protections, hazard pay, and due process. But we’re not done with this virus and it’s not done with us. There are a number of challenges and opportunities ahead as we navigate the “new normal”.

From a strategic standpoint, ACEP needs to address the significant decreases in ED volumes. We need to effectively message that EDs are safe and patients should not delay emergency care out of fear of contracting the virus. We also must collect data on adverse events and preventable morbidity and mortality resulting from delays to receive emergency care. The insurance lobbyists undoubtedly will use the decreased ED volume to justify their absurd claim that the majority of ED visits are unnecessary. ACEP must prepare a robust response to this insurance industry tactic.

Secondly, ACEP has an opportunity to take back the white hat and reframe the issue of surprise billing and out of network coverage. Fundamentally, the cost of providing care is tied to the cost of maintaining our country’s safety net. As more people have lost their jobs and their health insurance at the hands of the pandemic, we now have an expanding role in providing access for the most vulnerable members of society. Changes to payor mixes and payment methodology will threaten the viability of that safety net. ACEP has an opportunity to reframe the national reimbursement conversation based on the need to fund preparedness, surge capacity, and safety net care.

Third, we need to proactively disseminate the lessons learned from this pandemic to improve the supply chain for and distribution of PPE. Having states and hospitals compete with one another in bidding wars for limited resources is unacceptable and must end. Having our frontline physicians fear for their safety or job security if they speak out is abhorrent. Distribution of supplies at a state, regional, and local level requires greatly enhanced communication and coordination systems. Crisis planning has to occur before the start of the next disaster.

Finally, we need to embrace emergency medicine not as a room or even a department. We are the leaders in an acute care system that extends well beyond the walls of the hospital. We need to extend our outreach through telemedicine and new health care delivery models, advancement of technology and data sharing, and through driving innovation in emergency care. There are exciting opportunities for emergency physicians to provide new venues of access, deliver the highest quality care for our patients, and provide exceptional leadership across the entire spectrum of acute unscheduled care.
CANDIDATE DATA SHEET

Gillian R. Schmitz, MD, FACEP

Contact Information
111 Ottawa Run
Shavano Park, TX 78231
Phone: 210-542-7783
E-Mail: GillianMD@gmail.com

Current and Past Professional Position(s)

Current Academic Appointments
  Associate Professor
  Department of Military and Emergency Medicine
  F. Edward Hébert School of Medicine
  Uniformed Services University of the Health Sciences

  Adjunct Associate Professor
  Department of Emergency Medicine
  University of Texas Health, San Antonio
  San Antonio, TX

Employment Experience
  2017-Current
  Dept. of Defense/ Uniformed Services University
  Department of Emergency Medicine
  Brooke Army Medical Center (BAMC)
  Ft. Sam Houston, TX
  (Academic Military Residency Program and Level 1 Trauma Center)

  2012-Current
  Adjunct Associate Professor
  Associate Residency Program Director (2012-2016)
  Department of Emergency Medicine
  University of Texas Health, San Antonio
  San Antonio, TX
  (Academic Civilian Residency Program and Level 1 Trauma Center)

  2016-2018
  Associate Medical Director
  Executive Director for Policy and Advocacy
  Spectrum Healthcare, Full Spectrum Emergency Room
  San Antonio, TX
  (Community Practice/ Small Democratic Group)

  2011-2012
  Assistant Professor
  Department of Emergency Medicine
  UCSD Medical Center
  San Diego, CA
  (Clinical shifts at both academic county hospital and private community hospital)
2009-2011
Assistant Professor
Department of Emergency Medicine
Georgetown University/Washington Hospital Center, Washington, DC
(Clinical shifts at suburban community hospital)

2007-2009
Curriculum Director
Department of Emergency Medicine
Wilford Hall Medical Center, Lackland AFB, TX
(Military Level 1 Trauma Center)

Part Time/ Moonlighting Employment
Greater San Antonio Emergency Physicians (GSEP), San Antonio, TX -small democratic group
Adeptus, First Choice ER, San Antonio, TX – Freestanding Emergency Department
Persons Memorial Hospital, Roxboro NC – Rural emergency medicine

Education (include internships and residency information)

Emergency Medicine Residency
University of North Carolina
Chapel Hill, NC (2007)

Loyola Stritch School of Medicine
Maywood, IL
Degree: Doctor of Medicine (2004)

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.)

ABEM

Professional Societies

ACEP
Government Services ACEP
Texas ACEP
Council of Residency Directors (CORD)
Texas Medical Association (TMA)
EMRA Alumni

National ACEP Activities – List your most significant accomplishments

Vice President, American College of Emergency Physicians (2019-present)
Board of Directors, American College of Emergency Physicians, (2016-present)

Board Liaison to:
- Committees: Bylaws, Membership, Chapter Relations Committee, and Academic Affairs Committee
- Sections: Rural EM, Tactical EM, Freestanding, Dual Certification, Young Physician Section, and Locum Tenens Sections
- Organizations: EMRA, Annals of Emergency Medicine, JACEP, Emergency Medicine Foundation
- Task Forces: Residency Visits and Outreach Task Force, Supply Chain and PPE Task Force

ACEP Academic Affairs Committee
Committee Chair (2013-2015)
Sub-committee chair (2005-2016)
ACEP Medical Legal Committee
2011-2014

Annals of Emergency Medicine Editor in Chief Task Force 2014, 2018

ACEP Young Physicians Section
Chair 2008-2010
Member 2007-present

Technical Advisory Group (TAG) Workforce Task Force
2006-2009

EMRA Board of Directors
2005-2007

*ACEP Chapter Activities – List your most significant accomplishments*

Government Services State Chapter of American College of Emergency Physicians
President 2015-2016
President Elect 2014-2015
Board of Directors 2011-present
Membership Chair 2011-2013
Councilor 2011-2016

Texas ACEP Chapter
Texas Leadership and Advocacy Fellow (TLAF)
Residency Visit Committee

*Practice Profile*

**Total hours devoted to emergency medicine practice per year:** 2100 Total Hours/Year

*Individual % breakdown the following areas of practice. Total = 100%.*

- Direct Patient Care 50 %
- Research 10 %
- Teaching 10 %
- Administration 30 %
- Other: 

*Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)*

I work clinically at a military academic training site that is a Level 1 Trauma Center and an emergency medicine residency training program. I am employed through the Department of Defense and teach at Brooke Army Medical Center, the Uniformed Services University of the Health Sciences, and the University of Texas Health in San Antonio, TX.

*Provide specific title(s) within your group, hospital, department, system (e.g Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)*

Vice Chair of Education, Brooke Army Medical Center
Clerkship Director, Uniformed Services University

*Expert Witness Experience*

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

<table>
<thead>
<tr>
<th>Defense Expert</th>
<th>Cases</th>
<th>Plaintiff Expert</th>
<th>Cases</th>
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<tbody>
<tr>
<td>X</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CANDIDATE DISCLOSURE STATEMENT

Gillian R. Schmitz, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer:  
   Department of Defense/ Uniformed Services University of the Health Sciences

   Address:  
   4301 Jones Bridge Rd, Bethesda, MD 20814

   Position Held:  
   Associate Professor, Department of Military and Emergency Medicine

   Type of Organization:  
   Government/ Military Academic Training Center

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

   Organization:  
   American College of Emergency Physicians Board of Directors

   Address:  
   4950 W. Royal Lane, Irving, TX 75063-2524

   Type of Organization:  
   National Membership Organization

   Duration on the Board:  
   4 years

   Organization:  
   Government Services ACEP

   Address:  
   

   Type of Organization:  
   Chapter Board of Directors

   Duration on the Board:  
   6 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE

☐ If YES, Please Describe:
4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

- NONE
- If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

- NONE
- If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

- NO
- If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Gillian R. Schmitz

Date 5/9/20
July 10, 2020

Dear Members:

The Government Services Chapter ACEP (GSACEP) and the American Association of Women Emergency Physicians (AAWEP) wholeheartedly endorse the candidacy of Gillian Schmitz, MD, FACEP, for the position of President-elect for the American College of Emergency Physicians.

Gillian’s service to GSACEP throughout the years has been extensive, innovative, and passionate. There are few members as ready to step up to a challenge as Gillian, and even fewer who bring her level of passion to the Chapter. She served as President from 2015-2016 and Chair of GSACEP’s Membership Committee from 2011-13, a period of significant growth, and remains an active participant in GSACEP’s residency visits and Board. She served as Chair of our Awards Committee and been an active member of our Education and Conference Planning Committee and recently started a Medical Student Mentorship Committee. She has worked with EMRA and CORD to advocate for military residents and emergency medicine training, including the creation of a specific EMRA chapter for military residents (GSEMRA).

Gillian has been honored numerous times for her efforts on behalf of emergency medicine. She has received numerous teaching awards, the National Early Career Award from the Academy for Women in Academic Emergency Medicine (AWAEM), EMRA's 45 under 45 Award, and ACEP's National Teaching Award. She served as the Chair of the Committee for Advancement of Women and Minorities at the University of Texas Health Science Center and continues to be an advocate for diversity and inclusion in emergency medicine.

Nationally, Gillian has been contributing to ACEP since her days as a resident. From 2005-2007, she served on The Emergency Medicine Residents Association (EMRA) Board of Directors. She subsequently became involved and chaired ACEP’s Young Physician Section. She chaired the National Academic Affairs Committee of ACEP from 2013-2015, having served as subcommittee chair since 2005. She served as a subcommittee Chair for ACEP’s Medical Legal Committee and subsequently served as the Board liaison to numerous other ACEP committees, sections, and task forces.

Her work and collaboration in academics expands to other EM organizations where she has also participated in ABEM’s EM Model Task Force and chaired the Joint Milestone Task Force for CORD. She has been a national speaker for ACEP, SAEM, CORD and EMRA. She has published research in most of EM’s major journals and serves as a reviewer for Annals, JEM, and an invited expert for the New England Journal of Medicine. Gillian is a strong advocate for collaborative work, for recognition of the contributions of all, and for perseverance in advocating emergency medicine goals, no matter what the challenges.

The emergency physicians of GSACEP and of the Association of Women Emergency Physicians urge our fellow members to vote for Dr. Gillian Schmitz for President-elect.

Sincerely,

Andrea Austin, MD, FACEP  
President, GSACEP

Sarah Hoper MD, JD FACEP  
Chair, AAWEP
Dear Colleagues and Friends,

What a crazy time to be an emergency physician. While others have run away from danger, we have run headfirst into uncertainty. When the country realized we did not have enough supplies to protect our frontline workers, we improvised our own PPE and fought to change the supply chain. When the public looked for information, we were the experts on national and local news to address their fears. When our patients and our colleagues got sick, we picked up extra shifts, we led the disaster planning and surge capacity for our hospitals, and we promoted research to find evidence-based solutions. We have grieved together after losing one of our own, Dr. Breen, and countless others. We reminded the country that public health is not politics. We became recognized heroes by our communities and nation’s leaders.

**Communication.** This pandemic has highlighted to me the importance of communication and support for one another. As a membership organization of over 40,000 members, one of our biggest challenges has always been reaching and engaging our diverse members. COVID-19 forced us to communicate differently- dozens of Zoom meetings between candidates and state chapter boards, weekly calls amongst the chapter Executive Directors, an enhanced engagED platform to disseminate information and lessons learned, weekly discussions between ACEP and the CDC, etc. Communication is essential in times of uncertainty as is *listening* to our members. This disruptive change has been catalytic in providing more support for state chapters, more integration between the national Board and individual states, and more engagement of our members. Strategically, I think ACEP needs to build on this momentum and modify the infrastructure of our organization to better support state chapters and listen to our individual members.

**Unity.** Our specialty and country have become increasingly divided on a number of political and controversial topics that impact emergency medicine. Tackling these challenging issues will require collaborative action. ACEP needs to have a unified voice to advocate for our patients and our members. As a member of multiple medical and EM organizations, I have a diverse network of internal and external relationships within the house of medicine and a demonstrated ability to leverage them to protect our specialty.

**Vision.** This is an unprecedented time with numerous challenges and opportunities for our specialty. My vision is to emphasize the value of emergency medicine to our legislators, create a more rational fee structure to support the safety net, improve transparency and efficiency in health care, increase access to mental health, invest in health technology, preserve autonomy of physician practice, and empower emergency physicians to innovate, lead and define the “new normal” of acute unscheduled care.

Thank you for your trust, support, and service to our College. Thank you for allowing me the opportunity to serve as a member of the Board and Vice President of the American College of Emergency Physicians. I have never been prouder to be an emergency physician and I have never been more grateful to have such outstanding colleagues. Our ability to adapt, overcome, and persevere in the setting of uncertainty is what defines us as a specialty. Emergency physicians will be the leaders who navigate us out of this storm, who fight and advocate for what is best for our patients, and who never tire of doing the right thing. Stay strong and stay safe. I stand proudly beside you to help lead our specialty and College.

Gillian R. Schmitz, MD, FACEP
Endorsed by The Government Services Chapter and AAWEP

GILLIAN SCHMITZ, MD, FACEP

Leadership Community Vision

National Leadership
- ACEP Vice President
- ACEP Board of Directors
- Chair, Academic Affairs Committee
- National Speaker for ACEP, CORD, SAEM, & EMRA
- Chair, ACEP Young Physician Section 2008-2009
- EMRA Board of Directors 2005-2007

ACEP Chapter Activity
- Government Services Chapter
  - Past President, Membership, and Awards Chair
- Texas Chapter
  - Leadership and Advocacy Fellow

Academic Leadership
- Vice Chair of Education, BAMC
- Associate Residency Director - UT San Antonio
- EMF Grant Recipient and Board of Trustees
- EMRA National Mentorship Award
- Chair of Faculty Development and Career Advancement of Women and Minorities

Community Experience and Hospital Leadership
- Previous Physician Owner and Associate Medical Director of a Small Democratic Group
- Clinical Experience in Private Practice, Military, Freestanding and Rural Emergency Departments

Candidate for ACEP-President Elect
Why Gillian Schmitz for ACEP President-elect?

- The job of an ACEP President is to be the spokesperson of the College. One of my greatest strengths is public speaking. Whether testifying at the state legislature, giving interviews on national TV, speaking to EM physicians around the country at national emergency medicine conferences, or lecturing to medical students and my community at a local level, this is what I do and this is where I excel.

The spokesperson needs to articulately deliver content in a way that is informative, engaging, and tailored to the audience. I am very comfortable and confident speaking in front of live audiences and media cameras, recording podcasts, giving live interviews, and meeting with legislators. I have not only the knowledge base of critical issues in emergency medicine, but the ability to confidently deliver our message and serve as the primary spokesperson for the College.

- I have leadership experience in both academic and community practice settings. My work experience goes beyond doing clinical shifts - I have personally dealt with the challenges of running a group, fought for fair reimbursement, started a new residency, and ensured a physician-led voice in strategic planning and business operations.

I’ve served as an Associate Medical Director of a small democratic group and helped manage operations, brought billing in-house, and fought for fair reimbursement from insurance companies who delayed, denied, and ignored repeated attempts to cover their beneficiaries. I’ve served as an Associate Program Director and the founding faculty for an EM residency training program and understand the challenges of establishing a new residency and nurturing key relationships with other departments and the community. I have worked in military hospitals, rural hospitals, free-standing EDs, small democratic groups, large community hospitals and academic centers. I have practiced in 5 states, suffered through every EMR imaginable, and experienced a wide breadth of patient populations, state advocacy issues, and practice environments. This diversity of experience will make me a stronger leader and ensure that ACEP represents and embodies a variety of ED settings and physicians who practice in them.

- Vision

This is an unprecedented time with numerous challenges and obstacles for our specialty, but also a number of opportunities. I believe in taking the lessons learned from this pandemic and applying them to provide better patient care, increased access, and more connectivity and support amongst our ED community. My vision is to highlight the value of emergency medicine to our legislators, underscore the need to adequately support and fund disaster preparedness and the safety net of health care, increase access to mental health, improve transparency and efficiency, invest in health technology and telemedicine, preserve autonomy of physician practice and empower emergency physicians to innovate, lead, and define the “new normal” of acute unscheduled care and healthcare delivery.
Gillian R. Schmitz, MD, FACEP

Personal Information:

111 Ottawa Run
San Antonio, TX 78231
Phone: (210)542-7783
GillianMD@gmail.com

Licensure:

State: Texas
License No: M6869
Initial Date: 5/31/2007
Renewal/Expiration: 5/31/2023

Certification:

Board Certification: (ABEM) #40554
Date of Initial Certification: Dec 4, 2009
Concert Recertification: October 2018
Date of Re-certification: Dec 31, 2029

Current Academic Appointments

06/18-present  Associate Professor
Department of Military and Emergency Medicine
F. Edward Hébert School of Medicine
Uniformed Services University

09/12-present  Adjunct Associate Professor
Department of Emergency Medicine
University of Texas Health
UT Long School of Medicine
San Antonio, TX

Employment Experience

08/17-present  Department of Emergency Medicine
Brooke Army Medical Center (BAMC)
Ft. Sam Houston, TX

01/16-05/18  Associate Medical Director
Executive Director for Policy and Advocacy, Spectrum Healthcare
Full Spectrum Emergency Room
San Antonio, TX

07/12-07/16  Associate Residency Program Director
Department of Emergency Medicine
University of Texas, San Antonio
San Antonio, TX
07/11-07/12 Assistant Professor
Department of Emergency Medicine
UCSD Medical Center
San Diego, CA

07/09- 07/11 Assistant Professor
Department of Emergency Medicine
Georgetown University/Washington Hospital Center, Washington, DC

07/07-07/09 Curriculum Director
Department of Emergency Medicine
Wilford Hall Medical Center
Lackland AFB, TX

06/04-07/07 Emergency Medicine Resident
(Chief Resident 2007-2007)
Department of Emergency Medicine
University of North Carolina
Chapel Hill, NC

Education

2004-2007 University of North Carolina
Chapel Hill, NC
Emergency Medicine Residency
Chief Resident 2006-2007

2000-2004 Loyola Stritch School of Medicine
Maywood, IL
Degree: Doctor of Medicine

1994-1998 University of Virginia
Charlottesville, VA
Degree: Bachelor of Arts (Biology)

National Leadership Experience

American College of Emergency Physicians
Vice President (2019-present)
Board of Directors (2016-present)

National Academic Affairs Committee (American College of Emergency Physicians)
Committee Chair (2013-2015)
Sub-committee chair (2005-2016)

National Medical Legal Committee (American College of Emergency Physicians)
2011-2014

Joint Milestone Task Force - Council of Residency Directors (CORD)
Chair 2012-2014

Government Services State Chapter of American College of Emergency Physicians
President 2015-current
President Elect 2014-2015
Board of Directors 2011-present
Membership Chair 2011-2013
Councilor 2011-present

Annals of Emergency Medicine Editor in Chief Task Force (American College of Emergency Physicians) 2014, 2018

Young Physicians Section (American College of Emergency Physicians) Chair 2008-2010
Member 2007-present

National Model of Emergency Medicine Task Force
American College of Emergency Physicians 2013-2014

Technical Advisory Group (TAG) Workforce Study
American College of Emergency Physicians 2006-2009

Emergency Medicine Residents Association (EMRA) Board of Directors 2005-2007

Chief Resident
University of North Carolina 2006-2007

Graduate Medical Education Committee

Honors and Awards

2019- “45 Under 45” National Award- Emergency Medicine Resident’s Association

2019- Dean’s Impact Award. Uniformed Services University.

2018- Top 50 Peer Reviewer for the Annals of Emergency Medicine

2017- National Mentorship Award. Awarded by Emergency Medicine Resident’s Association

2016- Recognized as Texas Super Doctor “Rising Star”

2015- Recognized by San Antonio Scene on list for “Best Doctors in San Antonio”

2014 – Faculty Teaching Award University of Texas Heath Science Center San Antonio.


2011- Faculty Mentoring Award. Department of Emergency Medicine. Georgetown University and Washington Hospital Center.

2010- Faculty of the Quarter. Department of Emergency Medicine. Georgetown University and Washington Hospital Center.
2010- National Early Career Faculty Award. Academy for Women in Academic Emergency Medicine (AWAEM) Awarded through the Society for Academic Emergency Medicine (SAEM)

2010 - Early Career Achievement Award. Loyola Stritch School of Medicine Alumni Award Ceremony.

2010 - Junior Faculty of the Year Award. Department of Emergency Medicine. Georgetown University and Washington Hospital Center.

2007 - Pioneer Award. (University of North Carolina). Given to top graduating resident for outstanding performance as an emergency physician.

2006 - The Chancellor’s List Academic Honor Society.

2003-2004 Alpha Sigma Nu Honor Society

2003-2004 Father Fahey Scholarship for academic achievement, leadership, and service (Loyola Stritch School of Medicine)


1999 Nominated for Barchi Prize and awarded best presentation at national meeting Military Operations Research Society

Research Grants


2014 – Durata Therapeutics. Retrospective chart review of management of skin and soft tissue infections in the emergency department.

2008 – Finalist and Recipient of Emergency Medicine Foundation (EMF) Grant. Prospective Randomized Placebo Controlled Trial of Antibiotics in Treatment of Uncomplicated Skin Abscess Study.

2008 – Department of Defense. Prospective Randomized Placebo Controlled Trial of Antibiotics in Treatment of Uncomplicated Skin Abscess Study.

2008- Clinical Research Office at Wilford Hall Medical Center for Determining Effectiveness of Simulation on Teaching Emergency Medicine Interns Central Line Placement. Associate Investigator

Peer Reviewed Publications


Olderog CK. **Schmitz G.** Bruner DR. Clinical and epidemiologic characteristics as predictors of treatment failures in uncomplicated skin abscesses within seven days after incision and drainage. *J Emerg Med* 2012. 43(4):605-11


**Peer Reviewed Books and Chapters**


Weinstock Michael, Klauer Kevin. Bouncebacks 2! Medical and Legal. Schmitz G (Chapter 8) October 2011


Schmitz G and Tews M. Resident Involvement in Medical Student Education. Medical Student Educator Handbook (Lansing, MI: Society for Academic Emergency Medicine, 2010.)


Audio and Video Publications


Schmitz GR. Emergency Medicine Reviews and Perspectives (EM RAP) November 2010.


Non-Peer Reviewed Publications


Peer Reviewed Abstracts


Schmitz GR, Olderog C. Clinical and Epidemiologic Characteristics as Predictors of Treatment Failures in Uncomplicated Skin Abscesses within Seven Days after Incision and Drainage. International Conference on Antimicrobial Research (ICAR2010), 3-5 November, Valladolid, Spain.


**Schmitz GR.** Can a Resident-Student Mentorship be a Useful Supplemental Tool for Medical Students Interested in Emergency Medicine? Educational tool developed by Emergency Medicine Resident’s Association (EMRA) to mentor medical students. IRB exempt approval. Presented at 2006 National CORD Conference.

Broder J. **Schmitz G.** Assessment of Head CT Interpretation Abilities of Fourth-year Medical Students. Determined the ability of fourth-year medical students to identify a variety of head CT scan abnormalities and presence of contraindications to thrombolytic therapy. Measured the effect of a teaching intervention on these endpoints. Poster abstract at Scientific Assembly 2005.

**Journal Reviewer**

*New England Journal of Medicine*
Subject expert for discussion forum for skin and soft tissue infections
2016

*Annals of Emergency Medicine*
Reviewer
2015-present

*American Journal of Emergency Medicine*
Reviewer
2013-present

*Journal of Emergency Medicine*
Reviewer
2012-present

*Scandinavian Journal of Trauma, Resuscitation, and Emergency Medicine*
2015-present

*Emergency Medicine: Open Access*
2011-2014


**Pediatrics**
Invited Reviewer  
2010-present

**Scandinavian Journal of Infectious Diseases**
Invited Reviewer  
August 2011

**Media Reports**
Joint Commission backs clinicians demanding freedom to bring their own PPE to work. Healthcare Dive. April 2020.

CBS Good Morning Interview March 2020.

Last Week Tonight with John Oliver on HBO. March 2020.

**National and International Presentations (selected)**

Rural Emergency Medicine  
Maine ACEP Annual Meeting  
Sugarloaf, ME  
March 2020

Hacking Your EM Life: Work Life Integration  
Scientific Assembly  
American College of Emergency Physicians  
Denver, CO 2019

Physician Wellness and Resiliency  
Scientific Assembly  
American College of Emergency Physicians  
Denver, CO 2019

Emergency Obstetrics  
Emergency Medicine and Acute Care Conference  
New York, NY  
June 2019

Top Plain Films You Don’t Wanna Miss  
Summit to Sound National Meeting  
Seattle, WA April 2019

Pregnancy in Trauma: Baby on Board  
Summit to Sound National Meeting  
Seattle, WA April 2019

Pediatric Pearls  
Emergency Medicine and Acute Care Conference  
Vail, CO  
March 2019

ATLS Update: What has Changed?  
Emergency Medicine and Acute Care Conference
Vail, CO March 2019

Pediatric Fever
Emergency Medicine and Acute Care Conference
Maui, HA
Feb 2019

Opioid Epidemic
Emergency Medicine and Acute Care Conference
Maui, HA
Feb 2019

Risk Management: Physician Beware!
Emergency Department Director’s Academy
Dallas, TX
Nov 12, 2018

More than Acute Coronary Syndrome: Other Life-Threatening Causes of Chest Pain
National Advanced Emergency Medicine Bootcamp
Las Vegas, NV
September 2018

State of the Art: Resuscitation of the Acute Bleeding Patient
National Advanced Emergency Medicine Bootcamp
Las Vegas, NV
September 2018

The Critically Ill Medical Patient
National Advanced Emergency Medicine Bootcamp
Las Vegas, NV
September 2018

Transfusions: Risks, Benefits and Controversies
National Advanced Emergency Medicine Bootcamp
Las Vegas, NV
September 2018

End of Life Care
Leadership and Advocacy Conference
Washington DC
May 2018

Diagnostic Imaging in Emergency Medicine
Society of Emergency Medicine Physician Assistants
San Antonio, TX, May 2018

Malpractice Litigation Stress: Doctor Beware! Emergency Department Director’s Academy, ACEP. Dallas, TX Nov 2017.

Freestanding Emergency Departments: Threat, Opportunity, or Both?

Malpractice Litigation Stress: Doctor Beware! Emergency Department Director’s Academy, ACEP. Dallas, TX Feb 2017


Don’t Blink: Top Plain Film Diagnoses You Can’t Afford to Miss. National Scientific Assembly. American College of Emergency Physicians (ACEP), Las Vegas, NV Oct 2016

Don’t Blink: Top Plain Film Diagnoses You Can’t Afford to Miss. National Scientific Assembly. American College of Emergency Physicians (ACEP), Boston, MA Oct 2015.


Emergency Medicine Residents Association
National Medical Student Forum
“The Road to Residency: What to Expect on Interview Day”
Boston, MA. Oct 2015

Don’t Blink: Top Plain Film Diagnoses You Can’t Afford to Miss. Coastal Emergency Medicine Conference. Kiawah Island, South Carolina. June 2015


Don’t Blink: Top Plain Film Diagnoses You Can’t Afford to Miss. National Scientific Assembly. American College of Emergency Physicians (ACEP), Chicago, IL Oct 2014.


I Can’t Get No Satisfaction – or Can I? Patient Satisfaction Scores in the ED
State and Regional Presentations

Breaking the Glass Ceiling
Women in Leadership Emergency Medicine Conference
San Antonio, TX
November 2019

Invited Grand Rounds Speaker
Department of Emergency Medicine
Brown University
Providence, RI
June 2019
Invited Grand Rounds Speaker
Department of Emergency Medicine
Jacobi / Montefiori Emergency Medicine Residency Program
Albert Einstein College of Medicine
Oct 2018

Southeast Regional Emergency Medicine Conference
Kiawah Island, SC
June 2018

Invited Grand Rounds Speaker
Department of Emergency Medicine
Medical University of South Carolina (MUSC)
June 2018

Invited Grand Rounds Speaker
Department of Emergency Medicine
Georgetown University
Washington Hospital Center
May 2018

Invited Grand Rounds Speaker
Department of Emergency Medicine
University of California Fresno
March 2018

Invited Grand Rounds Speaker
Department of Emergency Medicine
University of Wisconsin
Feb 2018

UT San Antonio Health Science Center
Grand Rounds Invited Speaker
Women in Leadership
November 2017

Illinois ACEP Annual Meeting
Keynote Speaker
Transitioning from Resident to Junior Faculty
August 2017

New York ACEP Annual Scientific Assembly
Keynote Speaker
So You’ve been Sued, Now What; Top Plain Film Diagnoses You Don’t Want to Miss
July 2017

Grand Rounds Speaker - Eastern Virginia Medical School
August 2017

Grand Rounds Speaker - Louisiana State University (LSU Shreveport)
April 2017

Southwest Texas Regional Advisory Council Meeting
Trauma in Pregnancy
April 28, 2016

Grand Rounds Speaker – San Antonio Military Medical Center (SAMMC)
Department of Emergency Medicine
ACEP Residency Visit – Leadership Panel
Don’t Blink: Plain Film Diagnoses You Can’t Afford to Miss
April 27, 2016

Grand Rounds Speaker- Medical University of South Carolina
Department of Emergency Medicine
Don’t Blink: Plain Film Diagnoses You Can’t Afford to Miss
June 4, 2015

Coastal Emergency Medicine Conference
Kiawah Island, SC
Don’t Blink: Plain Film Diagnoses You Can’t Afford to Miss
June 5, 2015

Grand Rounds Speaker- San Antonio Military Medical Center
Department of Emergency Medicine
HIV: Common but Critical Chief Complaints in the Emergency Department
Faculty Development Lecture: Academic Portfolio
May 8, 2014

Grand Rounds Speaker University of North Carolina
Department of Emergency Medicine
Risk Management: What Every Physician Should Know
April 16, 2104

Texas Chapter of American College of Emergency Physicians Annual Meeting
Invited Speaker
HIV: Common but Critical Chief Complaints in the Emergency Department
April 11, 2014

Grand Rounds Speaker – University of Texas Houston
Department of Emergency Medicine
Risk Management: What Every Physician Should Know
Advanced Wound Care: Putting the Pieces Together
February 6, 2014

Governmental Services Annual Meeting, American College of Physicians.
Lake Tahoe, NV 2012

Governmental Services Annual Meeting, American College of Physicians.
Genitourinary Emergencies in the Non-Pregnant Female.
San Antonio, TX. March 2011

Emergency Medicine Residency Grand Round Keynote Speaker
Regions Emergency Medicine Residency Program
Health Policy: Current Issues and Crises. Regions
Local and Institutional Service
2018-current Faculty Development (BAMC), Chair
2018-current Committee for Advancement of Women and Minorities (BAMC)
2018-current ACLS Instructor
2017-current Medical Student Mentoring and Clerkship Committee (BAMC)
2017-current Resident Selection Committee (BAMC)
2017-current Dept of EM Research Committee (BAMC)
2013- current Committee for Advancement of Women and Minorities (UTHSCSA) Chair 2015-2016
2014-2016 Graduate Medical Education Milestone Subcommittee (UTHSCSA)
2014-2016 Resident Duty Hour and Fatigue Mitigation Subcommittee (UTHSCSA)
2012-2016 Graduate Medical Education Committee (UTHSCSA)
2013-2014 Admissions Committee (Medical School)
University of Texas Health Science Center San Antonio
2012-2016 Longitudinal Preceptor (UTHSCSA)
2012-2015 Cardiac Risk Stratification in the Emergency Department/ Cardiac CT Committee (UTHSCSA)
2012-current Medical Student Mentoring (UTHSCSA)
2009-2011 Ambulatory Care Attending / Preceptor
Georgetown University Medical School
2009-2011 Research Committee
Department of Emergency Medicine
Georgetown University/ Washington Hospital Center
2009-2011 Promotion and Tenure Committee
Department of Emergency Medicine
Georgetown University/ Washington Hospital Center
2009-current Practice Committee/ Risk Management
Department of Emergency Medicine
Georgetown University/ Washington Hospital Center
2009-current Curriculum Planning Committee/ Resident Education
Department of Emergency Medicine
Georgetown University/ Washington Hospital Center
2008-2009 Institutional Review Board
Department of Wilford Hall Medical Center
2007-2009 Resident Education and Curriculum Committee
Department of Emergency Medicine
Wilford Hall Medical Center
2020 Board of Directors Candidates

Michael J. Baker, MD, FACEP
• Written Questions
• Candidate Data Sheet
• Disclosure Statement
• Endorsement
• Campaign Message
• Campaign Flyer
• CV

Alison J. Haddock, MD, FACEP
• Written Questions
• Candidate Data Sheet
• Disclosure Statement
• Endorsement
• Campaign Message
• Campaign Flyer
• CV

James L. Shoemaker, Jr., MD, FACEP
• Written Questions
• Candidate Data Sheet
• Disclosure Statement
• Endorsement
• Campaign Message
• Campaign Flyer
• CV
Aisha T. Terry, MD, MPH, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

Arvind Venkat, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV
Question #1: Describe your skills, background, knowledge, or unique abilities outside of ACEP that will make you an effective Board member.

Our world has been turned upside down this year due to the COVID-19 pandemic. Each day, emergency physicians take on the newest challenges with our sleeves rolled up, and our minds open to possibilities. During such times, we must ensure that ACEP has experienced leadership for the expected set of challenges that are ahead of us. Right now, the ACEP Board needs a leader who is comfortable innovating in both physical and digital environments. As an ACEP Board member, I will apply my unique leadership skills in telehealth, innovation, and collaboration to ensure that emergency physicians have the resources they need to take care of not only our patients but also ourselves.

THERE HAS NEVER BEEN A MORE IMPORTANT TIME FOR THE ACEP BOARD TO LEAD INNOVATION.

As a result of my many years of service to the college and time as a medical director, my ability to recognize and implement innovation makes me uniquely qualified among the candidates. Telemedicine and virtual collaboration will be the new normal for the foreseeable future. I have considerable experience in both areas.

- Current Director of Telemedicine within my group. Former CEO of a multi-state telemedicine company.
- Created resources on telemedicine with the ACEP telemedicine section members, health systems, and EMS agencies.
- National COVID-19 Pandemic Response Team leader who put together a team that successfully deployed telemedicine workflows and technologies across 60 emergency center sites in 45 days for safety, patient surges, and access to care.
- Managing workforce challenges in rural and underserved areas using telemedicine to get us to ACEP’s vision that “Patients seeking emergency care are treated by board-certified emergency physicians who are supported.”
- Past innovations including the creation of the first longstanding ultrasound course for Michigan ACEP, deployment of the first unified computerized physician order entry system to its residents for a major health system, and organizing both an emergency care collaborative and technology innovations panel across a large, 83 hospital health system.

INNOVATION REQUIRES COLLABORATION FOR LASTING SOLUTIONS.

- Michigan College of Emergency Physicians President: I lead a team to defeat a “three strikes rule” for Medicaid within our state that would have devastated reimbursement and access to care. Through collaboration with state health leadership, health policy leaders, and chapter leaders from other states facing similar issues, we created a legislative report detailing why three strikes rules do not work.
- National Chapter Relations Committee: I have worked with state chapters to create resources, including leadership development programs, LAC leadership topics, and chapter collaboration through roundtable discussions.
- Leadership Diversity Task Force and Diversity & Inclusion Task Force: Appointed by Dr. Becky Parker, I developed a consensus to revise the council campaign rules to encourage more diverse representation by BOD candidates. Furthermore, I was proud to help recruit the first members to create the Diversity, Inclusion, & Health Equity (DIHE) section, which carries on the diversity and inclusion mission of the task forces.

We need innovative Board members who can collaborate both within and across organizations to innovate on COVID-19, surprise billing, workforce challenges, rural EM, telemedicine, and other issues. I am honored to have been mentored by leaders within ACEP to develop my leadership skills. I would be equally honored to have the opportunity to do the same for others by applying my leadership background and desire to innovate to the ACEP Board of Directors and its members. Please connect to share your thoughts with me @MBaker911 on Twitter or LinkedIn.com/MBaker911

Question #2: What are the two greatest opportunities and threats to ACEP?

GREATEST THREATS: COVID-19 AND CONSOLIDATION

ACEP is a strong organization that watches for threats and opportunities and develops strategic plans around them. The COVID-19 health emergency is both a direct and indirect threat to ACEP. Directly, ACEP risks losing valuable members, recent graduates, education opportunities, chapter support, and more to furloughs and burnout associated with COVID-19. Indirectly, the lower reimbursements to hospitals and physicians will lead to a desire to reduce the cost of care. Some emergency physicians have already experienced a 20% or higher wage drop. A loss of CME benefits will drive our members to
low-cost options for continuing education. As hospitals cut positions to save money, more work will be placed on the physician. Emergency physician positions might be filled with less costly nurse practitioners or physician assistants who require must be adequately supervised and trained. ACEP can find innovative ways to connect with members and support them in the workplace during this challenging time. Opportunities might include asynchronous learning, virtual grand rounds, PA/NP collaboration standards, expansion of the Engaged platform, and revising workplace-related policies.

The second threat is the consolidation of insurers, health systems, and physician groups. Although ACEP has faced consolidation in the past, the level of consolidation today has the potential to restrict needed competition. As insurance carriers become larger with less competition, they will force new ways to reduce payments to physicians. One example is the ongoing attempts to pass unfair “surprise billing” legislation. Reduced competition among employers raises concerns from our members on ensuring fair compensation, quality patient care, due process, and a safe working environment. ACEP’s vision statement declares that “Emergency physicians practice in an environment in which their rights, safety, and wellness are assured.” Fortunately, ACEP leaders can work with hospitals, health systems, and physician groups to establish fair workplace policies.

**GREATEST OPPORTUNITIES: BIG DATA AND INSURANCE REFORM**

One of ACEP’s most significant opportunities is to create and analyze big data through CEDR, E-QUAL, and EMF sponsored research. Reliable data can support the adoption of new concepts, such as telemedicine and electronic records improvements. The consolidation of health systems provides opportunities to collect data in a standardized way. For example, I worked to convince a 93-hospital health system to support CEDR reporting for any participating site. Lastly, EMF must be strongly supported in its vital support of independent research efforts and developing future researchers.

ACEP’s other opportunity is to push for insurance reforms. The COVID-19 pandemic demonstrated the value of emergency medicine to the healthcare system. Our work with disaster preparedness and ACEP’s quick development of COVID resources such as the ACEP COVID-19 Field Guide (acep.org/corona/covid-19-field-guide) stunned many outsiders who thought the emergency center was only a high-priced place to receive medical care. ACEP can use that realization to push for fair payment, an end to narrow networks and surprise billing, and identify mechanisms to ensure adequate healthcare coverage. Even during a pandemic, ACEP continues to lead by coordinating state and federal resources with state chapters and emergency physician groups to push for a fair resolution to the surprise billing issue. ACEP has the opportunity to re-affirm its commitment to its vision that “All patients have health care coverage that ensures access to emergency services. Legally mandated health care services are fully funded.” ACEP needs Board members who can quickly recognize and adapt to new threats and opportunities.

**Question #3: Does ACEP provide enough support to its chapters? Is there more ACEP should do?**

ACEP is strongly linked to the success of its state chapters in recruiting new members, identifying unique state challenges, and demonstrating the value of an ACEP membership. ACEP currently provides support through membership information sharing, connections with national leaders, by-laws support, websites, electronic newsletters, chapter management, and legislative resource such as the annual LAC conference. Can more be done? Yes.

**ACEP MUST ENSURE SUFFICIENT CHAPTER RESOURCES WHILE UTILIZING ECONOMIES OF SCALE**

The level of chapter support from ACEP is improving, but there is more to do. ACEP has used its size to provide less expensive ways for chapters support of websites, organization management, electronic newsletters, and membership data.

- Chapter support for membership growth, outreach, and strategic planning with chapter board members
- Data collection on non-member website visitors to identify potential new members and patient allies
- Collect information on the diversity of our members. Recognize chapters actively addressing inclusiveness
- Build on the efforts of the DHIE section to support mentoring on both a state and national basis

**STATE CHAPTERS FORM A LABORATORY OF NEW IDEAS AND OPPORTUNITIES**

As a subcommittee chair within the NCRC, I reviewed the best ideas of chapters each year through the chapter grant program. The recently suspended chapter grant program was the primary way ACEP connected with innovative chapter programs. We must innovate to restore the value of this program. Loss of the chapter grant program means loss of the ability to track key chapter projects and ideas. This program created a searchable database of projects for other chapters to emulate. New Jersey ACEP’s leadership development program is one such example of a chapter grant that benefited other chapters. My home Michigan chapter used the information from the NJ chapter grant to create its own Leadership Development program, which accepts 8-12 future leaders per year. We need an ACEP Board member who innovates for our members, chapters, and patients.
CANDIDATE DATA SHEET

Michael J. Baker, MD, FACEP

Contact Information
3680 Creekside Dr
Ann Arbor, MI 48105
Phone: 734-657-7072 (cell)
E-Mail: mbaker911@gmail.com

Current and Past Professional Position(s)
- Director of Telehealth, EPMG/Envision (2014-present)
- Medical Director, Munson Healthcare Cadillac (2019-present)
- Clinical Assistant Professor, Michigan State University College of Osteopathic Medicine (2018-present)
- ED Informatics Representative, Clinical Excellence Committee, Trinity-Health (2018-present)
- Chief Executive Officer, CAREnQ Telemedicine Solutions LLP (2015-2018)
- Member, Telemedicine Clinical Quality Committee, St. Joseph Mercy Hospital (2015-present)
- Chairperson, Emergency Department Information Technology Committee, Trinity-Health (2012-2019)
- Chairperson, Optimizing Information Technology, Trinity-Health (2019-present)
- Medical Director, St. Joseph Mercy Hospital Saline, Maple, Canton (2010-2018)
- Director, Quality Improvement, Saline Hospital (2007-2010)
- Cerner Physician Liaison, St. Joseph Mercy Hospital (2007-present)
- Adjunct Clinical Instructor, University of Michigan College of Medicine (2003-present)
- Director, Program in Ultrasonography, St. Joseph Mercy Hospital (2002-2015)
- Chairperson, CME Committee, St. Joseph Mercy Hospital (2002-2010)
- Core Faculty, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency (1998-present)
- Attending Physician, Saline Hospital Emergency (1998-2015)
- Attending Physician, St. Joseph Mercy Hospital, Ann Arbor, MI (1996-present)
- Attending Physician, Providence Hospital Emergency, Southfield, MI (1996-1998)

Education (include internships and residency information)
- University of Michigan, Ann Arbor, MI; BS received 1989
- Ohio State University, Columbus, OH; MD received 1993
- University of Michigan, Ann Arbor, MI; Residency in Emergency Medicine completed 1996

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.)
- American Board of Emergency Medicine (ABEM) – Continuously certified since initial certification in 1997

Professional Societies
- American College of Emergency Physicians (FACEP)
- Michigan College of Emergency Physicians
- American Medical Association
- American Telemedicine Association
- American Institute of Ultrasound in Medicine
- Michigan State Medical Society
- Greater Detroit Area Health Council

National ACEP Activities – List your most significant accomplishments
Diversity and Inclusion Task Force (2015-2018)
• As subcommittee chair, lead team in researching and recommending the dissemination of diversity and inclusion activities in EM that educates about bias and promotes cultural competence including recommendations for
  o Implicit Bias Training every 3 years for ACEP Board (2017 BOD session)
  o Creation of an ACEP Diversity & Inclusion Section with Board liaison (Diversity, Inclusion, and Health Equity Section)
  o Creation of diversity and inclusion section grant or chapter grant
  o Addition of demographic data to future ACEP membership surveys
• Identified and submitted articles to ABEM on diversity and inclusion for future LLSA activities
Diversity Leadership Task Force (2016-2018)
• Identified barriers to diversity in leadership and actively implemented enduring solutions including council resolutions, formal recognition of the Leadership Development Advisory Group, election campaign rules, and annual award recommendations
National Chapter Relations (2013-present)
• Actively participated in the submission, review, and approval of chapter grants
• As subcommittee chair, identified and implemented leadership development opportunities including
  o Chapter forum topics
  o LAC leadership day topics
  o Sharing of state chapter leadership resources
  o Update Chapter Leadership resource web page
Council Steering (2018-19)
• Successfully served as subcommittee chair for the Annual Meeting Subcommittee
  o Planned annual council meeting
  o Reviewed ACEPs progress on past council resolutions
Telemedicine Section (2013-present)
• Authored multiple sections of section grant project examining quality measures in emergency telemedicine.
• Represented ACEP at the 2019 TelEmergency summit, New Orleans, LA.
• Connected past Ultrasound Section chair with Telemedicine section chair to aid in strategic planning due to similarities with implantation of new technologies
• Co-author on “ACEP COVID-19 Field Guide: Telehealth and Teletraige” (2020)

**ACEP Chapter Activities – List your most significant accomplishments**

**Awards**
• Ronald R Krome, MD Meritorious Service Award (2016) – “The recipient’s personal leadership attributes will include one, but not limited to one of the following examples: Inspirational, Innovative, Diplomatic, Planner, Organizer, Manager/Administrator, Arbitrator, Consensus Maker, and Decision Maker”
• Chapter Service Award (2004)

**President & Board of Directors/Executive Committee (2004-2010, 2012-2015)**
• Successfully led a team to fight off a “three strikes rule” in Michigan by facilitating MCEP’s participation in a year-long, legislature-appointed expert panel on high-utilizers and a consensus report to the state legislature.
• Created strategic planning process for committee chairs, Fostered new leader development through committee structure improvements.
• Guided college through loss of key staff member which resulted in a temporary limitation of resources.

**Education chair (2009-2013)**
• Guided multiple conference directors in creating multiple CME conferences in a variety of locations
• Streamlined CME development and application process
• Rebuilt annual conference from low of 40 participants to over 100 registrants
• Implemented process for reviewing and improving the sustainability of conferences

**Newsletter Editor (1998-2005)**
• Redesigned publication, added case studies to allow young physicians to have interesting cases published, added on-line publishing

**Technology Task Force (2000-2005)**
• Created and maintained original web site and e-mail addresses for MCEP
• Lead recommendations for purchase of member management system

**Practice Profile**

**Total hours devoted to emergency medicine practice per year:** 2080+ Total Hours/Year

**Individual % breakdown the following areas of practice. Total = 100%.**

- Direct Patient Care 30%
- Research 0%
- Teaching 10%
- Administration 60%
- Other: Administration includes Dir. of Telehealth, Site Medical Director, and Informatics

**Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)**

I have practiced for 23 years in a variety of clinical setting from small, rural locations to high volume, urban emergency centers, all with the same emergency physician group. Currently, I am employed with a nationwide, privately-held contract management group in both clinical and leadership/administrative roles. I see patients at two main sites, an 80K ED (Level 1 trauma center, part of a large, national, multi-hospital health system) and a 100K ED (Level 1 trauma center, part of an academic university) with occasional shifts at a 35K hospital-owned urgent care center.

**Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)**

- Director of Telehealth, Midwest Region, Envision
- Medical Director, Munson Cadillac Emergency Center, Envision
- Chair, Optimizing Information Technology, Trinity-Health
- Adjunct Clinical Instructor, Emergency Medicine, University of Michigan
- Clinical Assistant Professor, Michigan State University College of Osteopathic Medicine

**Expert Witness Experience**

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

- Defense Expert 0 Cases
- Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Michael J. Baker, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: EPMG – An Envision Physician Services Company
   Address: 2000 Green Rd
   Ann Arbor, MI 48105
   Position Held: Director of Telehealth and Managing Partner
   Type of Organization: None

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

   Organization: Michigan College of Emergency Physicians
   Address: 6647 W. St. Joseph Highway
   Lansing, MI 48917
   Type of Organization: ACEP State Chapter
   Duration on the Board: 13 years

   Organization: CAREnQ Telemedicine Solutions, LLP
   Address: 2000 Green Rd
   Ann Arbor, MI 48105
   Type of Organization: Telemedicine LLP
   Duration on the Board: 4 years (ended 2018)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:
4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Michael J Baker, MD, FACEP       Date       June 16, 2020
Dear Fellow Councillors:

It is with great pleasure that the Michigan College of Emergency Physicians and the Emergency Telemedicine Section endorse Michael Baker, MD, FACEP for a position on the ACEP Board of Directors.

Mike served with distinction as a member of MCEP’s Board of Directors for twelve years. He was President of our Chapter from 2013-14, at which time he brought the College through an internal crisis. He successfully fought off an attempt to bring the “three strikes rule” to Michigan and brought national leaders into the conversation with the Michigan Department of Community Health to create a report to the legislature listing the reasons for high utilization of the emergency center by select populations. He has been a strong supporter of the MCEP Leadership and Development program and education programs. He continues his involvement as a valuable member of the College, remaining active on our Education Committee.

In addition to his work at the state level, Mike has been a tremendous asset to national ACEP. He has been active in ACEP leadership, Chapter support, as well as the ACEP Council, where he has served as a Councillor for nine years. He has tremendous experience and involvement with the ACEP Emergency Telemedicine Section. He has co-authored ACEP’s published definition of Emergency Telemedicine, co-authored the Telemedicine Section of the ACEP COVID-19 Field Guide, represented ACEP at the University of Mississippi Medical Center Tele-Emergency Summit as well as assisted with council resolution development. Dr. Baker was also appointed to help lead diversity and inclusion efforts through participation on both the ACEP Diversity and Inclusion Task Force and the ACEP Leadership Diversity Task Force.

As a member of the National Chapter Relations Committee, he has been supporting chapter needs and identifying topics, speakers, and format recommendations for LAC lectures and Chapter leadership sessions. At the ACEP Council, he has actively served on reference committees, the Tellers Committee, and the Council Steering Committee, which has allowed him to cultivate successful relationships with current and past leaders. With each endeavor, Dr. Baker has built upon and proven his ability to lead by his determination and dedication to strengthening the future of ACEP.
In addition to these activities, he is a full-time active clinician and engaged academically at the University of Michigan/St. Joseph Mercy Hospital residency program. Furthermore, Dr. Baker, as the Director of Telehealth for his medical group, continues to look ahead to the future of emergency medicine and explore how technology can assist the specialty in reaching new heights.

I would respectfully ask that you join our Chapter and the Emergency Telemedicine Section in support of the election of Michael Baker, MD, FACEP, to the Board of Directors of the American College of Emergency Physicians.

Regards,

Warren Lanphear, MD, FACEP
President, MCEP

Edward A. Shaheen, MD, FACEP
Chair, Emergency Telehealth Section

Aditi Joshi, MD
Chair-Elect, Emergency Telehealth Section
Dear Councillors,

Each year, we have assembled the ACEP council to learn from each other, identify problems/solutions, and elect College leaders. This year is different. Instead of in-person meetings, virtual technology will bring us together. The COVID-19 public health emergency highlights the cracks in our broken medical system, including inadequate access to care, widening insurance gaps, and the challenges to digital health. Emergency centers have transformed into screening areas, holding beds, and intensive care units. Rural hospitals, which make up around 50% of US hospitals, face worsening financial, access, and workforce challenges. I can contribute requisite experience with rural emergency centers, telemedicine, and collaboration. Medicine is changing rapidly, and ACEP needs a knowledgeable board member who will advocate, innovate, and mentor.

To advocate effectively, Board members must have a passion for energizing and inspiring others. I love my experiences as a clinician, residency faculty member, rural medical director, regional telemedicine director, and state/national leader. Board members must demonstrate the value of ACEP to our young physicians and members through three mechanisms 1) building tools to create leaders, 2) legislative activity, 3) creating resources for emergency physicians. As an ACEP Board member, I can apply my passion by advocating for many issues such as fair payment, due process, telemedicine, education, and board certification value.

As an ACEP Board member, I will encourage ACEP to find innovative ways to support our members during this challenging time. I would grow our membership by collecting and utilizing data on non-members who view our content, such as the COVID-19 field guide and ACEP apps. Digital health can enable every emergency center to have a board-certified emergency physician, but ACEP must break the out-dated government and private payor restrictions on utilizing telehealth. Other innovation opportunities include asynchronous learning, virtual grand rounds, PA/NP collaboration standards, and expansion of mobile device access to ACEP content. I would also use the spotlight of COVID19 to improve our healthcare safety net, remove burdensome regulations, and ensure fair payment.

Mentoring future leaders remains a necessary skill of ACEP Board members. With my work chairing National Chapter Relations Committee objectives, I created resources and chapter round tables addressing the needs of chapters in training future leaders. As a member of the Leadership Diversity Task Force and the Diversity and Inclusion Task Force, I identified and dismantled roadblocks for ACEP members that limit participation or advancement. As an ACEP Board member, I will seek out and support leadership development innovations such as the Diversity, Inclusion, and Health Equity section’s mentorship program. Influential leaders are a critical resource for ACEP that I will continue to develop as a member of the ACEP Board.

Picking the right ACEP Board member is vital to ensure that our emergency physicians and our patients remain supported. With my experience and vision to strengthen ACEP and Emergency Medicine, I am the right person for the ACEP Board in this rapidly changing environment.

Michael J Baker, MD, FACEP
ACEP Board of Directors Candidate
As an engaged member of ACEP, I enthusiastically support ACEP’s mission to promote high-quality emergency care and advocate for its value. As a Board member, I will serve our members by securing the resources, tools, and support necessary to meet our mission goals. As a leader, I will apply my skills of advocacy, innovation, and mentoring to help ACEP work though the many challenges ahead of us in this unique time.
ACEP’s Mission is My Mission

ACEP’s mission is essential to me because I love what I do in emergency medicine. I am a practicing emergency physician, rural medical director, and telemedicine director who takes pride in helping people who need medical care most. As a Board member, I will inspire others, build tools, create leaders, shape policy, and secure resources for accessing and delivering emergency care.

Challenges Must Be Addressed

The COVID-19 emergency highlighted emergency medicine issues including fair compensation, industry consolidation, and rapid adoption of telemedicine. Fair compensation is at risk from "surprise billing" legislation, cuts to the 2021 Medicare Fee Schedule, and lost revenue due to COVID-19. Emergency medicine is being left out of telemedicine opportunities by outdated regulations and payor requirements. Consolidation of management groups, insurance payors, and hospital systems continues to reduce competition. ACEP’s strong voice can ensure boarded emergency physicians lead the care team in every emergency center and receive due process, fair payment, and safe practice environments.

Passion to Adcovate, Innovate, and Mentor

Board members provide energy and resources to our members, chapters, sections, and organizations. My passion for innovation focuses on the value of emergency medicine, developing future leaders, placing boarded emergency physicians in every emergency center, and collecting data to support the quality of emergency care. As a Board member, I can help ACEP remain the big tent that collaborates across organizations and advocates for our members, patients, and the public.

What Others Say:

• "Identifies trends, technologies, & opportunities"
• "Listen, reflects, advocates, takes action"
• "Delivers results"
• "Dedicated, energetic, connected"

Key Accomplishments:

• Defended MI Against “Three Strikes” Rule
• National COVID-19 Task Force Member
• Negotiated payments for EM Telemedicine
• NCRC Leadership Resources, LAC Leadership events
• Task Force: Supported Transparency, DIHE Section

A SERVICE-FOCUSED LEADER WITH THE RIGHT KNOWLEDGE AND SKILLS FOR THESE CHALLENGING TIMES

E-Mail: mbaker911@gmail.com  Twitter/LinkedIn: @MBaker911
Curriculum Vitae

Personal Data:
Name: Michael J. Baker

Education:
1981-1985 Chagrin Falls High School, Chagrin Falls, OH
1985-1989 The University of Michigan, Ann Arbor, Michigan; B.S. received (major in Cellular Molecular Biology)
1989-1993 The Ohio State University College of Medicine, Columbus, Ohio; MD
1993-1996 Emergency Medicine Residency, The University of Michigan Medical Center, Ann Arbor, Michigan

Clinical Appointments:
1996-1998 Attending Physician, Department of Emergency Medicine, Providence Hospital, Southfield, Michigan
1996- Attending Physician, Department of Emergency Medicine, St. Joseph Mercy Hospital, Ann Arbor, Michigan
1998- Attending Physician, Department of Emergency Medicine, Saline Hospital, Saline, Michigan

Academic Appointments:
1998- Core Faculty, University of Michigan/St. Joseph Mercy combined emergency medicine residency program
2003- Adjunct Clinical Instructor, Emergency Medicine University of Michigan

Consulting Positions:
2015-2018 CEO, CAREnQ Telemedicine Solutions, LLP

Scientific Activities:
1992 Emergency Department Diagnosis of Acute Myocardial Infarction in Patients Presenting with Chest Pain, The Ohio State University College of Medicine, Columbus, Ohio
1990-1991 Evaluation of Operation Aware Drug and Alcohol Prevention, The Ohio State University College of Medicine, Columbus, Ohio
2001 A Randomized, Double-Blind Study to Determine the Efficacy of Levalbuterol versus Racemic Albuterol in the Treatment of Acute Asthma, Sepracor, St. Joseph Mercy Hospital, Ann Arbor, Michigan, Sub-Investigator

Grant Support:
None

Certification and Licensure:
- 1995: Advanced Trauma Life Support
- 1996: Advanced Cardiac Life Support
- 1996-: State of Michigan Physician and Controlled Substance License #4301062015
- 1997-: American Board of Emergency Medicine Diplomat (Last recertification 2006)

Military Service:
None

Honors and Awards:
- 2001: Fellowship, American College of Emergency Physicians
- 2004: Michigan College of Emergency Physicians Chapter Service Award
- 2005: Nomination, Golden Apple Teaching Award, UMMC/SJMH Residency in Emergency Medicine
- 2016: Ronald R Krome, MD Meritorious Service Award, MCEP

Memberships and Offices in Professional Societies:
American College of Emergency Physicians
- 1999-: Ultrasound Section, Member
- 2000-2009: Medical Student Educator Section, Member
- 2012-: Councilor for MCEP
- 2013-: Telemedicine Section, Member
- 2013,2014: Council Reference Committee Member
- 2013-: National Chapter Relations Committee (NCRC)
- 2015-: NCRC subcommittee chair, Leadership forum
- 2015-: Council Tellers Committee Member
- 2015-1018: ACEP Diversity and Inclusion Task Force
- 2016-2018: ACEP Leadership Diversity Task Force
- 2018-: ACEP Council Steering member

Michigan College of Emergency Physicians (MCEP)
- 1998-2005: Assistant Editor, MCEP News and Views
- 2000-2005: Chairperson, MCEP Technology Task Force
- 2001-2008: Board Member, Michigan College of Emergency Physicians
- 2004-: Education Committee Member
- 2005-2009: Editor, MCEP News and Views
- 2009-2013: Chair, Education Committee, MCEP
- 2010-2011: Secretary, MCEP Executive Board
- 2011-2012: Treasurer, MCEP Executive Board
- 2012-2013: President Elect, MCEP Executive Board
- 2013-2014: President, MCEP Executive Board
2014-2015  Immediate Past-President MCEP Executive Board
2016-2017  Executive Director Search Committee
Society for Academic Emergency Medicine (Ultrasound section member)
American Institute of Ultrasound in Medicine
American Medical Association
American Telemedicine Association (2014-)

Teaching Activities:
1996-1998  Medical Education Director, Providence Hospital, Southfield, Michigan
1998-2002  Assistant Medical Education Director St. Joseph Mercy Hospital, Ann Arbor, Michigan
1998-2005  Emergency Medicine Clerkship Director, St. Joseph Mercy Hospital, Ann Arbor, Michigan
1997-      Lectures in Emergency Medicine for emergency medicine residents, University of Michigan, Ann Arbor, Michigan
1997-      Lectures in Emergency Medicine for 3rd and 4th year medical students, University of Michigan, Ann Arbor, MI
2002-2005  Co-Director, Program in Emergency Ultrasonography, St. Joseph Mercy Hospital, Ann Arbor, Michigan
2005-2015  Director, Program in Emergency Ultrasonography, St. Joseph Mercy Hospital, Ann Arbor, Michigan
2009-      Core Faculty, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residency
2013-      Ultrasound Faculty, University of Michigan/St. Joseph Mercy Hospital Emergency Medicine Residence

Extramural Invited Presentations:
<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>November</td>
<td>Ultrasound Physics and Knobs/US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2005</td>
<td>April</td>
<td>Ultrasound Physics and Knobs/US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2006</td>
<td>April</td>
<td>Ultrasound Physics and Knobs/US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2006</td>
<td>November</td>
<td>Ultrasound Physics and Knobs/US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2006</td>
<td>December</td>
<td>Introduction to Ultrasound, Ultrasound Physics, Trauma Ultrasound, University of Michigan, Ann Arbor, MI</td>
</tr>
<tr>
<td>2008</td>
<td>March</td>
<td>Ultrasound Guided Procedures, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2009</td>
<td>April</td>
<td>Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2009</td>
<td>September</td>
<td>Ultrasound Guided Procedures, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2010</td>
<td>April</td>
<td>Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2010</td>
<td>September</td>
<td>Ultrasound Guided Procedures, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
<tr>
<td>2011</td>
<td>April</td>
<td>Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI</td>
</tr>
</tbody>
</table>
2011, October  Ultrasound Guided Procedures, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2012, March  Critical Care Ultrasound, FAST and Beyond, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2012, October  Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2013, April  Critical Care Ultrasound, FAST and Beyond, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2014, September  Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2015, January  FAST Exam, Michigan College of Emergency Physicians, Winter Symposium, Boyne City, MI
2015, September  Introduction to Ultrasound, Ultrasound Physics, US lab proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2016, July  Emergency Telemedicine, Introduction and Impact, Michigan College of Emergency Physicians Summer Assembly, Mackinac Island, MI
2016, September  Introduction to Ultrasound, Physics, US Lab Proctor, Michigan College of Emergency Physicians Ultrasound Course, Lansing, MI
2018, September  Building and Leading Teams, Envision Midwest Leadership Forum, Chicago, IL
2018, October  911 Intercept: Mobile Integrated Healthcare to Decrease ED Utilization, Blue Cross Blue Shield Fall Summit, Detroit, MI

Committee and Administrative Service:

*University of Michigan*

1995-1996  House Officers’ Association Representative
2000-2001  Fourth Year Planning Committee for UMMC/St. Joseph Mercy Hospital combined residency program
2002-      Emergency Medicine Ultrasound Committee for UMMC/St. Joseph Mercy Hospital combined residency program

*Providence Hospital, Southfield, Michigan*

1996-1998  Graduate Medical Education Committee

*St. Joseph Mercy Hospital, Ann Arbor, Michigan*

1999-2010  Continuing Medical Education Committee, Member
1999       Transition Year Residency Review Committee
2002       Graduate Medical Education (Planning) Retreat
2002-2010  Chairperson, Continuing Medical Education Committee
2004-2006  Chairperson, Commercial Support Policy Committee
2008  Member, Hand Off Task Force
2010-2014  Medication Reconciliation Committee
2012-  ED Council
2013-  Discharge Process Improvement Team
2014-2018  Medication Cycle Improvement Team

St. Joseph Mercy Hospital, Saline, Michigan
2007-2010  Quality Improvement Director, FirstNet Physician Liaison
2010-2018  Director, Saline Emergency Center/Urgent Care
2014-2017  Director, Maple Urgent Care

St. Joseph Mercy Canton Health Center, Canton, Michigan
2008-2010  Director, Urgent Care

CHE/Trinity Health, Novi, Michigan
2012-2019  Emergency Department Information Technology Committee, Co-chair and founder
2019-  Optimizing Information and Technology Expert Panel Chair
2014-2016  Medication Cycle Improvement Team
2015-  Telemedicine CQC Subcommittee
2018-  Emergency Center Clinical Excellence Council, ED Informatics Representative

Envision/Emergency Physicians Medical Group, PC
2014-  Director of Telehealth

Munson Medical Center, Cadillac, MI
2019-2020  Medical Director, Emergency Center

Completed Publications, Professional Journals:
Additional Publications upon request

Completed Publications, Books:
Question #1: Describe your skills, background, knowledge, or unique abilities outside of ACEP that will make you an effective Board member.

I am passionate about ACEP’s power as an organization to be the leading advocate for emergency physicians. However, passion alone is insufficient.

I have a long track record of involvement in organized medicine, from my time as a medical student with AMSA, my board service with EMRA, and, more recently, leadership roles with the Texas Medical Association including serving as an Alternate Delegate from Texas to the AMA. I have particular experience and interest in state-level advocacy and advocating for the underserved, and I bring a broad knowledge base and network that comes from the scope of these experiences to the ACEP board.

While I currently practice in a county hospital affiliated with a medical school, my first three years out of residency were spent in community practice. I have not forgotten my experiences working as a single-coverage doc with limited specialty availability, and when I am considering how ACEP policies might impact EM practice, I can easily recall the “out of the ivory tower” EM that is the bread-and-butter of daily practice for many of our members. I have experienced multiple state chapters of different sizes, from Michigan to Washington to Texas.

I am a young physician, a demographic that is always under-represented on the ACEP Board. Being a young physician, I am particularly focused on the importance of leadership development. I look forward to continuing a current project focused on bringing together our leadership development programs from across the college, including Chapter-based programs and those developed by YPS and EMRA, to ensure that we break down silos and collaboratively innovate to better serve a critical demographic of our membership. Within my own department, I lead our faculty development programs and there is thematic overlap between these two projects.

I am known on the board as a member who is not afraid to ask hard questions and challenge the status quo. My thoroughness and tenacity has come from a variety of leadership roles that I have served over the years, including currently leading a subcommittee for the Baylor College of Medicine curricular redesign project and serving as a Faculty Senator. Each leadership experience has afforded me new perspectives and new lessons, but also opportunities to improve myself as a communicator, educator, advocate and team member.

Question #2: What are the two greatest opportunities and threats to ACEP?

ACEP has 41,435 members, and while our membership is growing, our rate of growth is declining. The growing number of EM residencies in the US has brought an increase in our candidate membership, but we are seeing a drop in the percentage of graduating residents who retain their membership. ACEP must ensure that we are the premier source of opportunities – for networking, education and personal development – for emergency physicians. We must demonstrate that we share our members' values and are advocates for them and their most vulnerable patients. While some will dedicate the time and effort required to be councilors and committee members, we must also offer smaller innovative opportunities for members to get involved with issues that are critical to them personally to support their growth as educators and advocates. As a board member, I have been involved in our efforts to trial new membership models that meet member needs at every career stage. The picture isn’t grim – our overall membership is still up 5% this year – but we should embrace this opportunity to ensure that residency-trained emergency physicians look to ACEP first as an advocate for them on the frontlines. We must show our members that we are not afraid to put the needs of the individual emergency physician first – advocating for physician-led teams with no absentee chart signing when working with NPs and PAs, and paid parental leave for EPs – while maintaining a viable emergency medicine practice and fighting external threats to our livelihood like “surprise billing” legislation that allows insurers set arbitrary and unviable reimbursement levels and persistent insurer downcoding while we provide critical services.
As we lead the frontlines in the fight against COVID-19, the eyes of the country have been drawn to emergency physicians. For ACEP, this has presented an opportunity for us to serve as a critical clearinghouse of information, including the COVID Field Guide and the EngagED coronavirus community. Our staff has done an incredible job of finding and sharing resources, like free hotel nights and meals, as we have balanced our dedication to our patients with the threat to our families. However, some of ACEP’s core activities have been put at risk by COVID. We offer robust online educational offerings, but our premiere educational and social event has always been an in-person annual meeting. As the Board Liaison to the Education Committee, I have helped convert our annual meeting into an UnConventional experience that will offer unique educational and networking moments. To protect us from the threat of COVID in our EM practice, the College has advocated tirelessly for more resources for us – for more PPE, liability protections, hazard pay and adequate insurance coverage for patients seeking COVID-related care. COVID has brought an immediacy to our advocacy efforts and reminded legislators of the critical role that we play in the health care system.

Question #3: Does ACEP provide enough support to its chapters? Is there more ACEP should do?

ACEP’s chapters are a diverse group with different sizes, strengths and needs. There is always more ACEP can do to support our chapters, but we should not take a one-size-fits-all approach. National ACEP must match our offerings to the needs of our chapters through open dialogue and inquiry with both chapter executive directors and chapter board members. As a NEMPAC board member, I appreciate NEMPAC’s deliberate outreach to state chapters when vetting candidates to ensure that local leaders have an opportunity to build advocacy relationships and weigh in on decisions as to which candidate receives support. Some of ACEP’s biggest advocacy priorities – like medical liability reform and out-of-network billing – are predominantly state issues, making it essential to support state-level lobbying on these critical issues. However, our support must be balanced by ensuring chapter autonomy. As Chair of the State Legislative Committee, I worked with a team to develop a memo addressing best practices in the case of disagreements over state legislative matters between national ACEP and state ACEP chapters. Our recommendations of optimizing communication between chapters and the national office and offering early resources to the states on controversial state issues remain critical in the current environment.

As we move forward, particularly in an era of virtual meetings, national ACEP can do more to connect chapters and share best practices. Some of our finest innovations have happened at the state level, but haven’t always been widely disseminated and made easily accessible. National ACEP can help build bridges between chapters, ensuring that great ideas spread beyond chapter borders and working cooperatively with states to increase membership numbers and enhance member value across the country. I look forward to continuing my efforts to spread best practices for chapter leadership development in my next term as an ACEP board member.
CANDIDATE DATA SHEET

Alison J. Haddock, MD, FACEP

Contact Information
1408 Maryland St; Houston, TX; 77006
Phone: (425) 246-6310
E-Mail: ajh2003@gmail.com

Current and Past Professional Position(s)
Current:
Assistant Professor of Emergency Medicine
Director of Health Policy: Advocacy
Assistant Director of Faculty Development
Department of Emergency Medicine at Baylor College of Medicine in Houston, TX

Former: Attending Emergency Physician at Tacoma Emergency Care Physicians (small democratic group in Washington State) and Attending Emergency Physician with CEP America (primarily at Edmonds, WA site)

Education (include internships and residency information)
Medical School: Cornell Medical College, MD, 2007
Undergraduate: Duke University, BS, 2003

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified
American Board of Emergency Medicine, Board Certified, 2012

Professional Societies
ACEP, TCEP, TMA, AMA, CORD, EMRA Honorary/Life Member

National ACEP Activities – List your most significant accomplishments
Awards
ACEP 9-1-1 Network Member of the Year, 2011
Council Horizon Award, 2016
EMRA “45 Under 45”, 2019

Board Service
EMRA Board of Directors: Legislative Advisor (2010-2012)

Committee / Section Involvement:
ACEP State Legislative & Regulatory Committee: Member 2012-2017; Chair 2015-2017
ACEP Federal Governmental Affairs Committee 2010-2017
ACEP Education Committee, Educational Meetings Subcommittee: 2013-2017
Member of the AAWEP, Palliative Medicine, Social EM and Young Physicians Sections

Current Board Liaison Positions:
Committees: Education, Emergency Medicine Practice, Well-Being
Sections: AAWEP, Telehealth, Palliative, Wellness
Council Participation & Leadership
Past Alternate Councilor/Councilor for EMRA delegation, WA Chapter, TX Chapter
Past Council Steering Committee member, Council Reference Committee member

Co-Editor of *EMRA Advocacy Handbook*, 5th edition released at LAC 2019
Past speaker at both LAC and annual meeting

ACEP Chapter Activities – List your most significant accomplishments
Texas College of Emergency Physicians Board Member: 2016-2019
TCEP Board Liaison to TCEP Government Relations Committee: 2016-2019
TCEP Leadership and Advocacy Fellow: 2015-2016
TCEP Leadership and Advocacy Fellowship Co-Director: 2016-2017

Practice Profile
*Total hours devoted to emergency medicine practice per year:* ~2200 Total Hours/Year

*Individual % breakdown the following areas of practice. Total = 100%.*
- Direct Patient Care 30%
- Research 10%
- Teaching 35%
- Administration 25%
- Other: _____________________________ ___%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
I work for Baylor College of Medicine at Ben Taub Hospital, a busy safety-net county hospital and Level One trauma center in Houston, TX. My primary responsibilities include direct patient care, bedside teaching, and several teaching and leadership roles within the medical school.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)
Assistant Director of Faculty Development
Learning Community Advisor
Curriculum Renewal Committee Member
Medical Ethics Scholar, Center for Medical Ethics and Health Policy, Baylor College of Medicine
Faculty Senator

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

<table>
<thead>
<tr>
<th>Defense Expert</th>
<th>Cases</th>
<th>Plaintiff Expert</th>
<th>Cases</th>
</tr>
</thead>
</table>

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# CANDIDATE DISCLOSURE STATEMENT

**Alison J. Haddock, MD, FACEP**

1. **Employment** – *List current employers with addresses, position held and type of organization.*

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor College of Medicine</td>
<td>1 Baylor Plaza</td>
<td>Assistant Professor of Emergency Medicine</td>
<td>Medical School</td>
</tr>
<tr>
<td></td>
<td>Houston, TX 77030</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Board of Directors Positions Held** – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Type of Organization</th>
<th>Duration on the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Emergency Physicians</td>
<td>4950 W. Royal Lane</td>
<td>National Medical Specialty Society</td>
<td>2017 - present</td>
</tr>
<tr>
<td>Texas College of Emergency Physicians</td>
<td>401 W. 15th Street, Suite 695</td>
<td>State Medical Specialty Society</td>
<td>2016 - 2019</td>
</tr>
<tr>
<td>National Emergency Medicine Political Action Committee</td>
<td>4950 W Royal Lane</td>
<td>Political Action Committee</td>
<td>2012 – present</td>
</tr>
</tbody>
</table>
Organization: Emergency Medicine Residents Association
Address: 4950 W Royal Lane
Irving, TX 75063
Type of Organization: Medical Specialty Society
Duration on the Board: 2010 – 2012

Organization: Friends of the Texas Medical Center Library
Address: 1133 John Freeman Blvd.
Houston, TX 77030
Type of Organization: Nonprofit 501(c)3
Duration on the Board: 2016-2020

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Alison Haddock

Date

June 7, 2020
July 30, 2020

Dear ACEP Councillors,

On behalf of the TCEP Board of Directors we are writing you to express our support of Alison Haddock, MD, FACEP who is seeking re-election to the national ACEP Board of Directors.

Dr. Haddock has served Emergency Medicine well during her current term on the Board. She exemplifies the best in emergency medicine physicians… intelligent, deliberative, engaged and passionate about EM and patient care. During COVID, she has been a regular face in the media as a spokesperson for both ACEP and TCEP and has done an amazing job representing emergency physicians.

Dr. Haddock has been an engaged leader for many years with both TCEP and ACEP and we are proud to support her run for the ACEP Board.

Sincerely,

Robert Hancock
Robert Hancock, DO, FACEP
President
Thank you, councillors, for electing me to my first term of ACEP Board of Directors. The past three years have been challenging and rewarding. I am seeking a second term to continue to advocate for the individual emergency physician and grow our organization.

Advocacy
Advocacy is most effective when a large group of individuals with shared interests unite behind a common goal. ACEP is the ultimate large group of emergency physicians and being a part of our advocacy efforts is incredibly fulfilling and meaningful.

Our health care system is increasingly putting profits over patients and emergency physicians are stuck in the middle. We entered into the field because we wanted to have the skills and ability to help people at their time of greatest need, regardless of their ability to pay. However, we cannot accomplish this within a system that fights against us at every turn. If profits are all that matters, we will see EPs widely replaced by NPs and PAs and insurance companies that refuse to provide reasonable compensation for the expert level of care that we provide. We know that residency-trained, board-certified emergency physicians are the individuals who can deliver the highest-quality emergency care to the public.

Our health care system continuously fails our patients as soon as they step outside of our department, increasing our burnout and professional frustration. ACEP can help by serving as an advocate for us, our patients, and our practice – whether the issue is out-of-network billing, physician wellness and mental health, or sensible public health measures to keep our patients safe. One organization cannot fix this system-wide problem in healthcare alone, but we can make inroads where it matters most for our members.

Membership
ACEP is experiencing a decline in the growth of our membership. To solve this issue, we need to demonstrate our impact and strive to find new ways to add value for our members. Advocacy efforts and successes at both the state and national level must be broadly communicated to emergency physicians, members, and non-members, to demonstrate a key value of membership. Graduating residents must be supported and engaged through education, professional development, and networking opportunities to encourage them to keep their membership as young physicians. All of these efforts must be made in partnership with our chapters, which are often the first point of contact for our members.

I’m excited that I am currently working on an initiative to virtually partner our chapters and our Young Physicians Section to enhance our offerings for young physicians. While COVID has made some of these initiatives more complex, it has also offered additional opportunities for us to demonstrate the value of our organization - bringing members together under a common cause to share best practices and advocate together to improve our practice and improve outcomes for our patients.

I would be honored to be your choice to continue to serve on the ACEP Board of Directors.

Alison Haddock, MD, FACEP
RE-ELECT
ALISON HADDOCK
FOR ACEP BOARD

PASSION FOR THE SPECIALTY

PROVEN LEADERSHIP
• Dedicated worker
• Challenger of the status quo
• A voice for young physicians
• Community and academic experience

VISION FOR ACEP
Increase transparency
Advocate for the individual Emergency Physician
Grow ACEP Membership
Put patients over profits
Support leadership development
GENERAL BIOGRAPHICAL INFORMATION

Personal
Full Name: Alison Jonelle Haddock
Citizenship: US Citizen

Education
Bachelor of Science, Program II Major in Biolinguistics, Duke University
Durham, N.C.
Cum Laude Graduate
August 1999 – May 2003

Doctor of Medicine, Weill Medical College
New York City, N.Y.
August 2003 – May 2007

Residency, University of Michigan, Emergency Medicine
Ann Arbor, M.I.
June 2007 – June 2011

Academic Appointments
Faculty Positions at BCM
Assistant Professor of Emergency Medicine
Director of Health Policy: Advocacy; Department of Emergency Medicine
2014 – present
Assistant Director of Faculty Development; Department of Emergency Medicine
2019 – present

Medical Ethics Scholar, Center for Medical Ethics and Health Policy, Baylor College of Medicine
2018 – present

Other Advanced Training
Baylor College of Medicine Master Teacher Fellowship Program
October 2017 – September 2019

Other Information
Honors or Awards
Texas Monthly “Rising Star Super Doctor”, 2019
Baylor College of Medicine Early Career Faculty Award for Excellence in Patient Care, 2019

Houston Business Journal Health Care Hero, “Rising Star Award”, 2018

American College of Emergency Physicians Council Horizon Award, 2016

American College of Emergency Physicians 9-1-1 Network Member of the Year, 2011

Khare Award Academic Scholar, University of Michigan EM Residency, 2010

**Board Eligibility/Certification**

Certified by the American Board of Emergency Medicine, 2012
Active Maintenance of Certification

**Other Non-academic Positions (Historical)**

Tacoma Emergency Care Physicians, Tacoma, WA
Attending Emergency Physician, 2011-2013

CEP America, Edmonds, WA
Attending Emergency Physician and Partner, 2013-2014

**RESEARCH INFORMATION**

**Research Support**

Technical Title of Project: Biomarkers in Acute Stroke (BASE)
Name of Funding Agency: Ischemia Care, LLC
Investigator Relationship or Role on Project: site PI
Funding: research staff funded, PI not funded
2015 – 2018

**National Scientific Participation**

**Peer Reviewer**

Emergency Medicine Reports
2018 – present

Annals of Emergency Medicine
2018 – present

**Elected Positions**

American College of Emergency Physicians (ACEP) Board of Directors
Elected October 2017 to a three-year term

ACEP is the largest national organization of emergency medicine physicians. Board members oversee all aspects of the organization including setting organizational policy, developing clinical policies, and overseeing educational activities and quality management programs.
Invited Lectures, Presentations, Research Seminars: national

American College of Emergency Physicians Annual Meeting (October 2019)
Denver, CO
“#Insurance Fail: Who is Covering these Surprise Bills?”

Arrowhead Regional Medical Center Emergency Medicine Residency Grand Rounds (June 2019)
Colton, CA
“Basic Billing and Coding for EM Residents” & “ACEP Update” & “Federal Advocacy in EM”

Kent Emergency Medicine Residency Grand Rounds (June 2018)
Warwick, RI
“Getting Sued One Month Out of Residency: A True Story”

FeminEM Idea Exchange (October 2017)
New York City, NY
“Don’t Just Get Mad: Get Involved – Advocacy for the FeminEM”

Minnesota ACEP Annual Meeting: Keynote Lecture (November 2016)
Edina, MN
“Emergency Care and the Changing Political Landscape”

University of Michigan Grand Rounds (August 2016)
Ann Arbor, MI
“Getting Sued One Month Out of Residency: A True Story”

Leadership and Advocacy Conference, American College of Emergency Physicians
Washington, DC
“Hot Topics: Prudent Layperson” (May 2018)
“State Level Advocacy” Panel (May 2018)

“Out of Network / Balance Billing: Where Are We?” (March 2017)

“State Strategies to Deal With Out of Network / Balance Billing” (May 2016)

“Current Issues in Health Policy” (May 2013)

New York Emergency Medicine Health Policy Assembly (November 2012)
New York City, NY
“20 Things EM Residents Can Do to Improve U.S. Healthcare”

Invited Lectures, Presentations, Research Seminars: local

Policy Prescriptions Health Policy Symposium (April 2018)
Houston, TX
“Universal Coverage: Getting There from Here”

Texas College of Emergency Physicians (TCEP) Annual Conference (April 2016)
Houston, TX
“Health Policy Current Events” with Cedric Dark

Publications

Full Papers in Peer Review Journals


Full Papers Without Peer Review: In Preparation


Haddock A, Song A, Pillow M. Gender and Racial Disparities in Media Representation of Physicians and Surgeons. Completing and seeking venue for publication.

Abstracts


Books Edited


Book Chapters Written:


Other Works: Communication To Scientific Colleagues

Haddock A & Monroe H. Vermont to Launch All-Payer Accountable Care Organization Model for Financing Health Care. ACEPNow. January 10th, 2017


TEACHING INFORMATION

Didactic Coursework

Educational Leadership Roles

Curriculum Renewal Workgroup Member (2019 – present)
  Redesigning the MS1 curriculum at BCM
  0.2 FTE support from Office of the Provost

Critical Thinking and Problem Solving (CTAPS) Facilitator (2018 – present)
  Designed several curricular units in inaugural year, 2018-2019
  0.1 FTE support from Office of the Provost

Learning Community Advisor – Indigo Quad (2019 – present)
  Supporting the professional development of a group of MS1-MS4 students
  0.1 FTE support from Office of Student Affairs

Courses Taught at BCM Within the Primary Department

  Regularly precept BCM and external elective students during their EM rotations
  Formal mentor to EM residents: Moises Gallegos (Class of 2018), Shehni Nadeem (Class of 2019), Pranali Koradia (Class of 2020), Nicole Lew (Class of 2021)

EM Residency Didactics Presentations

  EP3 “Professionalism in Practice” Unit Leader – October 2019
  Reimbursement Workshop – August 2019
  Intern Orientation: Risk Mitigation – July 2019
  EP3 “Health Economics” Unit Leader – May 2019
  Reimbursement: Medical Decision Making – April 2019
  EP3 “Lifelong Learning” Unit Leader – January 2019
  Clinical Pathologic Case Conference: Rickettsial Disease – September 2018
  Communications Simulation: Code Status Discussions – July 2018
  Intern Orientation: Risk Mitigation – June 2018
EP3 “End of Life” Unit Leader – May 2018
How Residents Can Improve Health Care – March 2018
“Business of Medicine” Panel – February 2018
Malpractice Mock Trial – January 2018
“Getting Sued One Month Out of Residency” – January 2018
Intern Orientation: Risk Mitigation – June 2017
Death Notification Role-Playing Didactics – June 2017
Billing & Coding Workshop – May 2017
Adverse Events / Medical Errors – March 2017
Wellness Small Groups – December 2016
Approach to Abnormal Vitals – September 2015
Simulation: Wide Complex Tachycardia – January 2015
Mock Oral Boards Examiner – March 2015, March 2016 & March 2017

Courses Taught at BCM External to the Primary Department

Small group leader for MS1 Ethics Course – Spring 2016 & Spring 2017 & Spring 2019
  Spring 2018: redesigned one unit of the curriculum with Christi Guerrini
Small group leader for MS1 IPS Course (problem-based learning) – Fall 2017 – Spring 2018
Social Determinants of Health Curriculum Facilitator – July 2017

Faculty Participant with two pre-clinical electives primarily led by Dr Cedric Dark:
  “Business of Medicine” combined BCM/UT elective for MS1/MS2
    Spring 2015, Spring 2016, Spring 2017
  “Health Policy Journal Club” BCM elective for MS1/MS2
    Fall 2017, Spring 2018, Fall 2019

Faculty Guest Speaker:

  “Physician as Advocate: Beyond the Exam Room” Elective, invited by Dr Joey Fisher
    June 2018

  “From Clinic to Capitol: Physicians as Advocates” Elective, invited by Dr Claire Bocchini
    September 2017

  “The Policy Process” with Cedric Dark, General Surgery Residency Didactics
    February 2015

Curriculum Development Work at BCM

Course(s)/Curricula to Which Contributions Have Been Made
  Health Policy Curriculum for EM Residents, tied to ACGME/ABEM EM Milestones
Role in Course/Curriculum Development
  Co-developer with Drs Cedric Dark and Tyson Pillow
Audience(s) for Course(s)/Curricula Developed
  Residents nationwide, with initial focus on EM Residents
Non-didactic Teaching While at BCM

Resident Training
- Every clinical shift (20hrs/week) includes residency training and development
- Active participant in daily white board rounds, weekly residency conference

Medical Student Mentoring
- Informal mentor to several current medical students
- Have presented to EMIG on Health Policy and Organized Medicine Leadership

Faculty Development / Continuing Medical Education

- American Board of Emergency Medicine: Oral Examiner 2017 – present
- ACEP Education Committee, Educational Meetings Subcommittee: 2013-2017
  - responsible for planning Health Policy and Risk Management tracks (total 20hrs of content)
  - more than 6,500 annual attendees at this largest national conference in Emergency Medicine
- TCEP Track Planner, 2017-2019
  - responsible for Health Policy Track for Texas College of Emergency Physicians annual meeting

Lectures and Presentations, national

- Association of American Medical Colleges Group on Faculty Affairs and Group on Women in Medicine and Science Joint Professional Development Conference, July 2019
- Hosted “Table Topic” on “Finding Fulfillment through Advocacy”

PATIENT CARE AND CLINICAL CONTRIBUTIONS

Patient Care Responsibilities

- Provide patient care at Ben Taub in the Emergency Center
- Provide patient care at Baylor St Luke’s McNair campus on a PRN basis
- Harris Health Ethics Committee Member, assist with clinical Ethics Consult service 4 weeks/year

SERVICE CONTRIBUTIONS

Administrative Assignments and Committees

- Faculty Senate Delegate, Department of Emergency Medicine (2017-2018)
- Faculty Senator, Department of Emergency Medicine (2018-2020)
  - Participant in Strategic Planning and Communication Committee
- Medical Executive Committee, Department of Emergency Medicine (2017 – present)
  - Faculty Diversity Task Force member and Exec Committee Liaison, 2018 – present
- Faculty Retreat Coordinator, Department of Emergency Medicine (2018 – present)
Planned curriculum and organized retreats in collaboration with other faculty members
Full-day retreats: May 2019, October 2019, May 2020 (cancelled due to COVID)

Co-Founder, FEM@BCM
Organization within the department created with a mission “to promote the advancement and equity of women in emergency medicine by mentoring and inspiring leadership”
Events have included faculty and residents including social events and service projects

**National Education or Voluntary Health Organization Participation**

**National Board Service:**
American College of Emergency Physicians (ACEP), Board of Directors: 2017-present
Emergency Medicine Residents Association (EMRA), Board Member (Legislative Advisor): 2010-2012
National Emergency Medicine Political Action Committee (NEMPAC) Board of Trustees

**National Committees:**
ACEP State Legislative Committee
  Board Liaison: 2017-present
  Chair: 2015-2017
  Member: 2012-present
ACEP Membership Committee Board Liaison, 2017-present
ACEP Federal Governmental Affairs Committee: 2010-present
EMRA Health Policy Committee: 2018-2012
EMRA Awards Committee: 2012-2016

**ACEP Council:**
  ACEP Council Steering Committee: 2015-2017
  ACEP Council Reference Committee: 2013 and 2015 (Committee B on policy issues)

**National Task Forces:**
ACOG (American College of Obstetrics & Gynecology) Pregnancy and Heart Disease Presidential Task Force, ACEP representative, 2018-2019
ACEP-EDPMA Joint Task Force on Reimbursement Issues, Balance Billing group: 2016-present
National Perinatal Association workgroup on 1st trimester pregnancy loss in the ED, 2016-2017
ACEP Alternative Payment Models Task Force: 2015-present
ACEP Delivery System Reform Task Force: 2011-2012

**National ACEP Sections:**
Palliative Medicine Section, Board Liaison, 2018-present
Telemedicine Section, Board Liaison, 2017-present
American Association of Women Emergency Physicians (AAWEP), Board Liaison, 2017-present
Member of the AAWEP, Palliative Medicine and Young Physicians Sections

**Chapter Committees and Leadership:**
Texas College of Emergency Physicians (TCEP) Board of Directors: 2016-2019
Co-Chair, TCEP Leadership and Advocacy Fellowship Program: 2016-2018
TCEP Government Relations Committee: 2015-present
TCEP Education Committee: 2015-present
TCEP Leadership and Advocacy Fellow: 2015-2016
Washington ACEP Chapter Legislative Affairs Committee: 2011-2014

State/Local Leadership:
Texas Medical Association (TMA) Leadership College: 2015-2016
TMA Council on Health Promotion: 2016-present
Harris County Medical Society (HCMS) Quality Committee: 2016
HCMS Board on Medical Legislation: 2016-present
Alternate Delegate, Harris County Medical Society at TMA Council, 2016
Delegate, Young Physicians Section and HCMS at TMA Council, 2017 & 2019
TMA Select Committee on Medicaid, CHIP and the Uninsured, 2017
Delegate, Texas Delegation to the Young Physicians Section at AMA Meeting, June & November 2017
Alternate Delegate, Texas Delegation to the House of Delegates at AMA Meeting, June & November 2017

Member, Board of Directors, Friends of the Texas Medical Center Library: 2016-2020

Other Pertinent Information
Completed BCM “Career Advancement Series: Assistant Professor Women” – 2018

Representative from Department of EM to BCM Faculty Development Forum

Major Education Workshops Attended
Clinical Teachers as Coaches: A Symposium on How to Be A Master Coach
October 12th, 2018

Scholarly Writing Retreat: Presented by CRIS
October 26th, 2018
2020 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

James L. Shoemaker Jr., MD FACEP

**Question #1:** Describe your skills, background, knowledge, or unique abilities outside of ACEP that will make you an effective Board member.

As an ACEP Board of Directors candidate, I will bring my skills as an independent, actively practicing community emergency physician with an expertise in reimbursement and advocacy to the College. I am an unrestricted voice focused on issues that impact our specialty and the patients we serve, and I am humbled to have this opportunity to serve. I have been fortunate to have been mentored by some of the greatest emergency physicians. My Emergency Medicine journey began when I nearly drowned at the age of four and was resuscitated by an off-duty paramedic. This planted the seed for my future career, as I was enamored by science and medicine from that point forward.

Fast forward three decades to when I was asked to attend an Indiana ACEP Board meeting — I was amazed by the collective wisdom of my colleagues and by how they were tackling issues facing Hoosiers head-on and challenging the healthcare insurer complex as well as other assaults on our specialty. I expressed interest and was able to join the Board. When I later served, I continued to build upon my skill set in order to help my group, my local chapter, our patients and the specialty as a whole to face many barriers and challenges. I do not always have the answer; but I am an active listener, and I am engaged, strategic and fun to be around. I work for a seat at the proverbial table, and I seize opportunities to contribute and make an impact. I strive to enthusiastically support and buoy others to accomplish goals. I come from an impoverished background as a youth, and I have learned what hard work, dedication and motivation can yield. I promise to bring this same work ethic to the ACEP Board working on behalf of our patients and colleagues.

Many of you may know that I was originally planning to run for the ACEP Board next year. However, as a Reimbursement Fellow and as the Alternate Representative for Emergency Medicine at the RUC, I have seen firsthand how the landscape of EM reimbursement continues to negatively change, resulting in decreased revenues and the unfortunate furlough or displacement of our colleagues, with some unable to find other employment. I feel my independent voice and contributions will benefit the College and specialty NOW, and my family supports me and agrees that the time is right.

I am an objective thinker that appreciates input from all sides to collaboratively work toward meaningful and tangible outcomes. I am not afraid to think outside of the box, and I am not afraid to disagree and articulate my reasoning. ACEP has afforded me some amazing opportunities to become an expert and champion for my colleagues and our patients in the reimbursement and advocacy arena. I have applied these skills as well as those that I developed at work as both Department Chairman and as Quality and Compliance director to better serve my group and colleagues. I have learned how to tactfully anticipate and address issues proactively in a way that is appreciated and embraced. Now, I am ready to give back to the College and my colleagues for believing in me.

**Question #2:** What are the two greatest opportunities and threats to ACEP?

There may never be a more important time for ACEP than now. COVID-19 was an unexpected cessation to life as we knew it that will have negative reverberations for an unknown amount of time. Clearly, the landscape of life “pre-pandemic” has been greatly changed. It is essential that ACEP use this opportunity to highlight that Emergency Medicine physicians do wear the white hat and are essential frontline heroes. This can serve as a catalyst to ensure funding is available for preparedness and for those presenting to the ED and to ensure frontline heroes have stabilization of their livelihoods and jobs. The paradoxical decrease in patient volumes presenting to the ED and stoppage of hospital elective procedures from COVID-19 in many areas initiated a negative and cascading domino effect of less revenue which led to furloughing of essential workers and job losses for some of our colleagues. We need do better. We must do better. It is clear that the public view of our specialty and the House of Medicine has never been stronger. Let’s use this to our advantage. I am ready, willing and able to do this with my unbiased voice that is free from outside pressures. Now is the time to lobby Congress for repeal of budget neutrality to prevent further cuts to our reimbursement and negate recent successes at the RUC, to have a method for making physicians whole financially and with appropriate tools and gear needed to perform their jobs safely. The optics are in our favor and we need to use this potential silver-lining from the COVID-19 pandemic to protect us from the next unexpected event.
Question #3: Does ACEP provide enough support to its chapters? Is there more ACEP should do?

ACEP membership is diverse and spans the entire United States. Working on behalf of the nearly 40,000 ACEP members is an awesome task but worthy of our time and dedication to ensure our specialty is protected now and in the future for our colleagues and patients. College state chapter support is crucial to be successful in this endeavor. The landscape of the College is a reflection of the size of the state and its membership: large chapters are often run like a business with large budgets, employed staff, potential revenue streams and many resources; whereas, small and some medium sized chapters may be bare bones and have difficulty with finances, organization and involvement. I recognized this early on in my career and as a result, the first National ACEP committee I joined was National Chapter Relations Committee (NCRC) as the objectives of this committee were and are aligned to continue outreach and ensure chapters of all sizes have access to ACEP resources (networking, advocacy, grants, logistics, etc.), a voice in the College and resources to ensure they can be successful. The ACEP staff do amazing work for smaller chapters to help fill the gap of limited resources and we need to ensure Chapters know what is available to them such as financial help via grants, composition of bylaws, financial planning and Chapter communications via newsletters, email, and other venues.

To further this ambition of buoying up all Chapters, I sought and was selected as the current Chairman of the NCRC as I feel it is vital to ensure small and medium sized chapters continue to have the support and resources needed to be the voice for their state, our colleagues and our specialty. As we outlined the objectives for my term as Chairman of NCRC, we felt it was essential to continue exploring the results of the Chapter surveys to be responsive to Chapter needs and to collaborate with other ACEP committees such as the Education, Membership and Communication committees to develop resources to address smaller chapter needs in the education, communication and membership arenas. In that spirit, I think partnering a small chapter with a larger chapter with regular video and internet communication can help address a lot of issues and we can all learn from one another. Assembling Chapter Executive Directors together to discuss local and national issues is also invaluable. Continuing the State Chapter round tables at LAC is also beneficial to help facilitate discussion and bring Chapters together. Pooling of resources and helping Chapters work collaboratively can provide more access and avoid duplication of efforts that take time and finances not always available to the chapter. Struggling Chapters can also be identified to ensure they are meeting their basic requirements regarding chapter governance and ACEP can help remediate any problems to ensure compliance. The extreme value of ACEP membership needs to be communicated to our colleagues so that they understand their dues are paid back many times over with ACEP’s collective efforts. Reinforcement of the value of membership is essential as many CME funds and incomes have been negatively impacted by COVID-19. Together we are stronger – we must continue fighting for the specialty we have grown to love. ACEP State Chapter outreach is integral to that success.
CANDIDATE DATA SHEET

James L. Shoemaker Jr., MD FACEP

**Contact Information**

14302 Southold Drive  
Granger, IN 46530  
**Phone:** cell/home (269) 267-3953  
**E-Mail:** jshoemakermd@gmail.com

**Current and Past Professional Position(s)**

2 – Director of Quality for EEPI (2016-present)  
3 – Director of Compliance for EEPI (2016-present)  
4 – Indiana University School of Medicine, South Bend Volunteer Clerkship Faculty (2011-present)

**Education (include internships and residency information)**

1 – Edinboro University of PA, Edinboro, PA (1993-94) attended Freshman year and transferred  
2 – Dickinson College, Carlisle, PA (1994-97), B.S. Biology *cum laude*  
3 – Indiana University Bloomington/Medical Sciences Program (1998-2000), M.A. Physiology with thesis  
4 – Indiana University School of Medicine, Indianapolis, IN — (2000-2004), M.D. in 2004  

**Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified**

ABEM Board certified — certificate expires December 31, 2028

**Professional Societies**

1 – ACEP Member (2004-present)  
2 – ACEP Fellow (2010-present)  
3 – Indiana ACEP Member (2007-present)  
4 – AMA Member (2018-present)  
5 – EMRA Alumni Member (present)  
6 – Indiana State Medical Association (2007-present)  
7 – EDPMA Group Member (2017-present)

**National ACEP Activities – List your most significant accomplishments**

2 – Member of Council Steering Committee (2019-present)  
3 – ACEP Alternate Delegate for AMA/Specialty RVS Update Committee (RUC) (2019-present)  
4 – Reimbursement Committee (2015-present)  
5 – Reimbursement Committee Workgroup 2 (2018-present)  
6 – Chairman, National Chapter Relations Committee (present)  
7 – Member of National Chapter Relations Committee (2013-present)  
8 – Coding and Nomenclature Advisory Committee Member (2018-present)  
9 – ACEP Council Reference Committee ‘A’ Member (2018 Council)  
10 – ACEP Clinical Resources Review Committee Member (2018-present)

**ACEP Chapter Activities – List your most significant accomplishments**

1 – President of Indiana Chapter of ACEP (2015-2016)  
2 – Vice-President of Indiana Chapter of ACEP (2014-2015)  
3 – Secretary/Treasurer of Indiana Chapter of ACEP (2013-2014)
Practice Profile

Total hours devoted to emergency medicine practice per year: 2250 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 85%  Research 0%  Teaching 5%  Administration 10%  Other: ____________________________ %

Describe current emergency medicine practice. (e.g., type of employment, type of facility, single or multi-hospital group, etc.)

I work in a private, independent and wholly democratic group in Northern Indiana near Notre Dame University. I began with Elite Emergency Physicians (EEPI) after residency and have been with the group continuously since 2007. We now have 40+ board-certified EM physician partners and employ multiple advanced practice providers. EEPI holds contracts at four community-based hospitals in three different hospital systems. We annually care for over 185,000 patients among our sites. Physicians joining the group become full voting and profit-sharing partners after a one-year provisional process. The corporate structure of our group is managed by partners that are democratically voted into Administrative roles which are compensated and executed while also working shifts in the department providing direct patient care. Our community-based hospital Emergency Departments welcome Indiana University School of Medicine MS-IV students through our departments for ED Clerkship teaching.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

EEPI positions:
1 - EEPI Director of Quality (2016-present)
2 - Management Team Member of EEPI (2012-present)
3 - EEPI Compensation Committee Member (2010-present)
4 - EEPI Compliance Committee Chair (2016-present)
5 - Volunteer Clinical Faculty for IUSM EM Clinical Clerkship (2011-present)
6 - Member of the IUSM Interview Admissions Team (2017-present)

Elkhart General Hospital (EGH) Positions:
1 – Chairman and Medical Director of EGH Emergency Department (2012-2016)
2 – Chairman and member of EGH ED Quality Assurance Committee (2012-2016)
3 – Medical Co-Director EGH Chest Pain Center (2014-2017)
4 – Medical Co-Director for EGH EMS Program (2010-2012)
5 – Member of EGH Medical Executive Committee (2012-16, 2018-present)
6 – Member of EGH Trauma and Trauma QI committees (2012-present)
7 – Member of EGH Cardiovascular Services and Cardiovascular Services QI Committees (2012-present)
8 – Member of EGH Stroke and Stroke QI Committees (2016-present)

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases  Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

James L. Shoemaker Jr., MD FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: Elite Emergency Physicians, Inc.
   Address: 600 East Boulevard
   Elkhart, IN 46514
   Position Held: Partner, Attending, Director of Quality and Compliance
   Type of Organization: Private, Democratic and Independent Group of EM Physicians and APPs

2. Board of Directors Positions Held – List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.

   Organization: Indiana Chapter of ACEP BOD
   Address: 630 N. Rangeline Rd. – Suite D
   Carmel, IN 46032
   Type of Organization: Emergency Medicine Professional Organization
   Duration on the Board: Board Member 2011-2016; Ex officio Board member 2016-present

   Organization: Elite Emergency Physicians, Inc.
   Address: 600 East Boulevard
   Elkhart, IN. 46514
   Type of Organization: Private, Democratic and Independent Emergency Medicine Group
   Duration on the Board: 2007-present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:
4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

James L. Shoemaker Jr., MD FACEP Date September 20, 2020
September 18, 2020

To Whom It May Concern:

I am the current President of the Indiana Chapter of the American College of Emergency Physicians, and am writing to express our chapter’s enthusiastic support for Dr. James Shoemaker (Jamie) in his campaign for a position on the National ACEP Board of Directors.

Dr. Shoemaker has been a leader within the Emergency Medicine community on the state as well as national levels. He has served as Treasurer/Secretary, Vice President, then President of Indiana ACEP (in 2015-2016), and continues to serve as an Ex Officio Board member. In these capacities, he has been active in tackling various issues affecting Hoosier emergency physicians and their patients, particularly fair reimbursement, balance billing, APRN scope of practice, and others. His expertise in these areas has been a huge asset to the state chapter Presidents (including myself) who have followed him as we advocate for excellence in emergency care for all Hoosiers.

Dr. Shoemaker has also established himself as a leader on a national scale. He has served on multiple National ACEP committees including the Reimbursement Committee, Coding and Nomenclature Advisory Committee, Chapter Relations Committee (of which he is the current chairman), Clinical Resources Review Committee, and National ACEP Steering Committee. His involvement in these varied committees gives him a broad understanding of the workings of the College, and gives him the insight needed to recognize and address the highest-priority issues facing ACEP membership.

In a time when independent Emergency Physician groups are finding it challenging to maintain their independence, Dr. Shoemaker has the unique and valuable perspective of being primarily employed in a private democratic group. He has been a long-time member and leader of Elite Emergency Physicians, Inc., which provides care in several community ED’s in northern Indiana. He understands the issues facing EP’s in independent groups because he has been there; this makes him well positioned to advocate for similar groups on a national level.

Indiana ACEP Officers and Board of Directors 2020/2021

Lauren Stanley MD, FACEP
President

Tyler Johnson DO, FACEP
Vice President

Daniel Elliott MD
Secretary-Treasurer

Bart Brown MD, FACEP
Immediate Past President

Board Members:
Mary Blaha DO
Heather Clark MD
Kyle English MD, FACEP
Daniel Garrison MD
Tricia Kreuter MD, FACEP
Neil Malhotra MD, FACEP

Justin Ritorya MD, FACEP
Nick Sansone DO, FACEP
Lindsay Zimmerman MD

E Nicholas Kestner III
Executive Director
Dr. Shoemaker has developed specific expertise in reimbursement issues. In 2018, he was selected to be an ACEP Reimbursement and Leadership Development (RLDP) Fellow. As fair reimbursement faces assault from all directions, especially from insurers’ efforts, Dr. Shoemaker has worked to establish a voice in the conversation between EP’s, insurers, and other relevant parties in order to advocate for fair reimbursement. His expertise in this area would be an asset to the national ACEP Board of Directors.

In sum, Dr. Shoemaker has demonstrated that he has the knowledge, dedication, and personal background to make him a unique and valuable asset on the National ACEP Board of Directors. As President of the Indiana chapter of ACEP, I am proud to call Jamie a colleague and friend, and I look forward to supporting his candidacy going forward.

Thank you for considering Dr. Shoemaker for the Board!

Lauren Stanley, MD FACEP
James L. Shoemaker Jr., MD FACEP

The current challenges and opportunities that face ACEP would be expertly addressed by my leadership on the ACEP Board of Directors. I am a motivated leader with a magnetic personality who would bring particular experience in the realms of reimbursement, physician wellness and enhancing College membership.

I recently recognized that with the current circumstances of emergency medicine, now is the time for me to participate on the Board. COVID-19 has presented a unique opportunity for our specialty to build on current recognition of the importance of emergency medicine both in the house of medicine and in the public. I would bring a unique knowledge base in reimbursement issues to the Board at this time with which we could capitalize on the moment and better ensure improved value of emergency care. This could in turn help to stabilize the job market for emergency physicians, which has been so tumultuous in 2020. What’s more, I want the councilors to have the opportunity to elect Directors via a contested election, so they truly have a mechanism to demonstrate the values that they currently see as most important for leaders of the College.

I have knowledge and experience in the world of reimbursement, from the micro-level of democratic group management and department chairmanship, to the macro-level of federal regulation and legislation. I understand the tough choices practice groups have to make in creating fair systems of compensation. I am comfortable in the complete process of reimbursement from the code assignment and claim submission to the value assigned by insurance companies. This knowledge base was crystallized through my selection to the ACEP Reimbursement Fellowship, and then utilized most recently as ACEP’s Alternate Representative to the RUC, where I work with ACEP’s team to convey the value of emergency care to the rest of the house of medicine.

Even more importantly, I will work to translate proper reimbursement into emergency physician wellness. With proper reimbursement, ED chairs and practice groups are better able to maintain ED staffing that truly reflects patient acuity and volume, thus encouraging career longevity rather than physician burnout. With appropriate revenue to departments and practice groups, physicians are able to work with our APP colleagues according to best practice workflows, rather than allow for creeping scope of practice. Proper reimbursement supports various practice environments, allowing physicians to thrive in both large and small groups, academic centers and rural hospitals. I will use my personal career experiences to help us lessen the mental and emotional burden that the threat of medical malpractice brings. I can also be a champion for physician due process and transparency, building off my years working as a Director of Quality for my independent clinical group.

As I strive to help ACEP lead emergency physicians towards improved reimbursement and wellness, College membership will be of increasingly clear value. During my time as president of the Indiana ACEP chapter, I was able to communicate to members about how membership fees are returned, many times over, with the gains our College makes in the reimbursement arena. My clinical practice in community medicine will help to shape educational offerings from the college to members from various practice settings. The work I have started as Chair of ACEP’s National Chapter Relations Committee is an extension of my priority of ensuring all chapters, regardless of size, receive the national support they need to bring their members valuable educational resources. I will work for all members.

The ACEP Board will benefit now from my skillset for future successes.

Please vote for me, James L. Shoemaker Jr., MD FACEP, for the Board of Directors.
An Independent Reimbursement and Advocacy Champion

James L. Shoemaker Jr., MD, FACEP

ACEP Board of Directors Candidate

Uniquely Positioned

• Partner in an independent, Democratic EM group
• A confident and unencumbered voice to represent our specialty, patients and colleagues
• An active listener and leader that engages others to find solutions
• Understands the dynamics of private group practice and the changing landscape of EM
• A problem solver and advocate

Reimbursement Expertise

• ACEP Reimbursement and Leadership Development Program Fellow
• Serves as ACEP’s Alternate Representative on the RUC
• Expertise and track record of tackling reimbursement issues at the local, state and national level
• Resolution Author to tackle healthcare insurer impacts to protect our patients and livelihoods

Committed to ACEP

• Steering Committee Member
• Indiana Councillor and BOD member
• Chairman, ACEP NCR Committee
• Member of ACEP Reimbursement, CNAC and Clinical Advisory committees
• Fellow in the College

Committed to You

• Focused on the need for due process rights for EM physicians
• Will demand transparency
• Provide resources for mental health stressors of EM such as litigation and depression

Proudly Endorsed by the Indiana State Chapter of ACEP

Email: jshoemakermd@gmail.com
Direct Cell: (269)-267-3953
EDUCATION
Western Michigan University (formerly MSU/KCMS) – Kalamazoo, MI

Indiana University School of Medicine – Indianapolis, IN
M.D. Allopathic Medicine 2000-2004

Indiana University – Bloomington, IN
M.A. Physiology 1998-2000
Thesis: “Oxygen-dependent binding of chloride to hemoglobin: The importance of the chloride shift in acid-base physiology.” Advisor: Henry Prange, Ph.D.

Dickinson College – Carlisle, PA
B.S. Biology 1994-1997
Graduated cum laude
Transferred to Dickinson from Edinboro University of PA after Freshman year with full scholarship

WORK EXPERIENCE
Elite Emergency Physicians, Inc. (EEPI)
Partner and Attending Emergency Medicine Physician 2007-present
Attending physician at Elkhart General and St. Joseph Hospital Emergency Departments

Chairman, Elkhart General Hospital Emergency Department 2012-2016
Work to streamline ED processes including direct bedding, decreasing LWBS, patient throughput, departmental representation on committees, handling all QA concerns and complaints, maximizing Press-Ganey performance and many other tasks to allow for smooth ED operations. Served as Vice-Chairman of the ED throughout 2011.

Chairman, Elkhart General Hospital ED Quality Assurance Committee 2012-2016
Review all ED deaths, 72-hour returns and any quality or behavioral concerns brought to the committee or hospital’s attention. Review charts to ensure the standard of care is met and provide feedback to providers and/or patients. Served on the committee from 2008-2011 before becoming Chairman.

Committee Member, Elkhart General Hospital ED Quality Assurance Committee 2008-present

Medical Co-Director, Elkhart General Hospital Chest Pain Center 2014-2017
Work to streamline EMS, ED and hospital processes for all patients presenting with typical and atypical chest pain. Standardize processes for patient’s requiring urgent percutaneous intervention and cardiac rule-outs for acute coronary syndrome. Implement best practices for all facets of coronary care from arrival to discharge, including aftercare.

Management Team Member of EEPI 2012-2016
Meet to discuss and act on the day-to-day operations of our multi-million-dollar Corporation. All facets of our dynamic group are discussed and acted upon by the Management Team for presentation to the Board of Directors by this Corporate Leadership group.

Member of EEPI Compensation and Compliance Committees 2010-present
This Corporate group meets to discuss Corporate compliance, chart audits, rules and regulations as well as pay structure and distribution. Address reimbursement issues and charting compliance.

Member of Elkhart General Hospital Medical Executive Committee 2011-2016, 2019-present
Represent the Emergency Department as Chairman on this vital committee that facilitates and manages the daily operations of the Hospital and Medical Staff.
Trauma Committee and Trauma Quality Assurance Committee Member
Serve on this hospital committee to review all trauma deaths, transfers and procedures. Intimately involved with Elkhart General Hospital’s roll-out of planning to become an ACS designated Level III Trauma Center. Review Trauma cases for Quality of Care under peer review processes. Serve as Trauma Liaison in ED. Serve as ED liaison for our Level III trauma center.

Cardiovascular Services and Cardiovascular Services Quality Assurance Committee
Serve on this hospital committee to review all Cardiovascular service line issues including, but not limited to, STEMI door-to-wire time, ECG interpretations, and CVQI issues.

ED Delegate for the EGH Cardiovascular Services Committee
Serve on this hospital committee to review all stroke patients presenting to the hospital for timely administration of thrombolytics or mechanical thrombectomy.

President (2015-2016) and Ex Officio Board Member, Indiana ACEP Board of Directors
Serve on the Board for Indiana’s chapter of the American College of Emergency Physicians. Intimately involved with State Chapter on issues germane to the practice of Emergency Medicine in IN and the Nation. Served as Secretary Treasurer 2013-2014, Vice-President 2014-2015 and President 2015-2016. Actively engage with state Legislator’s to advocate on behalf of the specialty and the House of Medicine in Indiana.

Councilor for Indiana ACEP at ACEP Scientific Assembly
Selected as one of allotted Councilors to represent IN ACEP at the National ACEP meetings. Councilors are responsible for synthesis, discussion and passage of ACEP’s clinical guidelines, standing on issues of national importance and representing the interests of their state as voting members at Scientific Assembly.

ACEP Council Reference Committee ‘A’ Member
Selected as one of the Reference committee members for ACEP SA 2018 Council meeting. Actively engaged in listening to Councilor testimony and discussing Resolutions as a committee for recommendations to the Council Speaker for council voting and Resolution outcomes. Selection is for one year only.

National ACEP Reimbursement Committee Member
Committee members actively participate in discussions with state Medicaid, HMO and PPO as well as National payors such as CMS and Medicare with billing and payment issues regarding emergency medicine and access to care. Assigned to WG6 (Medicaid issues) and actively participate on the WG2 calls and initiatives.

National ACEP Coding and Nomenclature Advisory Committee
Committee actively involved in analyzing Medicare, Medicaid and 3rd party payor processing policies for Deviations from CPT principles; Track payor issues that impact reimbursement; monitor ICD-10 Implementation; advocate for EM issues via the AMA CPT construct; develop FAQs to support EM colleagues with up-to-date information; explore Alternative Payment Model constructs and other tasks.

National ACEP Chapter Relations Committee
Committee members actively participate in discussions state ACEP chapters and act as liaisons to National ACEP. Coordinate and responsible for the disbursement of grant funding to Chapters.

Chairman, National ACEP Chapter Relations Committee

National ACEP Clinical Resources Review Committee
Committee reviews and makes recommendations to ACEP President or its representative concerning externally funded ACEP products. Define processes for product oversight and review. Review and comment on draft ACEP informational papers and topics. Review potential products and resources for organizations requesting ACEP comments.

National ACEP Steering Committee
Steering Committee members provide counsel to the speaker and vice speaker, provide leadership to councilors, coordinate the activities of the Council meetings, and develop policies, procedures, and resolutions as requested.
Medical Co-Director, Elkhart County EMS Medical Co-Director

Provided physician medical control and oversight of EMS Providers. Undertook complete revisions to EMS field protocols, provided QA feedback and educational opportunities.

EEPI Director of Quality


Indiana University School of Medicine Admissions Committee

Appointed to the IUSM Medical school Admissions Committee to interview and rank prospective students for admission to the IUSM.

Indiana University School of Medicine Clinical Faculty

Actively engaged in the Emergency Medicine clerkship education for the MS-IV IUSM students through direct patient contact, didactics and lectures. Help teach procedural skills to the medical students (intubation, suturing, ultrasound, cardioversion, ACLS and many others)

ACEP Reimbursement and Leadership Development (RLDP) Fellow

Selected from a pool of over seventy highly-qualified candidates as one of five RLDP Fellows. This outstanding opportunity is led by ACEP’s Reimbursement Director, David McKenzie, CAE, and is a totally immersive experience to help us develop the skills necessary to continue ACEP’s essential roles in the reimbursement arenas with CMS, commercial payors, Medicaid, RVS Committee and many committees/arenas. Some issues include balance billing, physician fee schedules, RVS committee, CPT, ERISA and many other arenas. Serve on the ACEP/EDPMA joint task force.

ACEP Alternate Representative for AMA/Specialty RVS Update Committee (RUC)

Selected as the Alternate Delegate for ACEP at the AMA Resource-Based Relative Value Scale (RBRVS) Update committee to serve the specialty of Emergency medicine and the House of Medicine as a whole in assignment and updates to the model used to pay physicians for services rendered for CMS. I also serve on multiple committees within the RUC structure.

PUBLICATIONS, PRESENTATIONS, LECTURES AND PAPERS

Multiple peer-reviewed publications, presentations and lectures available upon request.

MEMBERSHIPS

Fellow, American College of Emergency Physicians (ACEP)
Ex Officio Board of Directors Member and Past President of Indian ACEP Chapter
Member, American Medical Association
Member, EDPMA
EMRA Alumni Member

REFERENCES

Available upon request
2020 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Aisha T. Terry (Liferidge) MD, MPH, FACEP

**Question #1: Describe your skills, background, knowledge, or unique abilities outside of ACEP that will make you an effective Board member.**

In addition to having an in-depth understanding of organized medicine, a sober respect for fiduciary stewardship, and an acumen for measured and critical thinking, my Board leadership is further uniquely enhanced by my Washington, DC-based health policy experience, my quality expertise, and my diverse professional background.

My geographic proximity to and health policy ties in Washington, DC – the epicenter of our nation’s health care advocacy agenda – is a unique and ideal characteristic to have as a Board member. Having served as director and senior advisor of the George Washington University Department of Emergency Medicine’s multi-specialty health policy fellowship in Washington, DC for nearly 9 years, I have gained a mature health policy knowledge base and built countless relationships with key policymakers and agency leaders. These assets are key for leveraging the advancement of ACEP’s advocacy efforts in Washington, DC. Residing in the District of Columbia also affords me the unique advantage of easy physical access to numerous, important DC-based meetings. This past year, for example, I represented ACEP at several Centers for Medicare and Medicaid Services (CMS) meetings at their headquarters located right outside of D.C., to advocate for emergency physicians’ equitable evaluation relative to federal quality initiatives.

My Board role is also uniquely optimized by the fact that I serve as liaison to ACEP’s quality portfolio. I am the only Board member currently trained on ACEP’s quality initiatives, the complex process of quality measure development and implementation, federal legislation related to health care quality including the use of registries such as ACEP’s Clinical Emergency Data Registry (CEDR), and the intricacies of using health information technology to innovate the delivery of quality emergency care. This knowledge has uniquely prepared me to effectively champion ACEP’s vast and complex quality initiatives.

Finally, my diverse professional background affords me varied perspectives which is vital for being able to bridge gaps between a host of ACEP leaders, members, and stakeholders. This is a rare, yet crucial skill to have as an effective Board leader. My diverse set of professional experiences include being an academician in a busy urban emergency department, an emergency physician at a Veterans’ Affairs Medical Center, a health policy expert, a diversity champion, and a quality subject matter expert. This breadth of background provides me with the broad insight needed to effectively communicate with, advocate for, and build consensus amongst a myriad of types of emergency physicians and stakeholders.

**Question #2: What are the two greatest opportunities and threats to ACEP?**

ACEP’s greatest opportunity lies in boldly embracing the enormous opportunity to capitalize upon innovative technical advancement and data analytics in order to solidify emergency medicine as a premier leader of health care transformation, ensure the long term solvency of College operations through non-due revenue, and create sustainability of emergency medicine practice relative to quality standards and physician payment. ACEP’s clinical registry – CEDR – offers the perfect opportunity by which to accomplish these goals.

CEDR is currently used to collect and submit quality data to the federal government to evaluate emergency physicians’ provision of care. Since its inception in 2015, CEDR has collected data on over 50 million emergency department (ED) visits and saved emergency physicians over $300 million in avoided penalties. CEDR has even greater functional capacity, however. If fully optimized, CEDR could also serve as a vehicle for curating robust data, facilitating transformative research, and informing innovation around health care delivery. Strengthening CEDR’s technical infrastructure and diversifying its capacity would also provide the College with the ability to perform data analytics and pursue non-dues revenue by offering highly sought after, real time, robust emergency care data. A more widely adopted CEDR would additionally continue to foster high
emergency medicine quality standards, while protecting emergency physicians from penalties and creating eligibility for bonuses.

ACEP’s biggest threat is passivity as related to firmly defining the identity of our specialty and the roles of emergency physicians. This is necessary to ensure the longevity, growth, and integrity of our specialty. Emergency medicine (EM) must be identified as an essential safety net health care service. Emergency physicians must be clearly named as the lead clinician in the ED and the primary stakeholder in EM practice models. The coronavirus pandemic has magnified for the world what emergency physicians have always known; that is, that EM is absolutely essential and of tremendous value to the entire health care system. As such, emergency care should be compensated accordingly, regardless of patient volumes and viewed as a prized resource. ACEP now has an unprecedented opportunity to capitalize upon the momentum of the pandemic by insisting that policies and fiscal support structures fairly and durably recognize EM as vital and essential. As a champion of quality care, ACEP must also be intentional about clarifying the identity of the emergency physician in the clinical setting. While advance practice providers are welcomed and indispensable members of the ED team, their intended skillset does not equate to that of a physician and patients deserve to have their care led and supervised by the clinician with the highest level of competency - an emergency physician. Finally, the role of the emergency physician relative to the management of their practice should be addressed. EM practice models have evolved such that physician autonomy in the decision-making process for the practice has declined. In some instances, this has resulted in a shift away from patient-centered approaches to care. ACEP should study this phenomenon and model options that promote physician-led practice management, without creating excessive burden or risk.

**Question #3: Does ACEP provide enough support to its chapters? Is there more ACEP should do?**

Currently, ACEP’s relationship model with Chapters is largely structured in a vertical, relatively homogenous manner wherein ACEP serves a somewhat paternalistic and uniform support role to ensure that Chapters are properly equipped to thrive. While this approach might work very well for some Chapters, it might not for others. Each of ACEP’s 53 Chapters is unique in terms of size, leadership, geographic location, resources, historical context, challenges, and triumphs. Therefore, while it is vital for ACEP to regularly seek feedback from Chapters about how to best support them, this approach must also acknowledge the unique granularity of each Chapter and be crafted to address their specific needs and desires.

From an advocacy perspective, ACEP must recognize that State-level advocacy efforts are often more effective and efficient than federal efforts, in terms of timeliness and degree of meaningful influence. State policies often influence that of other states, and eventually that of the nation as a whole. ACEP should therefore focus on optimizing its support of Chapters relative to their local advocacy work and create opportunities for flow of information amongst Chapters relative to shared efforts and goals. In instances where Chapters have experienced great success relative to a specific issue, it would be wise for ACEP to learn from those experiences and consider applying best practices to national efforts. ACEP’s relationship model with its Chapters would therefore likely benefit from having a horizontal component added which affords Chapters structured opportunities to influence and interact with ACEP and other Chapters, particularly relative to advocacy matters. This approach recognizes the fact that, ultimately, ACEP and its Chapters’ success is collective and collaborative.
CANDIDATE DATA SHEET

Aisha T. Terry (Liferidge) MD, MPH, FACEP

Contact Information
3001 26th Street, NE, Washington, DC 20018
Phone: 443-801-8459
E-Mail: aterry@acep.org

Current and Past Professional Position(s)
- American College of Emergency Physicians (ACEP), Board of Directors Member (2017-present)
- Associate Professor of Emergency Medicine and Health Policy (2018 to Present)
- George Washington University Department of Emergency Medicine Health Policy Fellowship, Senior Advisor (2018-present)
- George Washington University Department of Emergency Medicine Health Policy Fellowship, Director (2012-2018)
- Assistant Professor of Emergency Medicine and Health Policy (2012-2018)
- Assistant Professor of Emergency Medicine (2007-2012)
- Clinical Instructor of Emergency Medicine (2006-2007)

Education (include internships and residency information)
- Columbia University Mailman School of Public Health, Executive Master of Public Health Program (2009-2011)
- University of Maryland Medical System, Emergency Medicine Residency Training Program (2003-2006)
- University of North Carolina at Chapel Hill School of Medicine, Medical Doctor Program (1999-2003)
- Duke University, Bachelor of Science in Biology Program, Minor Degrees in Chemistry and Spanish (1995-1999)

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
- ABEM (2007; 2018 recertified)

Professional Societies
- American College of Emergency Physicians (ACEP)
- American Medical Association (AMA)
- National Medical Association (NMA)
- Society of Academic Emergency Medicine (SAEM)
- District of Columbia Chapter of the American College of Emergency Physicians (DC ACEP)

National ACEP Activities – List your most significant accomplishments

Leadership:
- Board of Directors, Elected Member (2017-Present)
- ACEP Clinical Emergency Data Registry (CEDR) Committee, Board Liaison
- ACEP Quality and Patient Safety Committee, Board Liaison
- ACEP Quality Improvement and Patient Safety Section, Board Liaison
- ACEP Research Section, Board Liaison
- ACEP Diversity, Inclusion, and Health Equity Section, Board Liaison
- ACEP Trauma and Injury Prevention Section, Board Liaison
- ACEP Undersea and Hyperbaric Medicine Section, Board Liaison
- ACEP Nominating Committee (Council Committee), Member
- Journal of the American College of Emergency Physicians (JACEP), Editor-in-Chief Search Committee Task Force, Member (2017-2019)
- Diversity in Leadership Task Force, Appointed Member (2017-2018)
- Diversity and Inclusion Task Force, Appointed Chair (2016-2018)
- Public Health and Injury Prevention Committee Member (2005-2017)
- Disparities in Health Care Subcommittee, Chair (2009-2012)
- Healthy People 2020 Subcommittee, Member (2009-2011)
- Sobering Centers Subcommittee, Chair (2012-2014)
- Young Physicians Section, Member (2007-present)
- Associate Membership Task Force, Appointed Chair (2008-2009)

Educational Products:

Awards:
- ACEP Council Diversity Champion Award (2018; Inaugural Recipient)
- ACEP Council Teamwork Award (2009)
- Hero in Emergency Medicine Award (2008)

ACEP Chapter Activities – List your most significant accomplishments
- District of Columbia Chapter of the American College of Emergency Physicians
  - 2016-2017 Board of Directors member and Councilor
  - 2015-2016 Board of Directors member, Immediate Past President and Councilor
  - 2013-2015 Board of Directors member, President and Councilor
    - Revitalized Chapter; doubled revenue; membership increased by 50%
- Maryland Chapter of the American College of Emergency Physicians
  - 2007-2012 Board of Directors member
  - 2005-2012 Public Policy Committee member
  - 2005-2006 Public Relations Committee member

Practice Profile

Total hours devoted to emergency medicine practice per year: 900 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
  Direct Patient Care 50 % Research 10 % Teaching 25 % Administration 15 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
- Academic Multi-specialty Physician Group

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)
- Health Policy Fellowship, Senior Advisor
- School of Medicine, Learning Community Leader
- School of Medicine, Clinical Public Health Mentor
- School of Medicine, Professional Development Mentor
- School of Medicine, Clinical Skills and Reasoning Instructor
**Expert Witness Experience**

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

<table>
<thead>
<tr>
<th>Defense Expert</th>
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<th>Cases</th>
<th>Plaintiff Expert</th>
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<th>Cases</th>
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# CANDIDATE DISCLOSURE STATEMENT

**Aisha T. Terry (Liferidge) MD, MPH, FACEP**

1. **Employment** – *List current employers with addresses, position held and type of organization.*

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>George Washington University Medical Faculty Associates</td>
<td>2120 L Street, NW, Suite 450, Washington, DC 20037</td>
<td>Associate Professor of Emergency Medicine and Health Policy; Health Policy Section Chair; Health Policy Fellowship Senior Advisor; Attending Physician</td>
<td>Academic Multi-specialty Physician Group</td>
</tr>
</tbody>
</table>

2. **Board of Directors Positions Held** – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Type of Organization</th>
<th>Duration on the Board</th>
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</thead>
<tbody>
<tr>
<td>American College of Emergency Physicians</td>
<td>4950 W. Royal Lane, Irving, Texas 75063-2524</td>
<td>Emergency Medicine Specialty Organization</td>
<td>2017-Present</td>
</tr>
<tr>
<td>Minority Women in Science Foundation</td>
<td>P.O. Box 90134, Washington, DC 20090</td>
<td>501c3 Non-profit Organization</td>
<td>2006-Present</td>
</tr>
<tr>
<td>Legal Clinics for the Disabled</td>
<td>1513 Race Street, Philadelphia, PA 19102</td>
<td>Medico-legal Clinic</td>
<td>2019-Present</td>
</tr>
<tr>
<td>Organization</td>
<td>District of Columbia Chapter of the American College of Emergency Physicians</td>
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<tr>
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<td>4950 W. Royal Lane Irving, Texas 75063-2524</td>
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<tr>
<td>Type of Organization</td>
<td>State Chapter Specialty Organization</td>
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<td></td>
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<tr>
<td>Duration on the Board</td>
<td>2013-2017</td>
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<thead>
<tr>
<th>Organization</th>
<th>Maryland Chapter of the American College of Emergency Physicians</th>
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<tbody>
<tr>
<td>Address</td>
<td>4950 W. Royal Lane Irving, Texas 75063-2524</td>
</tr>
<tr>
<td>Type of Organization</td>
<td>State Chapter Specialty Organization</td>
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<tr>
<td>Duration on the Board</td>
<td>2005-2012</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Organization</th>
<th>Emergency Medicine Residents’ Association (EMRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>4950 W. Royal Lane Irving, Texas 75063-2524</td>
</tr>
<tr>
<td>Type of Organization</td>
<td>Emergency Medicine Residents’ Specialty Organization</td>
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<tr>
<td>Duration on the Board</td>
<td>2005-2008</td>
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<tr>
<th>Organization</th>
<th>Emergency Medicine Foundation (EMF)</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
<td>4950 W. Royal Lane Irving, Texas 75063-2524</td>
</tr>
<tr>
<td>Type of Organization</td>
<td>Emergency Medicine Research Foundation</td>
</tr>
<tr>
<td>Duration on the Board</td>
<td>2007-2008</td>
</tr>
</tbody>
</table>

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE

☐ If YES, Please Describe:
4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Aisha T. Terry MD, MPH, FACEP  Date  06.09.2020
September 9, 2020

Gary R. Katz, MD, MBA, FACEP
Chair
Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

Dear Dr. Katz,

As President of the District of Columbia Chapter, it is my pleasure to write to you on behalf of our three hundred and forty-five emergency medicine physician members, to proudly endorse **Aisha T. Terry, MD, MPH, FACEP** for election to the ACEP Board of Directors.

During her presidential leadership with the DC Chapter from 2013 to 2016, the Chapter’s activity soared and its revenue more than doubled. Dr. Terry served as a voting ACEP Councillor for many years. She continues to be an active member of the chapter.

Since 2004, Dr. Terry has been a member of multiple ACEP Committees and Sections. The Public Health and Injury Prevention Committee, the Young Physicians Section, and the 911 Legislative Network.

During her residency in Fall 2005, Dr. Terry was elected President of the national Emergency Medicine Residents’ Association (EMRA). Under her leadership, EMRA’s budget reached an all-time high of $1 million and she spearheaded the implementation of the ACEP/EMRA Mini-Health Policy Fellowship in Washington, DC. She has been and continues to be a mentor to many young ACEP members and Residents.

In 2008, she received a prestigious award from The College, Hero in Emergency Medicine, and in 2009 received The ACEP Council Teamwork Award.

Dr. Terry has also been a champion of diversity within our organization. She chaired ACEP's Diversity and Inclusion Task Force, which increased awareness, identified barriers and solutions to diversifying the physician workforce, and linked patient outcomes with workforce diversity. Dr. Terry was awarded ACEP’s 2018 inaugural Diversity Champion Award.

Dr. Terry has participated in collaborative research on many topics and published several peer reviewed publications. She has given numerous local, state, national and international lectures and speeches on topics such as the triage of emergency department patients to a medical home,
sustained growth formula (SGR) reform, coordinated and integrated health care, physician reimbursement, and innovative physician health policy education. Dr. Terry has also led health policy and stroke research efforts, partially through grant funding from the National Institute of Health (NIH).

At present, Dr. Terry works at the George Washington (GW) University School of Medicine in Washington, DC, where she fulfills her true passion for clinical practice, teaching, and mentoring as an associate professor of Emergency Medicine and Health Policy at GW and the Milken Institute School of Public Health. She serves as senior advisor of the Health Policy Fellowship of her department and serves as a Learning Community Leader in the School of Medicine. She also serves as a Professional Development Mentor which requires her to teach professionalism skills to medical students through small group sessions focused personal reflection and team-building exercises.

She is the chief executive officer of the Minority Women in Science Foundation (MWSF). The MWSF provides mentorship, tangible resources, networking opportunities, and career-long support to its beneficiaries. Over the years, the Foundation has provided numerous scholarships and several standardized test preparatory course grants to aspiring youth.

Dr. Terry has the courage and vision to lead ACEP toward a better future. She has demonstrated the highest level of commitment to emergency medicine, our Chapter, and the College. She is a skillful communicator, excellent clinician, and exemplary community member committed to the cause and mission of emergency medicine.

The DC Chapter is proud and fortunate to have a dedicated advocate to represent emergency medicine. We hope you accept this letter of endorsement and vote to re-elect Dr. Terry to the ACEP Board of Directors.

Sincerely,

Natasha N. Powell, MD, MPH, FACEP
President
DC ACEP Chapter
Dear Fellow ACEP Council Members:

It is with extreme gratitude and tremendous excitement that I embark upon my second quest for the privilege of serving our outstanding organization as a member of its Board of Directors. My first term of representing and advocating for you was filled with exceptional triumphs, intense challenges, and exponential growth. Thank you sincerely for the opportunity to serve and for investing in my leadership.

Time truly flies! It’s hard to believe that just three years ago, I successfully ran for the Board based primarily on the platform of being a health policy wonk, an academician, and a diversity champion. Today, I am happy to report that over the course of my first term, I have intentionally and necessarily broadened my skillset such that I feel well equipped to represent the College on everything from reimbursement to international policy. My Board role has been uniquely optimized by having served as liaison to ACEP’s quality portfolio. I am the only current Board member explicitly trained on ACEP’s quality initiatives, the complex process of quality measure development and implementation, federal legislation related to health care quality including the use of registries such as ACEP’s Clinical Emergency Data Registry (CEDR), and the intricacies of using health information technology to innovate the delivery of quality emergency care.

This knowledge has uniquely prepared me to effectively champion ACEP’s vast and complex quality initiatives.

I look forward to continuing to lead ACEP into a future that relies on its quality initiatives to advance 4 major goals: (1) emergency medicine quality measure development and implementation, (2) bridging gaps amongst various stakeholders within our specialty to ensure efficiency and cost control relative to quality measure development, (3) solvency of our specialty and College by way of optimized quality data reporting through CEDR and non-dues revenue opportunities, and (4) advanced technical infrastructure which fosters innovation to meet the demands of modernization and emergency care delivery re-design.

While I recognize that many of the issues that ACEP faces are complex and sometimes polarized, my philosophy is to always keep the ultimate goal in mind when challenges arise – that is, to uphold the College’s mission. ACEP’s mission statement speaks to advocacy - not just for emergency physicians - but also for patients and for the public. It also speaks to advancing quality emergency care. ACEP’s mission statement rightly puts emergency physicians in the driver’s seat, as we are more than capable of steering the practice of emergency medicine and the delivery of emergency care in the right direction.

As always, there is much at stake for our specialty and our patients, but somehow the year 2020 seems a bit different; I’m eager to use the momentum from these unprecedented times to push the College into a new, more authentic, and better prepared era of progress and leadership. You deserve leadership that is committed to ensuring that the College not only thrives, but also evolves to the next level. You deserve leadership that is transparent and uncomfortable with the status quo if it comes at the expense of our specialty and patients. You deserve leadership that works tirelessly for your interests. With those tenets in mind, I look forward to continuing to be the leader that you so deserve. I am eager to serve through transformative leadership and a broadly-equipped skillset. I humbly ask again for your vote and support, as we forge ahead into a bigger and brighter future for the American College of Emergency Physicians.

Sincerely your colleague,

Aisha Terry (formerly Liferidge) MD, MPH, FACEP
PROVEN LEADERSHIP. PREPARED TO TRANSFORM.

AISHA TERRY
(LIFERIDGE)
MD, MPH, FACEP

ACEP Board of Directors Candidate (Incumbent)

ACEP20 UNCONVENTIONAL VIRTUAL COUNCIL MEETING
- Health Policy Scholar
- Academician
- Quality Expert
- Diversity Champion

Re-Elect
Aisha Terry
(Liferidge)

Invest in Quality
- CEDR 2.0
- Data Analytics
- Lead Innovation in EM
- Lead the Re-design of Emergency Care Delivery

Prioritize Chapter Relations
- Customize Approach Based on Unique Features of Chapter
- Better Integrate National & Chapter Advocacy Efforts

Solvency
- Solve Out-of-Network Billing Problem
- Non-dues Revenue
- Optimize Revenue through MIPS Reporting via CEDR

District of Columbia
American College of Emergency Physicians
Curriculum Vitae

Aisha T. Terry (Liferidge), MD, MPH Associate Professor
of Emergency Medicine and Health Policy
Fellowship, Senior Advisor
Attending Physician
George Washington University School of Medicine
American College of Emergency Physicians, Board Member

DATE: June 2020

PERSONAL DATA:

3001 26th Street, NE
Washington, DC 20018
443-801-8459
aisha.t.terry@gmail.com

EDUCATION:

1999 Duke University
Durham, North Carolina
Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor

2003 University of North Carolina School of Medicine
Chapel Hill, North Carolina
Doctor of Medicine (MD)

2011 Columbia University Mailman School of Public Health
New York, New York
Executive Master of Public Health (MPH), Health Policy and Management Focus

POST GRADUATE EDUCATION AND MEDICAL TRAINING:

2003-2006 University of Maryland Medical System, Department of Emergency Medicine
Emergency Medicine Residency Program

COLLABORATIVE RESEARCH:

2001-2002 Ability of laypersons to administer the Cincinnati Prehospital Stroke Scale (CPSS) Study, University of North Carolina (Co-Investigator)
Preceptor: Jane H. Brice, MD, Department of Emergency Medicine
Description: Randomized validation study that sought to determine if the CPSS can be used by laypersons to help dispatchers recognize stroke prior to patient contact.
Participants’ ability to administer and interpret the results of the CPSS was evaluated. Data analysis revealed that the subjects’ administration and interpretation were accurate, (statistically significant) implying that laypersons are able to use the CPSS appropriately.

2004-2006 Rapid Assessment of Transient Ischemic Attack Etiologies (RATE) Clinical Trial
University of Maryland Medical System, (Research Assistant)
Preceptor: Marian LaMonte, MD, Department of Neurology

Description: Chart review of TIA (transient ischemic attack) patients evaluated and treated in an Emergency Department observation unit, aimed to determine TIA/stroke risk factors and to evaluate the feasibility of instituting an algorithm of comprehensively and appropriately evaluating TIA patients within 24 hours.

2008-2012 Neurological Emergencies Treatment Trials (NETT) Consortium, National Institute of Neurological Disorders and Stroke (NIH NINDS); Multi-center; Multiple Trials through 2012.
- ALIAS Phase III Trial, “Albumin in Acute Ischemic Stroke”
- RAMPART, “Rapid Anticonvulsant Medications Prior to Arrival Trial”
- POINT, “Platelet-Oriented Inhibition in New TIA”
- PROTECT, “Progesterone for Traumatic Brain Injury”

2012-2013 Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis, George Washington University, Department of Emergency Medicine (Principal Investigator) Description: Conducted at the Washington, DC Veterans Affairs Medical Center; retrospective pre and post intervention analysis to determine the impact of an ED-based triage protocol on patient health services utilization patterns and its cost.

2013-2014 Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education, George Washington University, Department of Emergency Medicine (Principal Investigator), Description: Conducted at George Washington University School of Medicine; pilot crossover study that compared the effectiveness of an online and in-person curriculum. 6 lecture topics were included in both the online and in-person formats. The effectiveness of each teaching format in promoting knowledge retention was evaluated through tests administered before and after completion of each topic module. Results suggests that an online curriculum to teach medical students health policy may be as effective as an in-person curriculum.

2015-present Teaching Health Policy to Residents Physicians: A National Survey and Curricula Recommendations, George Washington University, Department of Emergency Medicine (Principal Investigator), Description: Seeks to (1) understand the culture, attitudes, and interests in resident health policy education guiding graduate medical education policymakers and director through a series of qualitative interviews, (2) describe the national landscape and extent of resident health policy education across multiple specialties utilizing a cross sectional survey of residency program directors and designated institutional officials, and (3) develop recommendations for a tailored interactive toolkit for effective resident health policy education based on the feedback received.

PROFESSIONAL REGISTRATIONS, LICENSES, AND CERTIFICATIONS:

2008 Board Certified (ABEM) in Emergency Medicine; re-certified 2018
2006 Maryland, medical license
2011 Washington, DC, medical license (active)

EMPLOYMENT:
**Academic Appointments:**

2018-present  
Associate Professor, Department of Emergency Medicine  
Senior Advisor, Emergency Medicine Health Policy Fellowship  
George Washington University School of Medicine

2018-present  
Associate Professor, Department of Health Policy  
Milken Institute of Public Health, George Washington University

2012-2018  
Assistant Professor, Department of Emergency Medicine  
Director, Emergency Medicine Health Policy Fellowship  
George Washington University School of Medicine

2013-2018  
Assistant Professor, Department of Health Policy  
Milken Institute of Public Health, George Washington University

2007-2011  
Assistant Professor, Department of Emergency Medicine  
University of Maryland School of Medicine

**Other Employment:**

1998-1999  
Research Assistant, Duke University Department of OB/GYN  
Preceptor: Dr. Harold Schomberg  
Description: Performed tissue cultures, DNA preparation, western blotting, PCR related to the biochemical properties of various proteins involved in Reproductive Biology.

2006-2007  
Attending Physician, Department of Emergency Medicine  
Maryland Emergency Medicine Network  
Washington County Hospital Emergency Medicine Physicians

**SOCIETIES:**

2001 - present  
Society for Academic Emergency Medicine (SAEM)

2003 - 2011  
Maryland American College of Emergency Physicians (MD ACEP)

2002 – present  
American College of Emergency Physicians (ACEP)

2003 – present  
Emergency Medicine Residents’ Association (EMRA)

2008 – present  
American Medical Association (AMA)

2012 – present  
District of Columbia College of Emergency Medicine

2013 – present  
Medical Society of the District of Columbia

2015 – present  
National Medical Association (NMA)

**HONORS/AWARDS:**

**Duke University**

1996  
Dean’s List with distinction

1997  
National Dean’s List

1997  
Dean’s List

1998  
Dean’s List

**University of North Carolina at Chapel Hill School of Medicine**

1999-2003  
North Carolina Board of Governors Academic Scholarship  
Four-year scholarship funding full tuition, fees, and annual stipend; based of merit and
interest in practicing medicine in North Carolina

1999-2003 Edward-Hobgood Distinguished Scholarship, four-year scholarship based on scholastic achievement, character, and service

1999 Honors in Medical Embryology
2000 Honors in Humanities and Social Science
2001 Honors in Endocrinology
2001 Honors in Dermatology
2001 Honors in Reproductive Biology
2002 Society for Academic Emergency Medicine (SAEM), Southeastern Regional Conference, Best Student Presentation
2002 Seventh Annual Emergency Medicine Research Forum, Dept. of EM, UNC, Chapel Hill, Best Student Oral Presentation
2005 American College of Emergency Physicians Leadership and Advocacy Conference, Chair’s Challenge Scholar
2005 American College of Emergency Physicians/Emergency Medicine Residents’ Association Health Policy Mini-Fellowship, Washington, DC

University of Maryland Medical Center, Department of Emergency Medicine
2006 Mission Statement Award, recognizes leadership and excellence in academics during residency

American College of Emergency Physicians
2008 Hero in Emergency Medicine Award
2009 ACEP Council Teamwork Award
2018 ACEP Council Diversity Champion Award

Emergency Medicine Residents’ Association
2019 EMRA 45 Under 45

ADMINISTRATIVE DUTIES AND UNIVERSITY ACTIVITIES:

National Service:

American College of Emergency Physicians (ACEP)
2004-2006 Emergency Medicine Practice Management and Health Policy Section member
2005-present 911 Legislative Network member
2005-2017 Public Health and Injury Prevention Committee member
   --Disparities in Health Care Subcommittee, chair (2009-2012)
   --Healthy People 2020 Subcommittee, member (2009-2011)
   --Sobering Centers Subcommittee, chair (2012-2014)
2007-present Young Physicians Section, member
2008-2009 Associate Membership Task Force, appointed Chair
2016-2018 Diversity and Inclusion Task Force, appointed Chair
2017-2018 Diversity in Leadership Task Force, appointed member
2017-2020 Board of Directors, elected member
   - ACEP Quality and Patient Safety Committee, Board liaison
   - ACEP CEDR Committee, Board liaison
   - ACEP Quality Improvement and Patient Safety Section, Board liaison
   - ACEP Research Section, Board liaison
- ACEP Diversity, Inclusion, and Health Equity Section, Board liaison
- ACEP Undersea and Hyperbaric Medicine Section, Board liaison
- ACEP Trauma and Injury Prevention Section, Board liaison
- ACEP Nominating Committee (Council Committee), member

2017-present  ACEP 2nd Journal Editor-in-Chief Search Committee Task Force, member

**Emergency Medicine Residents’ Association (EMRA)** Board of Directors, Presidential cabinet
- 2005-2006  President-elect
- 2006-2007  President
- 2007-2008  Immediate Past-president

**Emergency Medicine Foundation (EMF)**
- 2006-2007  Board of Trustees member
- 2007  EMF Strategic Plan/Planned Giving Task Force member

**American Academy of Neurology**
- 2009-2015  Practice Parameters Guidelines on the Treatment of First Seizure, subcommittee member

**National Emergency Medicine Political Action Committee (NEMPAC)**
- 2020-2022  Board member

**State Service:**

**District of Columbia Chapter of the College of Emergency Medicine**
- 2013-2015  Board of Directors member, President and Councilor
- 2015-2016  Board of Directors member, Immediate Past President and Councilor
- 2016-present  Board of Directors member, Councilor through 2017

**The Maryland State Medical Society, MedChi**
- 2003-2011

**Maryland American College of Emergency Physicians (ACEP)**
- 2005-2006  Public Relations Committee member
- 2005-2012  Public Policy Committee member
- 2007-2012  Board of Directors member

**Maryland Stroke Alliance**
- 2009-2012  Executive Committee member

**Local Service:**

**Baltimore City Medical Society (BCMS)**
- 2004-2011  Community outreach programs conductor
- 2005-2006  Membership Committee member

**Departmental:**

**George Washington University Department of Emergency Medicine**
- 2012 –2018  Health Policy Fellowship, Director, provide didactic teaching, foster professional development, and facilitate office placement with Congressional office, government agency, or think tank for aspiring emergency physicians with public health and health
policy interests.

2018-2019  Health Policy Fellowship, Director, provide didactic teaching, foster professional development, and facilitate office placement with Congressional office, government agency, or think tank for aspiring emergency physicians with public health and health policy interests.

University:

University of Maryland School of Medicine/University of Maryland Medical System
2004-2006  University of Maryland Medical System
  Medical Policy Sub-Committee member
2004-2006  Black House Officers Association
2007-2011  Introduction to Clinical Medicine II Instruction, Instruct second-year medical students in physical examination skills
2007-2011  Departmental liaison for the Departments of Emergency Medicine and Neurology

George Washington University School of Medicine
2014-present  Clinical Skills and Reasoning Instructor (CSR) in Practice of Medicine Course; instruct first and second-year medical students in history-taking and physical examination skills.
2015-present  Professional Development (PD) Mentor in Practice of Medicine Course; teach professionalism skills to first-year medical students through small group sessions focused personal reflection and team-building exercises.
2015-present  Learning Community Leader; lead faculty development exercises for faculty members teaching professional development to first year students.
2016-2018  Clinical Skills and Reasoning (CSR) Curriculum Theme, Co-director; responsible for the development, dissemination, and implementation of all CSR weekly faculty and student sessions for the School of Medicine, as well as faculty and student evaluation of materials application and remediation exercises.
2018-present  Clinical Public Health Mentor, develop and teach curriculum which exposes first and second year medical students to systems based learning.

Other Service:

Duke University
1996-1997  North Carolina Rural Health Coalition
1997  Organization for Tropical Studies Study Abroad Program in Costa Rica
1998  Duke University Black Professional Health Organization
1998-1999  Spanish Community Center of Durham volunteer

University of North Carolina School of Medicine
1999-2003  Student National Medical Association
1999-2003  Spanish-Speakers Assisting Latinos Student Association (SALSA)
1999-2001  Student Health Action Coalition (SHAC)
2000-2001  Community Service Co-chair
2000-2001  SALSA Co-leader
2000-2001  Laboratory Technician
2000  Medical Education Development (MED) Program, Teacher’s Assistant in Microbiology and Biochemistry
2000-2001  UNC School of Medicine Soup Kitchen Coordinator, Coordinated UNC medical students as cooks and servers each month, averaged 4 hours of service each month

2000-2001  Prevention in ACTion (PACT), 2000-2001, Vice President, coordinated community outreach targeting health promotion in local adolescent girls

2001-2003  Emergency Medicine Residents’ Association (EMRA), Medical Student Liaison

**TEACHING AND EDUCATIONAL ACHIEVEMENTS:**

2007-2011  Emergency Medicine Residency Clinical Pearls Author, Create and distribute weekly clinical instruction pertaining to neurological emergencies to medical students and emergency medicine residents and attendings, distribution of > 2000

2007-2011  Introduction to Clinical Medicine II Instruction, Instruct second-year medical students in physical examination skills (University of Maryland School of Medicine)

2007-present  Academic lecturer and bedside instructor to ~ 15 classes of emergency medicine residents (150+), off-service surgical and medical residents, and medical students, focus on and expertise in neurological emergencies and stroke and public health/health policy (University of Maryland Medical System, George Washington University Medical Center)

2009-2010  American College of Emergency Physicians Teaching Fellowship; intensive course for junior faculty that taught the fundamentals of teaching and evaluation, curriculum design and implementation, and skill in balancing an academic career with competing interests.

2012-2019  Implementation of Executive Coaching curriculum for all George Washington University Department of Emergency Medicine fellows

2012-2019  Implementation, management, and evaluation of health policy journal club independent study coursework for George Washington University Department of Emergency Medicine health policy fellows enrolled at the George Washington University School of Public Health

2014-present  Clinical Skills and Reasoning (CSR) Instructor, George Washington University School of Medicine and Health Sciences. instruct first, second, third and fourth year medical students in history taking and physical examination skills

2015-present  Clinical Skills and Reasoning (CSR) Group Leader, conduct first and second year medical student professional development and faculty development sessions.

2015-present  Professional Development (PD) Mentor; teach professionalism skills to first-year medical students through seminar-style courses, reflection exercises, and team-building.

2015-present  CSR/PD Learning Community Leader; lead faculty development exercises for faculty members teaching professional development to first year students.

2015-May-Jun  Guest lecturer, 11 emergency medicine residents (PGY1), 12 hours of lecturing Including multiple Neurology lectures; Madurai, India

2015-June  Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Mumbai, India

2015-Nov  Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Bubaneswar, India

2016-present  Clinical Skills and Reasoning (CSR) Theme Curriculum, Co-director; responsible for the development, dissemination, and implementation of all CSR weekly faculty and student sessions for the School of Medicine, as well as faculty and student evaluation of materials application and remediation exercises

2016-Dec  Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Delhi, India

2017-Mar  Guest lecturer, 20+ emergency medicine residents (PGY1-3), 12 hours of lecturing including written and oral Board review; Mumbai, India

2018-present  Clinical Public Health Mentor, develop and teach curriculum which exposes first and second year medical students to systems based learning.
**GRANTS AWARDED:**

6/1/07-5/31/09  
(Co-PI 5%)  
PI: M. Wozniak  
"ALIAS Phase III Trial in Albumin in Acute Ischemic Stroke"  
ALIAS Trial through NETT Consortium  
University of Michigan Fixed Price Per Patient Clinical Trial Contract

8/1/07-7/31/09  
(Co-Investigator 12.5%)  
PI: T. Ting  
"RAMPART Rapid Anticonvulsant Medications Prior to Arrival Trial"  
RAMPART Trial through NETT Consortium  
University of Michigan Fixed Price Per Patient Clinical Trial Contract

9/30/07 - 8/31/2012  
(Co-Investigator 25%)  
PI: B. Stern  
"Neurological Emergencies Treatment Trials (NETT) Network Clinical Site Hubs (U10)"  
National Institute of Neurological Disorders and Stroke (NIH NINDS) Cooperative Agreement  
Total Costs: $1,262,597.00

5/15/09 – 8/15/09  
(Pi, Mentor 10%)  
Intramural Grant funding portion University of Maryland School of Medicine Summer Research Internship for two medical students  
Total Grant: $4,000.00

10/01/12 – 10/01/13  
(PI 35%)  
"Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis”  
Clinical and Translational Sciences Institute-Children’s National (CTSI-CN) pilot grant.  
Total Grant: $ 39,000.00

07/01/2013 – 07/01/2014  
(PI 18%)  
"Teaching Health Policy: Developing a Portable E-learning Tool for Medical Student Education”  
George Washington University Medical Education Research Grant  
Total Grant: $ 14,900.00

**Grant Writing Experience:**

12/2009  
"The Feasibility of using Perfusion-weighted Brain MRI over Non-contrast CT to Emergently Diagnose Acute Ischemic Stroke: An Analysis of Accuracy, Cost Effectiveness, and Safety.”  
Emergency Medicine Foundation sponsored  
Proposed award amount: $50,000  
Hours devoted: 60+

12/2010 – 02/2011  
"Targeted Legislation and Regionalization Improves Stroke Patient Outcomes” Emergency Medicine Foundation (EMF), EMD and Genentech sponsored
Proposed award amount: $100,000
Hours devoted: 150+

05/2012 – 09/2012  “Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Patient-Centered Medical Home: A Health Services Utilization and Cost Effectiveness Analysis”
Hours devoted: 200+

01/2015  “Teaching Health Policy to Resident Physicians: A National Survey and Curricula Recommendations”
Hours devoted: 100+

PUBLICATIONS:

Book Chapters:

Peer-reviewed Journal Articles:


Publications currently being developed:

1. Liferidge AT, McCarthy M, Ding R, Blanchard J, Li S, Seton P. Triage of Low Acuity Emergency Department Patients to a Primary Care Clinic and Medical Home: A Utilization and Cost Effectiveness Analysis.


Abstracts and/or Proceedings:


COURSE DEVELOPMENT:

1. Liferidge, A. Health Policy for Medical Students - Portable Electronic-Learning Modules; product of grant-funded research; 2014.


4. Liferidge, A. Developed idea around and led efforts to implement an **Executive Coaching Curriculum** through *Executive Advantage, LLC* for all George Washington University Department of Emergency Medicine fellows. 2012 to Present.

**PRESENTATIONS:**

**Invited and Grand Rounds:**

**International:**

1. Liferidge AT. 4-week lecture series on the fundamentals of emergency medicine. Bali International Medical Center (BIMC), Bali, Indonesia, April 2006.
2. Liferidge AT. Trauma training program; biannual 1-week lecture series on designing and implementing trauma systems; Hunan Provincial Peoples Hospital. Changshan, Hunan, China. March 2019 to 2021.

**National:**

   - Discusses career development
- Discusses the work of the Minority Women in Science Foundation
- Discusses leadership through the American College of Emergency Physicians from the context of its Diversity and Inclusion initiative and unconscious bias education


State/Regional:


10. Liferidge AT. UT Southwestern Medical Center, Grand Rounds, “Tricks of the Trade for Managing HIV-related Emergencies.” Dallas, Texas, April 2015.

Local/Institutional:

Symposium: Health Policy Workshop/American Academy of Emergency Medicine.”
Georgetown University School of Medicine. Washington, DC, October 2013.


**Research:**


5. **Liferidge AT.** “Defining and Objectively Measuring Quality for an Inner City Academic Emergency Department.” Society for Academic Emergency Medicine Mid-Atlantic Conference, Georgetown University School of Medicine, Washington, DC, February 2013.

6. **Liferidge AT.** “Triage of Non-emergent Emergency Department Patients to a Medical Home through a Federally Qualified Health Center.” Society for Academic Emergency Medicine Mid-Atlantic Conference, Georgetown University School of Medicine, Washington, DC, Feb. 2013.


Preferred Communication:

1. LaMonte, Marian; Kuo, Dick; Barhout, Mona; Liferidge, AT; Yarbrough. Rapid Assessment of Transient Ischemic Attack Etiologies (RATE), ACEP Scientific Assembly, New Orleans, La, October 2006.

SERVICE TO THE COMMUNITY:

2006-present Dr. Aisha Liferidge Minority Women in Science Foundation (MWSF), 501c3 not-for-profit, Founder and CEO
Provides mentorship, tangible resources, networking opportunities, and career-long support to minority women with interest in science careers.
- Perform key note address speeches and talks which promote awareness and motivation at local, state, and national level
- Provided 13 scholarships to aspiring youth in 2013 totaling approximately $8,000
- Provided block grant to Sister Mentors though EduSeed funding SAT preparatory courses for 10 high school juniors in 2015 totaling approximately $7,000.
- Provided 10 academic and merit based scholarships to 10 rising college freshmen totaling approximately $25,000 in 2016.
- Renewed approximately $10,000 in academic scholarships to previous beneficiaries based on maintenance of GPA criteria in 2017.
- Annual scholarships granted.
- Regular and frequent presentations given for applicable groups.
2020 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Arvind Venkat, MD, FACEP

**Question #1: Describe your skills, background, knowledge, or unique abilities outside of ACEP that will make you an effective Board member.**

As an ACEP Board Candidate, my goal is to apply my background and skills to represent the entire membership in the mission to advocate for emergency physicians as the leaders in advancing emergency care. I have been fortunate in my 20 years of ACEP membership to serve with extraordinary leaders at the Chapter and National levels addressing multiple challenges for our specialty. I believe to be an effective Board member, it is vital one be available to our members, active in listening to their concerns, and effective in executing on the membership’s goals and desires as they serve on the front line of the healthcare system. I will bring this philosophy, background, and knowledge to my service on the Board, if elected.

Over the course of my career, I have been both a clinical researcher, with a focus on health services and health policy research, and an active ACEP member engaged in state and federal advocacy. If elected to the Board, I will serve as a bridge between two sides that do not commonly work together - those who generate and analyze data and those who use that data to advocate for our members, our patients, and the public. Advocacy without data is ideology and is likely to be ineffective against adversaries armed with superior resources. As a researcher, I have led teams that published on our most pressing advocacy priorities, including reimbursement, malpractice, patient experience assessment, and ED operations. This research included robust data from community, academic, pediatric, and freestanding EDs as well as urgent care centers. As an advocate, I have led teams that successfully overturned insurance downcoding, thwarted adverse balance billing legislation, and won acknowledgement that emergency physicians do not to need merit badges. In summary, I would bring to the ACEP Board a background and skill set of analyzing our clinical practice and applying data to advance our profession in the public space, addressing our need for effective advocacy informed by data.

Subsequent to the Covid-19 pandemic, our specialty faces a significant ethical challenge. Never before have we cared for patients while being unsure of whether we can protect ourselves, our families, our team members, and our patients. ACEP must address what this means moving forward for our members. Previously I have led the joint ethics response among ACEP, ENA, and SAEM in response to the Ebola epidemic, chaired the ACEP Ethics Committee and the same in my health system, published on the ethical challenges faced by emergency physicians, and successfully advocated for the Pennsylvania Chapter’s representation on the state’s crisis treatment standards panel. On the Board, I will bring an expertise in clinical ethics that is particularly relevant as the College considers the lessons of the Covid-19 pandemic.

**Question #2: What are the two greatest opportunities and threats to ACEP?**

ACEP and our members are at a crossroads. The Covid-19 pandemic accelerated our challenges, but also provided ACEP with a window to ensure emergency physicians and our patients have a better future, one where the emergency care system is properly resourced for all who need it.

Our greatest opportunity as a College and as emergency physicians is to capitalize on the public stature earned through the current crisis in order to advocate for a reimbursement system that recognizes our frontline public health role. This is a role we have always fulfilled, but now is the focus of public, governmental, and media admiration. We must seize this opportunity to push for direct funding of capacity and readiness at the emergency physician level. We deserve reimbursement for the expertise and preparation we deliver to our patients and our communities when crisis strikes. Having worked in reimbursement advocacy throughout my career and having witnessed how we are often placed on the defensive in debates over balance billing and insurance downcoding, our opportunity is to take our enhanced reputation from the current crisis to advocate pro-actively for reimbursement for our public health role. To prepare for the next crisis, whether it is the next wave of Covid-19, mass casualty events, or other societal ills which inevitably will present to the ED, we need all payers to compensate us for the patients we are rightly expected to be prepared to care for, not just those who seek our care. The specific ask may take the form of pushing for enhanced RVU attribution for our CPT codes to spread increased reimbursement across all payers or direct federal funding of emergency physicians and their practices, among other strategies. The opportunity to make the ask successfully will never be higher or more appropriate.
Our greatest threat as a College and as emergency physicians is that we will simply return to a reimbursement system nearly entirely based on volume of patients seen. It is unconscionable that, as we are called heroes by the public, our compensation is threatened. This results from a volume-based reimbursement system adversely driving the levels of emergency physician staffing, the role of mid-level providers in our practice, the divisions in our specialty on the scale and types of our practice organizations and their relationship with their constituent emergency physicians, and the personal well-being of our members when forced to work clinically on the thinnest of margins. We must use our enhanced stature from the current crisis to advocate successfully that emergency physicians, as the frontline against this pandemic and future public health crises, must be compensated as highly-skilled and essential public health professionals. The current reimbursement system based on volume alone divides us, leads to burnout, and jeopardizes the future of our profession and ACEP. This must change.

Question #3: Does ACEP provide enough support to its chapters? Is there more ACEP should do?
ACEP’s support of Chapters is a crucial issue as, to many of our members, the Chapters are the face of our College. Whether it is networking, continuing education, or advocacy, Chapters and their initiatives are cost-effective vehicles for these important member benefits. ACEP faces a significant financial challenge as our member totals plateau and the Covid-19 crisis puts immense financial strain on emergency physicians and their practices. We therefore must consider how enhanced Chapter support can be done smartly, not simply with enhanced financial resources.

First, ACEP can support Chapters by being as cost-effective as possible to avoid raising national dues except as a last resort. At a time of great financial strain within our profession, raising national dues would have a deleterious effect on membership with resultant downstream effects on Chapters. Second, ACEP is well-positioned from the Covid-19 pandemic to negotiate discounts benefitting Chapters in their priorities. For example, ACEP can use its scale to obtain group discounts for vendors similar to its arrangement for nationally-sponsored programming to allow Chapters to garner revenue from their conferences. This may extend to other services, such as accounting, marketing, communications, and IT services. We already have an example of this in the management of invested reserves many Chapters use. ACEP should expand the scope and scale of these opportunities. Third, ACEP will need to develop more effective plug-and-play resources to enhance Chapter advocacy efforts. Since much of health care is regulated at the state level, Chapter level grassroots advocacy is critical. While ACEP is responsive to Chapter requests for advocacy resources, those resources are not as ready-to-use as would be desired and are reactive to threats conveyed by Chapter leadership. A more pro-active approach to identify advocacy threats and opportunities with data-driven materials Chapters can use to advance our agenda is critical. Finally, as the Covid-19 crisis may limit the size and scale of future conferences, ACEP should examine working with Chapters to support regional meetings to engage with members where they are and offer continuing education in as cost-effective a manner as possible.
Contact Information
105 Breckenridge Drive, Wexford, PA 15090
Phone: 412-737-4660
E-Mail: avenkat@ahn-emp.com

Current and Past Professional Position(s)
Vice Chair for Research and Faculty Academic Affairs, Department of Emergency Medicine, Allegheny Health Network, Pittsburgh, PA
Ethics Committee Chair and Ethics Consultant, Allegheny General Hospital, Pittsburgh, PA
National Director of Research, US Acute Care Solutions, Canton, OH
Professor of Emergency Medicine, Drexel University College of Medicine, Philadelphia, PA

Education (include internships and residency information)
Emergency Medicine Residency, University of Cincinnati College of Medicine/University Hospital, Cincinnati, OH, 2000-2004
MD, Yale University School of Medicine, New Haven, CT, 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM, 2005-present

Professional Societies
ACEP, 2000-present
Pennsylvania College of Emergency Physicians, 2007-present
SAEM, 2000-present
Pennsylvania Medical Society, 2018-present
AMA, 2018-present
Allegheny County Medical Society, 2018-present

National ACEP Activities – List your most significant accomplishments
Member, ACEP Ethics Committee, 2012-present – Lead Author, Joint ACEP/ENA/SAEM Ethics Position Paper on Ebola Epidemic, 2015
Chair, ACEP Ethics Committee, 2016-2018
Councillor, Pennsylvania Chapter, ACEP Council, 2015-present
Member, Reference Committee, ACEP Council, 2017
Member, ACEP Council Steering Committee, 2018-present
Chair, Bylaws and Council Standing Rules Committee, ACEP Council Steering Committee, 2019-2020
Member, NEMPAC Board of Directors, 2019-present

ACEP Chapter Activities – List your most significant accomplishments
Pennsylvania College of Emergency Physicians Board of Directors, 2015-present
Pennsylvania College of Emergency Physicians Executive Committee, 2016-present
Pennsylvania College of Emergency Physicians President, 2019-2020

Practice Profile
Total hours devoted to emergency medicine practice per year: 1768 Total Hours/Year
Individual % breakdown the following areas of practice. Total = 100%.

- Direct Patient Care 28%
- Research 40%
- Teaching 15%
- Administration 17%
- Other: ________________ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Physician Partner, Multi-hospital Group, Attending Physician and Core Faculty Emergency Medicine Residency Program in Tertiary, Level 1 Trauma Center, and Attending Physician, Suburban Community Hospital

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Vice Chair for Research and Faculty Academic Affairs, Department of Emergency Medicine, Allegheny Health Network
Ethics Committee Chair and Ethics Consultant, Allegheny General Hospital
National Director of Research, US Acute Care Solutions

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

- Defense Expert 1 Case
- Plaintiff Expert 1 Case
CANDIDATE DISCLOSURE STATEMENT

Arvind Venkat, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Allegheny Health Network Emergency Medicine Management
   Address: 30 Isabella Street
   Pittsburgh, PA 15212
   Position Held: Vice Chair for Research and Faculty Academic Affairs, Department of Emergency Medicine, Allegheny Health Network and Ethics Consultant and Ethics Committee Chair, Allegheny General Hospital
   Type of Organization: Regional Multi-Hospital Emergency Medicine Group

   Employer: US Acute Care Solutions
   Address: 4535 Dressler Road, NW
   Canton, OH 44718
   Position Held: National Director of Research
   Type of Organization: National Emergency Physician Contract Management Group

2. Board of Directors Positions Held – *List all organizations and addresses for which you have served as a board member – including ACEP chapter Board of Directors. Include type of organization and duration of term on the board.*

   Organization: Pennsylvania College of Emergency Physicians
   Address: 415 Market Street, Suite 210
   Harrisburg, PA 17101
   Type of Organization: ACEP Chapter
   Duration on the Board: 2015-2021

   Organization: National Emergency Medicine Political Action Committee
   Address: 2121 K Street, NW, Ste 325
   Washington, DC 20037
   Type of Organization: ACEP Political Action Committee
   Duration on the Board: 2019-present
Organization: McCandless-Franklin Park Ambulance Authority

Address: 9925 Grubbs Road

Wexford, PA 15090

Type of Organization: Municipal EMS Agency

Duration on the Board: 2019-present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Less than 1% Equity Partner in US Acute Care Solutions (Not publicly traded)

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Arvind Venkat, MD, FACEP

Date May 8, 2020
Dear ACEP Councillors:

On behalf of the Pennsylvania College of Emergency Physicians (PACEP), it is my great pleasure to write this endorsement for Arvind Venkat, MD, FACEP as a candidate for the ACEP Board of Directors. Dr. Venkat has been a member of ACEP for 20 years and brings a track record of accomplishment in clinical practice, academics, national ACEP, and our Chapter that, at this time of challenge to our profession, will be of great value in advancing emergency care.

Dr. Venkat has devoted his professional life to the important realms of academics, clinical ethics, and advocacy. His scholarly activity has focused on understanding and educating emergency physicians on challenging and emerging patient populations, the ethical demands placed on emergency physicians and the wider health care community, and the operational, policy, and medico-legal issues that confront emergency medicine. Having practiced in the university, employed-physician, and larger group models, he has excelled in leading teams that have published in our highest impact journals and had multiple articles chosen as ABEM LLSA readings. Currently serving as Vice Chair of his department, National Director of Research in his large practice group, Chair of his hospital ethics committee, and Professor of Emergency Medicine, Dr. Venkat is recognized as an outstanding clinical, research, and administrative leader locally and nationally.

Within ACEP, Dr. Venkat has previously served with distinction as Chair of the ACEP Ethics Committee where he led that diverse body in advancing emergency care through policy development, scholarly activity, and review of ethics complaints. He led the joint ACEP, SAEM, and ENA position paper on ethical issues in response to the Ebola outbreak, a topic of particular resonance as we face Covid-19. Dr. Venkat is completing his term on the Council Steering Committee and recently joined the NEMPAC Board of Directors. Clearly, his track record at the national level is one of achievement in getting the best out of a wide swath of our members.

But it is in his service within PACEP that Dr. Venkat most exemplifies the skills that will be of great value should he be nominated as a candidate and elected to the ACEP Board of Directors. During his recently completed term as Chapter President, Dr. Venkat led our Chapter in bringing on our new Executive Director, achieving a reversal of our financial challenges, expanding our engagement with our younger members through a new Residents Day program, growing our membership to an all-time high, and spearheading our advocacy agenda in fighting off insurance down-coding, gaining recognition by our State Department of Health of Board Certification obviating any merit badges requirement, and blocking particularly adverse balance billing legislation. During the Covid-19 crisis, he has been a leading voice in Pennsylvania media and with the state government and Pennsylvania congressional delegation to convey accurate public health information and garner resources for emergency physicians and our patients. Dr. Venkat did this by leading broad coalitions within our Chapter and across a variety of public and organizational stakeholders.
As an academic emergency physician who sees the larger picture and successfully leads teams in advancing emergency care in ACEP, Dr. Venkat is an outstanding candidate for leadership at the national level. Our Chapter is proud to give him our highest endorsement to the Nominating Committee. Thank you for your consideration, and please do not hesitate to reach out to me (president@pacep.net) or our Executive Director (exec@pacep.net) with any questions.

Sincerely,

Shawn M. Quinn, DO, FACEP, FACOEP
President, Pennsylvania College of Emergency Physicians
My Fellow Councillors,

Emergency physicians stand at a crossroads. We are treated as heroes, but face challenges in delivering care to our patients. Like our predecessors, we will overcome this crisis and come out stronger, but we must work together starting today. My own experience and the good fortune I have gained through collaboration with many of you positions me to help fight, and win, our current battles. I am running for the ACEP Board of Directors on a three-tiered platform:

- Emergency Physicians have long stood ready to respond to whatever may walk through our doors and whatever crisis that may strike our communities. Yet, capacity and readiness are not considered by payers as value-adding components of fair reimbursement for emergency physicians. This is wrong, and I will work to correct it. I will also firmly oppose insurance company efforts to decimate our ability to provide emergency care through adverse balance billing legislation and down-coding of our professional services. I successfully led teams that have accomplished this at the state level and will bring the lessons from those victories to the Board.

- ACEP must advance the interests of all our members, regardless of practice type. ACEP membership trends are concerning, finances are challenging, and we are transitioning to a new Executive Director. I successfully led teams that addressed very similar issues at the Chapter level, including specific engagement with small, democratic groups and early career members to advance advocacy priorities, reverse a financial deficit, and on-board a new Executive Director and independent Chapter office. I believe that to enhance member value we must focus on what ACEP can do better than anyone else. This includes public advocacy for the leadership role of emergency physicians in emergency care, cost-effective continuing education that meets the unique credentialing and clinical requirements of emergency physicians, and specific programs and leadership opportunities for emergency medicine residents and early career emergency physicians so that they view ACEP membership as invaluable for the entirety of their professional careers.

- Profound ethical dilemmas face emergency physicians in our professional lives, with today’s pandemic threat extending to our own families. Emergency physicians and our teams are the nation’s front line against public health threats, yet we endure inadequate resources to treat our patients. This is unacceptable. I served as Chair of the ACEP Ethics Committee, led ACEP’s joint ethics response with ENA and SAEM to address the Ebola Epidemic, and successfully advocated for ACEP Chapter representation on the Commonwealth of Pennsylvania’s task force on crisis treatment standards. I will bring this experience to the Board as we address the significant ethical challenges that have been revealed by the current crisis.

With my passion for and dedication to our members, the specialty, and the patients we treat, I will work tirelessly on your behalf and that of our membership as an ACEP Board Member. I ask for your vote to have the opportunity to serve you and work to advance emergency care for all of our members and patients.
Leadership with Results
Arvind Venkat, MD, FACEP
ACEP Board of Directors Candidate
Proudly Endorsed by the Pennsylvania College of Emergency Physicians

Effective Advocacy
- Reversed Insurance Downcoding by Highmark Blue Cross
- Blocked Adverse Balance Billing Legislation
- Ended State-Level Merit Badges Requirement for Board Certified Emergency Physicians

Stronger Membership
- Expanded Chapter Membership to All Time High – Over 1900
- New Residents Day
- Reversed Chapter Financial Deficit
- On-boarded New Executive Director and Independent Office

Focus on Ethics
- Led Joint ACEP-ENA-SAEM Ethics Response to Ebola Epidemic
- ACEP Ethics Committee Chair
- Chapter Representation on State Crisis Treatment Standards Panel

Skilled Communicator
- Directed Pennsylvania Balance Billing Media Campaign
- 10 Years of Local, State, and National Media Appearances, including on Covid-19

“Dr. Venkat is a practicing emergency physician, researcher on emergency department operations and health policy, expert on ethical challenges in emergency care, public advocate for emergency medicine, and leader of teams that advance and achieve the goals of our members. He is an outstanding candidate for national leadership and has our highest Chapter endorsement for the ACEP Board.” – Shawn Quinn, DO, FACEP, President, Pennsylvania College of Emergency Physicians
Arvind Venkat, MD, FACEP

Home Address: 105 Breckenridge Drive
Wexford, PA 15090
Phone: 724-940-0215
Email: arvindvenkat@hotmail.com

Business Address: Department of Emergency Medicine
Allegheny General Hospital
320 East North Avenue
Pittsburgh, PA 15212
Phone: 412-359-6180
Fax: 412-359-8874
Email: avenkat@ahn-emp.com

Education

Doctor of Medicine, Yale University School of Medicine, 2000
New Haven, Connecticut
Thesis Title: Severity of Illness and Prognosis of Liver Transplant Candidates at Yale

Master of Arts, Harvard University, 1996
History of Science
Cambridge, Massachusetts
Thesis Title: A Unique Challenge: Attitudinal and Structural Impediments to a Timely, Nationally Coordinated Response to AIDS in the United States

Bachelor of Arts, Harvard College, 1996
Summa Cum Laude, History and Science
Cambridge, Massachusetts

Postgraduate Training

Residency in Emergency Medicine, Department of Emergency Medicine
University of Cincinnati College of Medicine
Cincinnati, Ohio
2000-2004
Employment History

1. Research Intern, Fogarty International Center, National Institutes of Health, Bethesda, Maryland, Summer 1997

2. Staff Physician, Department of Emergency Medicine, Fort Hamilton Hospital, Hamilton, Ohio, 2003-2004

3. Pediatric Transport Team, Department of Critical Care, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, 2003-2004

4. Clinical Staff, Department of Emergency Medicine, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, 2003-2005

5. Assistant Professor of Emergency Medicine, Department of Emergency Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, 2004-2007

6. Resident Research Director, Department of Emergency Medicine, Allegheny General Hospital, Pittsburgh, Pennsylvania, 2007-2009

7. Assistant Professor of Emergency Medicine, Drexel University College of Medicine, Philadelphia, Pennsylvania, 2007-2009

8. Ethics Consultant, Allegheny General Hospital, Pittsburgh, Pennsylvania, 2008-present

9. Director of Research, Department of Emergency Medicine, Allegheny General Hospital, Pittsburgh, Pennsylvania, February 2009-January 2013

10. Associate Professor of Emergency Medicine, Drexel University College of Medicine, Philadelphia, Pennsylvania, July 2009-January 2016

11. Associate Professor of Emergency Medicine (Adjunct), Temple University School of Medicine, Philadelphia, Pennsylvania, March 2011-January 2016

12. Vice Chair for Research and Faculty Academic Affairs, Department of Emergency Medicine, Allegheny Health Network, February 2013-present

13. Mentor and Faculty Member, US Acute Care Solutions Scholars Program, 2016-2017

14. Clinical Professor of Emergency Medicine (Adjunct), Temple University School of Medicine, Philadelphia, Pennsylvania, February 2016-June 2020

15. Professor of Emergency Medicine, Drexel University College of Medicine, Philadelphia, Pennsylvania, February 2016-present
16. Academic Officer (Research), Emergency Medical Services Institute, Allegheny Health Network, Pittsburgh, PA, March 2018-present

17. National Director of Research, US Acute Care Solutions, Canton, OH, April 2019-present

Certification and Licensure

1. Diplomate, American Board of Emergency Medicine, May 25, 2005-December 31, 2025 (Active)

2. State Medical Board of Pennsylvania – License Number MD 430815 (Active)

3. State Medical Board of Ohio – License Number 35-08-0501-V (allowed to expire due to moving from state, 10/2007)

4. Advanced Cardiac Life Support (Active)

5. Advanced Trauma Life Support (Active)

6. Pediatric Advanced Life Support (Active)

7. Credentialed to perform bedside ultrasound in the emergency department (FAST, Renal, Cardiac, Gallbladder, Pelvic, Aorta) under American College of Emergency Physicians guidelines (Active)

Honors and Awards

1. Phi Beta Kappa, Alpha-Iota Chapter, Harvard College, Cambridge, Massachusetts, June 1996

2. Society of Academic Emergency Medicine Excellence in Emergency Medicine Award, Yale University School of Medicine, New Haven, Connecticut, May 2000

3. Department of Surgery Honors for medical school thesis entitled Severity of Illness and Prognosis of Liver Transplant Candidates at Yale, Yale University School of Medicine, New Haven, Connecticut, May 2000

4. Fellow, American College of Emergency Physicians, October 2007


7. Commencement Speaker, Graduation Ceremony, Sri Venkateswara Temple, Pittsburgh, PA, June 16, 2013
Memberships and Offices in Professional Societies

1. Member, American College of Emergency Physicians, 2000-present
2. Member, Society for Academic Emergency Medicine, 2000-present
3. Member, American Academy for Emergency Medicine in India, 2007-2017
4. Member, American Society for Bioethics and the Humanities, 2008-2016
5. Member, American Academy of Emergency Medicine, 2010
6. Member, International Association for Education in Ethics, 2011-2012
7. Member, American College of Physician Executives, 2013-2014
8. Secretary, Pennsylvania College of Emergency Physicians, 2016-2017
9. Vice President, Pennsylvania College of Emergency Physicians, 2017-2018
12. Immediate Past President, Pennsylvania College of Emergency Physicians, 2020-2021

Professional Committees and Administrative Service

A. Institutional

Chair or Co-Chair

1. Chair, Allegheny General Hospital Ethics Committee, July 2008-present
2. Co-Chair, Organ Donation Advisory Council, Allegheny General Hospital, December 2008-present
3. Co-Chair, West Penn Allegheny Health System Ethics Committee, May 2012-July 2013
4. Chair, Allegheny Health Network System Ethics Committee, August 2013-April 2018
5. Chair, Research Committee, National Clinical Governance Board, US Acute Care Solutions, March 2016-March 2019
1. Member, Allegheny General Hospital Ethics Committee, January 2008-June 2008
2. Member, Allegheny General Hospital Institutional Review Board, March 2009-May 2017
3. Member, West Penn Allegheny Health System Integration Working Group on Ethics, June 2009-April 2012
4. Member, Search Committee, System Chair in Emergency Medicine, West Penn Allegheny Health System, October 2009-April 2010
5. Alternate Member, Allegheny-Singer Research Institute-West Penn Allegheny Health System Institutional Review Board, January 2010-May 2017
7. Member, Emergency Medical Services Medical Direction Committee, Allegheny Health Network, September 2014-June 2016
8. Member, Executive Committee, Department of Emergency Medicine, Allegheny General Hospital, October 2015-June 2019
9. Member, Diversity and Inclusion Council, US Acute Care Solutions, January 2016-December 2017
10. Member, Board of Directors, US Acute Care Solutions Political Action Committee, March 2016-present
11. Member, Executive Committee, US Acute Care Solutions Political Action Committee, June 2016-present
12. Member, US Acute Care Solutions Residency Oversight, Leadership and Organization Task Force, August 2016-December 2017
13. Member, Substance Abuse Committee, Allegheny General Hospital, December 2016-November 2017
15. Member, Academic Division Leadership Committee, US Acute Care Solutions, November 2018-present
16. Member, Allegheny Health Network Biobank Steering Committee, January 2020-present

B. Extramural

Local and Regional

1. Member, Education Committee, Pennsylvania Chapter of the American College of Emergency Physicians, 2008-2016

2. Program Committee Member, 2009 Scientific Assembly, Pennsylvania Chapter of the American College of Emergency Physicians, 2008-2009

3. Program Committee Member, 2013 Scientific Assembly, Pennsylvania Chapter of the American College of Emergency Physicians, 2012-2013

4. Member, Ethics and Compliance Committee, Allegheny County Emergency Medical Services Council, September 2014-April 2016

5. Member, Board of Directors, Pennsylvania College of Emergency Physicians, 2015-2021

6. Member, Executive Committee, Pennsylvania College of Emergency Physicians, 2016-2021

7. Member, Advisory Committee on Drug Treatment Services, Joint State Government Commission, General Assembly of the Commonwealth of Pennsylvania, September 2016-November 2017

8. Member, Strategic Planning Committee, McCandless-Franklin Park Ambulance Authority, February 2018-December 2018

9. Member, McCandless-Franklin Park Ambulance Authority Board, January 2019-December 2023

National and International

Reviewer and Editorial Board Member


2. Reviewer, Annals of Emergency Medicine, June 2006-present


5. Reviewer, *Journal of Emergencies, Trauma and Shock*, December 2008-present


10. Reviewer, *Vaccine*, June 2010-present

11. Editorial Board Member, *Journal of Medical Cases*, May 2011-present

12. Editorial Review Board Member, *Journal of Hospital Administration*, January 2012-present


15. Reviewer, *BMC Medical Informatics and Decision Making*, July 2012-present


17. International Editorial Review Board Member, *Clinical Nursing Studies*, October 2012-present

18. Editorial Board Member, *Journal of Nutritional Therapeutics*, October 2012-November 2013


27. Reviewer, *Emerging Infectious Diseases*, August 2015-present
28. Reviewer, *Elsevier Evidence-Based Medicine Center*, December 2015-present
31. Reviewer, *PLOS One*, October 2017-present

**Committee Member**

1. Member, Program Committee, Society for Academic Emergency Medicine Annual Meeting, 2009-2010
2. Member, Community Based Academic Physician Outreach Task Force, Society for Academic Emergency Medicine, 2012-2013
3. Member, Ethics Committee, Society for Academic Emergency Medicine, 2012-2017
4. Member, Ethics Committee, American College of Emergency Physicians, 2012-present
6. Member, Faculty Development Committee, Society for Academic Emergency Medicine, 2016-2017
7. Chair, Ethics Committee, American College of Emergency Physicians, 2016-2018
8. Member, Reference Committee – Governance and Membership, American College of Emergency Physicians Council, 2017
9. Member, Steering Committee, American College of Emergency Physicians Council, 2018-2020
   a. Member, Annual Meeting Subcommittee, 2018-2019
   b. Member, Standing Rules and Bylaws Subcommittee, 2018-2019
   c. Chair, Standing Rules and Bylaws Subcommittee, 2019-2020

10. Member, Board of Directors, National Emergency Medicine Political Action Committee, October 2019-present

Educational Activities

Advising/Mentoring

Scholarly Activity Projects Mentored listed by advisee(s) and projects mentored

1. Aaron W. Bernard, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2007

2. Kristiana R. Kaufmann, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2007
3. Jason McMullan, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, and Matthew Valento, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2007


4. Samuel Luber, Resident Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2005


5. Nathan White, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine and Benjamin Bassin, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2007


6. Jordan Bonomo, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine and Andrew Butler, Resident, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mentored 2004-2007

7. Robert Cooney, Resident, Department of Emergency Medicine, Allegheny General Hospital, Adarsh Srivastava, Resident, Departments of Emergency Medicine and Medicine, Allegheny General Hospital, Gregory Suares, Resident, Department of Emergency Medicine, Allegheny General Hospital and Cory Heidelberger, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2007-2008


8. Michael Marynowski, Resident and Attending Physician, Departments of Emergency Medicine and Medicine, Allegheny General Hospital, Mentored 2007-2012

b. ProCESS: Protocolized Care in Early Septic Shock, NIH P50-GM076659, April 1, 2011-May 31, 2012 (Mentored Co-Site Principal Investigator)
c. ProCESS: Protocolized Care in Early Septic Shock, ARRA Supplement, NIH 3P50GM076659-04S1, May 1, 2011-May 31, 2012 (Mentored Co-Site Prinicipal Investigator)
d. ProGReSS AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury, NIH R01DK083961, November 1, 2011-May 31, 2012 (Mentored Co-Site Principal Investigator)

9. Brian Shippert, Resident, Department of Emergency Medicine, Allegheny General Hospital and Douglas Hanneman, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2007-2008

10. Jennifer Yeck, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2008-2009

Arvind Venkat, Jennifer Yeck, “The Value of Laboratory Testing in the Trauma Patient”, Trauma Reports, Volume 10, Number 1, January/February 2009, 1-12

11. John M. Shea, Resident, Department of Emergency Medicine, Allegheny General Hospital, and Jeffrey T. Cook, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2008-2009


12. Omar Hammad, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2012-2013

e. Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke (POINT) Trial, University of California San Francisco/Neurological Emergencies Treatment Trials Network, NCT00991029, March 1, 2012-October 31, 2013 (Mentored Site Co-Investigator)
f. Stroke Hyperglycemia Insulin Network Effort (SHINE) Trial, NIH U01NS069498, April 1, 2012-May 2, 2013 (Mentored Site Co-Investigator)
g. Insights on Selected Procoagulation markers and Outcomes in stroke Trial (I-SPOT), NIH 1R01NS079077-01A1, September 27, 2012-May 2, 2013 (Mentored Site Co-Investigator)

13. Nathan Hemmer, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2010

Nathan Hemmer, Arvind Venkat, “Hyperkalemia and Atrial Pacemakers: What can the ECG tell you?”, Canadian Journal of Emergency Medicine, Volume 13, Number 6, November 2011, 409-410

14. Sunanda Nanduri, Resident, Department of Neurology, Allegheny General Hospital, Co-Mentored with Ashis Tayal, 2010-2011


b. Sunanda Nanduri, Gajanan G. Hegde, Arvind Venkat, Sandy Daley, Jack Protetch, Melissa Tian, Ashish Tayal, "Oral Anticoagulant Use and Decreasing Hematocrit are Significantly Associated with Discrepant ED Point-of-Care INR Results in Patients with Acute Cerebrovascular Disease," Resident Research Symposium, Allegheny General Hospital, May 19, 2011, Pittsburgh, PA (oral presentation)


15. Julianna Becker, Law Student, University of Pittsburgh School of Law, Mentored 2011

a. Arvind Venkat, Julianna Becker, The Effect of Statutory Limitations on the Authority of Substitute Decision Makers on the Care of Patients in the Intensive Care Unit: Case Examples and Review of State Laws Affecting Withdrawing or Withholding Life-Sustaining Treatment, Health Law, Regulations and Transactions, Duquesne University School of Law, April 24, 2012, Pittsburgh, PA

b. Arvind Venkat, Julianna Becker, “The Effect of Statutory Limitations on the Authority of Substitute Decision Makers on the Care of Patients in the Intensive Care Unit: Case Examples and Review of State Laws Affecting Withdrawing or Withholding Life-Sustaining Treatment,” International Conference on Education in Ethics, May 2, 2012, Pittsburgh, PA (oral presentation)

16. Candace Roman Crist, Resident, Department of Emergency Medicine, Allegheny General Hospital, and Robert Farrell, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2011-2012


17. John O’Neill, Attending Physician and Associate Program Director, Combined Emergency Medicine/Internal Medicine Residency Program, Allegheny General Hospital, Mentored 2012-2020

b. ProCESS: Protocolized Care in Early Septic Shock, NIH P50-GM076659, April 1, 2011-June 30, 2013 (Mentored Site Co-Investigator starting April 1, 2012)
c. ProCESS: Protocolized Care in Early Septic Shock, ARRA Supplement, NIH 3P50GM076659-04S1, May 1, 2011-August 31, 2013 (Mentored Site Co-Investigator starting April 1, 2012)
d. ProGReSS AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury and Consequences: Late Cardiovascular Consequences of Septic Shock, NIH R01DK083961 and 1R01GM097471-01A1, November 1, 2011-May 31, 2017 (Mentored Site Co-Investigator starting April 1, 2012)
e. Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke (POINT) Trial, University of California San Francisco/Neurological Emergencies Treatment Trials Network, NCT00991029, March 1, 2012-February 10, 2014 (Site Co-Investigator)
f. Stroke Hyperglycemia Insulin Network Effort (SHINE) Trial, NIH U01NS069498, April 1, 2012-May 2, 2013 (Mentored Site Co-Investigator)
g. Insights on Selected Procoagulation markers and Outcomes in stroke Trial (I-SPOT), NIH 1R01NS079077-01A1, September 27, 2012-May 2, 2013 (Site Co-Investigator)
h. Biomarkers of Acute Stroke Etiology (BASE), NCT02014896, August 20, 2014-January 31, 2020 (Mentored Site Principal Investigator)
i. Validation of Point-of-Care TBI Detection System for Head Injured Patients (B-AHEAD III Trial), Brainscope Company, Inc., December 9, 2014-January 1, 2016 (Mentored Site Principal Investigator starting April 1, 2015)

18. Chadd Nesbit, Resident and Attending Physician, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2007-2008 and 2012-2015

a. Arvind Venkat, Brian Shippert, Douglas Hanneman, Chadd Nesbit, David Piontkowsky, Sunil Bhat, Morgen Kelly, An Analysis of Emergency Department Utilization by HIV-Positive Adults in the Era of Highly Active Anti-Retroviral Therapy (HAART), Resident Research Symposium, Allegheny General Hospital, May 21, 2008, Pittsburgh, PA (oral presentation)
b. Arvind Venkat, Brian Shippert, Douglas Hanneman, Chadd Nesbit, David Piontkowsky, Sunil Bhat, Morgen Kelly, An Analysis of Emergency Department Utilization by HIV-Positive Adults in the Era of Highly Active Anti-Retroviral Therapy (HAART), Society for Academic Emergency Medicine, May 29-June 1, 2008, Washington, DC (poster)
d. ProGReSS AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury and Consequences: Late Cardiovascular Consequences of Septic Shock, NIH R01DK083961 and 1R01GM097471-01A1, November 1, 2011-April 1, 2015 (Mentored Site Co-Investigator starting April 1, 2012)
e. Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke (POINT) Trial, University of California San Francisco/Neurological Emergencies Treatment Trials Network, NCT00991029, March 1, 2012-February 10, 2014 (Mentored Site Co-Investigator)
f. Stroke Hyperglycemia Insulin Network Effort (SHINE) Trial, NIH U01NS069498, April 1, 2012-May 2, 2013 (Mentored Site Co-Investigator)
g. Insights on Selected Procoagulation markers and Outcomes in stroke Trial (I-SPOT), NIH 1R01NS079077-01A1, September 27, 2012-May 2, 2013 (Mentored Site Co-Investigator)
h. Validation of Point-of-Care TBI Detection System for Head Injured Patients (B-AHEAD III Trial), Brainscope Company, Inc., December 9, 2014-April 1, 2015 (Mentored Site Principal Investigator)
i. Use of a Point-of-Care TBI Detection System for Identification of Head Injured Patients Who Present to the Emergency Department, Brainscope Company, Inc., December 15, 2014-April 1, 2015 (Mentored Site Principal Investigator)
19. Meghan E. Groth, Pharmacy Resident, Department of Pharmacy, Allegheny General Hospital, Co-Mentored with Noreen H. Chan-Tompkins, 2011-2012


20. Victoria Huckestein, Undergraduate Student, University of Pittsburgh, Mentored Summer 2012

a. Research Intern, Department of Emergency Medicine and Allegheny Singer-Research Institute, Allegheny General Hospital, Summer 2012, Pittsburgh, PA

21. Jordan Ibarra, Undergraduate Student, Yale College, Mentored Summer 2012 and Summer 2013

a. Research Intern, Department of Emergency Medicine and Allegheny Singer-Research Institute, Allegheny General Hospital, Summer 2012 Pittsburgh, PA
c. Allergy, Asthma and Autoimmune Institute Summer Research Internship, West Penn Allegheny Health System, Summer 2013, Pittsburgh, PA
22. Kimberly Miller, Pharmacy Resident, Department of Pharmacy, Allegheny General Hospital, and Alyssa Tomsey, DO, Resident, Department of Emergency Medicine, Allegheny General Hospital, Co-Mentored with Molly McGraw, 2012-2013


23. Joseph Montibeller, MD, Resident, Department of Emergency Medicine, Allegheny General Hospital, and Hannah Todorowski, Undergraduate Student, John Carroll University, Mentored Summer 2013

a. Adult Emergency Department Patients with Acute Asthma and Survey of Local Asthma Centers: 36th Multicenter Airway Research Collaboration (MARC-36) Study, Massachusetts General Hospital and Novartis Pharmaceuticals, July 8, 2013-December 8, 2013 (Mentored Site Co-Investigators)
b. Allergy, Asthma and Autoimmune Institute Summer Research Internship, West Penn Allegheny Health System, Summer 2013, Pittsburgh, PA (Todorowski)

24. Michael Rubin, MD, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored September 2013-June 2016

ProGRess AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury and Consequences: Late Cardiovascular Consequences of Septic Shock, NIH R01DK083961 and 1R01GM097471-01A1, September 11, 2013-June 30, 2016 (Mentored Site Co-Investigator)


26. Tamara Slain, Nurse Educator, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2013-2016

c. Emergency Department Project Coordinator, Pennsylvania Screening, Brief Intervention and Referral to Treatment (SBIRT) Interdisciplinary Training Program, Substance Abuse and Mental Health Services Administration 1U79TI025406-01, September 1, 2013-January 31, 2016
27. Christopher Jenrette, MD, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored, 2013


28. Uchenna Onyekwere, Medical Student, Temple University School of Medicine, Mentored October 2013-June 2014

a. ProGReSS AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury and ConsequenceS: Late Cardiovascular Consequences of Septic Shock, NIH R01DK083961 and 1R01GM097471-01A1, October 1, 2013-June 30, 2014 (Mentored Site Co-Investigator)

29. Mitchell Kosanovich, Attending Physician, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2013-2014

Erica Hardy, Mitchell Kosanovich, Arvind Venkat, “Infectious Disease,” Sex and Gender in Acute Care Medicine, eds: Alyson J. McGregor, Esther K. Choo and Bruce M. Becker, Cambridge University Press, Cambridge, United Kingdom, 2016, 147-162
30. Brooke Paha, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2013-2014

RM08-3002 - A Phase III Randomized Double-Blind Placebo Controlled Trial to Evaluate the Efficacy and Safety of Nitazoxanide and Nitazoxanide plus Oseltamivir in the Treatment of Acute Uncomplicated Influenza, The Romark Institute for Medical Research, NCT01610245, July 14, 2013-July 23, 2014 (Mentored Site Co-Investigator)

31. Jonathan Drori, Resident, Department of Medicine, Allegheny General Hospital, Mentored 2014


32. Diwura Owolabi, Pharmacy Resident, Department of Pharmacy, Allegheny Health Network and Richard Rowland, Resident, Department of Emergency Medicine, Allegheny General Hospital, Co-Mentored with Molly McGraw and Lauren King, 2014-2015


a. Doctoral Committee Member, September 2014-2015 – Dissertation Title: Fine Particulate Matter Ambient Air Pollution and Cardiovascular Disease


34. Brian S. Marcus, Medical Student, Yale University School of Medicine, New Haven, CT, 2013-2014


35. David Kim, Resident, Department of Medicine, Allegheny General Hospital, Mentored 2014

36. Ryan O’Connor, Fellow, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, Ali Kazemi, Fellow, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital and Michael Asaly, Resident, Department of Emergency Medicine, Allegheny General Hospital, Co-Mentored with Elie Aoun, Attending Physician, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, 2013-2015


37. Steven Perry, MD, JD, Resident, Department of Emergency Medicine, Allegheny General Hospital, Mentored 2015


38. Charles Feronti, DO, Attending Physician, Department of Emergency Medicine, Allegheny Health Network, Mentored 2015-2020

b. *Validation of Point-of-Care TBI Detection System for Head Injured Patients (B-AHEAD III Trial)*, Brainscope Company, Inc., December 9, 2014-January 1, 2016 (Mentored Site Co-Investigator starting April 1, 2015)
g. *A Prospective Evaluation of UCH-L1 and GFAP Biomarker Kinetics after Mild Brain Injury Trauma (VIGILANT)*, Banyan Biomarkers, Inc., NCT02541123, November 13, 2015-January 31, 2017 (Mentored Site Principal Investigator)
h. Retrospective Study of Treatment Patterns and Outcomes for Patients Receiving Factor Xa Inhibition Who Required Urgent Reversal of Anticoagulation in the Setting of Serious/Life-Threatening Bleeding Or Urgent/Emergency Surgery in the United States, Portola Pharmaceuticals, Protocol Number 15-507, December 22, 2015-October 1, 2016 (Mentored Site Principal Investigator)

i. Multicenter Trial of Rivaroxaban for Early Discharge of Pulmonary Embolism from the Emergency Department (MERCURY PE), Janssen Research and Development, LLC, NCT02584660, February 2016-May 2017 (Mentored Site Principal Investigator)

39. Lara Kratochwill, Pharmacy Resident, Department of Pharmacy, Allegheny Health Network and Margaret Powers, Resident, Departments of Emergency Medicine and Internal Medicine, Allegheny General Hospital, Co-Mentored with Molly McGraw and Lauren King, 2014-2015


40. Julia E. Karoski, Pharmacy Resident, Department of Pharmacy, Allegheny Health Network and Crystal Hammer, Resident, Departments of Emergency Medicine and Internal Medicine, Allegheny General Hospital, Co-Mentored with Molly McGraw and Lauren King, 2014-2016

41. Krista M. Foster, PhD Candidate in Operations Management, Katz Graduate School of Business, University of Pittsburgh, Co-Mentored with Jennifer Shang, Sunder Kekre, and Gajanan G. Hegde, 2015-present


c. Doctoral Committee Member, Katz Graduate School of Business, University of Pittsburgh, Pittsburgh, PA, 2018-2019


42. Alexander Zoretich, MD, Resident, Department of Emergency Medicine, Allegheny General Hospital, 2019


Clinical Activities

*A. Major Clinical Activities*

1. Staff Physician, Departments of Emergency Medicine, University Hospital and Jewish Hospital, Cincinnati, Ohio, 2004-2007

2. Staff Physician, Department of Emergency Medicine, Allegheny General Hospital, Pittsburgh, Pennsylvania, 2007-present

3. Ethics Consultant, Allegheny General Hospital, Pittsburgh, Pennsylvania, 2008-present

*B. Health Care Education of the Lay Community*


3. Arvind Venkat, "Advanced Directives and Medical Ethics," *Saturday Night Special with Rick Bergman*, KDKA 1020AM, 10-11pm, January 8, 2011, Pittsburgh, PA (Radio Show)


9. Closure Speakers’ Bureau Member, Jewish Healthcare Foundation, August 2012, Pittsburgh, PA

10. Arvind Venkat, “Cardiopulmonary Resuscitation and Medical Ethics,” *Mike Pintek Show*, KDKA 1020AM, 12-1230pm, March 5, 2013, Pittsburgh, PA (Radio Show)


16. Robert Arnold, Eli Seidman, Arvind Venkat, Nancy Zionts (moderator), Post-Film Panel on End-of-Life Decision Making, JFilm Festival, April 19, 2015, Pittsburgh, PA

18. Arvind Venkat, “Medicare Reimbursement for End-of-Life Care Counseling by Physicians,” KDKA 1020AM, 6-615pm, July 9, 2015, Pittsburgh, PA (Radio Show)


40. State Senator Lindsey Williams, **Arvind Venkat**, *Telephone Town Hall on Covid-19*, 38th Senatorial District, Commonwealth of Pennsylvania, 700-830pm, March 17, 2020


Grant Support and Other Funded Activities (Individual Amount Attributable/Total Direct Funding)

1. Site Principal Investigator, ProCESS: Protocolized Care in Early Septic Shock, NIH P50-GM076659, April 1, 2011-June 30, 2013 - $20,896/$20,896

2. Site Principal Investigator, ProCESS: Protocolized Care in Early Septic Shock, ARRA Supplement, NIH 3P50GM076659-04S1, May 1, 2011-August 31, 2012 - $8,700/$8,700


4. Site Principal Investigator, ProGReSS AKI: Protocolized Goal-directed Resuscitation of Septic Shock to Prevent Acute Kidney Injury and Consequences: Late Cardiovascular Consequences of Septic Shock, NIH R01DK083961 and 1R01GM097471-01A1, November 1, 2011-May 31, 2017 - $16,250/$16,250

5. Site Co-Investigator (Mentorship of Site Principal Investigator Omar Hammad, MD), Evaluation of Ecallantide for the Acute Treatment of Angiotensin Converting Enzyme Inhibitor Induced Angioedema: Phase II, Dyax Corporation, NCT01343823, January 1, 2012-June 15, 2012 - $17,913/$17,913

6. Site Co-Investigator, Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke (POINT) Trial, University of California San Francisco/Neurological Emergencies Treatment Trials Network, NCT00991029, March 1, 2012-February 10, 2014

7. Site Co-Investigator, Stroke Hyperglycemia Insulin Network Effort (SHINE) Trial, NIH U01NS069498, April 1, 2012-May 2, 2013

8. Site Principal Investigator, Pittsburgh Aerosol Research and Inhalational Epidemiology Study (PARIES), Electric Power Research Institute, EP-P29581/C13936, April 3, 2012-March 1, 2013 -$10,774/$10,774


10. Site Co-Investigator, A Sample Collection Study to Validate the Astute Medical NephroCheck™ Test in Critically Ill Subjects at Risk for Acute Kidney Injury, Astute Medical, Inc., NCT01573962, April 23, 2012-October 1, 2012

11. Co-Investigator and Site Principal Investigator (Emergency Medicine), PHILA-NETT – Neurological Emergency Treatment Trials Network, NIH 5U10NS059039-06, June 1, 2012-June 30, 2017


17. Principal Investigator, *Outdoor Air Pollution, Airway Inflammation and Acute Exacerbations of Asthma*, Breathe Pennsylvania, July 1, 2013-July 1, 2014 - $10,000/$10,000


19. Site Principal Investigator, RM08-3002 - *A Phase III Randomized Double-Blind Placebo Controlled Trial to Evaluate the Efficacy and Safety of Nitazoxanide and Nitazoxanide plus Oseltamivir in the Treatment of Acute Uncomplicated Influenza*, The Romark Institute for Medical Research, NCT01610245, July 14, 2013-April 1, 2014 - $7,400/$7,400


22. Site Principal Investigator, *Pittsburgh Aerosol Research and Inhalation Epidemiology Study (PARIES) Update*, Allegheny County Health Department, Subaward No. 9010266 (601204-1), April 1, 2014-March 31, 2015 - $9,994/$9,994

23. Site Principal Investigator, *ConsequenceS: Late Cardiovascular Consequences of Septic Shock*, NIH 3RO1GM097471-03S1, June 1, 2014-May 31, 2017 - $8,400/$8,400


25. Co-Investigator, *Retrospective Analysis of the Association Between Outdoor Air Pollution and Acute Exacerbations of Cardiac and Respiratory Diseases in Pittsburgh*, Heinz Endowments, Grant Reference #: E2157, July 1, 2014-June 30, 2015, $24,088/$45,000


27. Principal Investigator, *Coordinating Care for Individuals with Substance Use Disorders: Social Worker Screening, Brief Intervention and Referral to Treatment Training and Implementation in the Emergency Department and Inpatient Settings*, Pennsylvania Department of Human Services and Allegheny County Health Choices, Inc., July 30, 2014-August 1, 2016 - $100,000/$100,000


29. Site Co-Investigator (Mentorship of Site Principal Investigator John O’Neill, MD), *Biomarkers of Acute Stroke Etiology (BASE)*, Ischemia Care, LLC, NCT02014896, August 20, 2014-January 31, 2020, $67,668/$67,668

30. Site Co-Investigator (Mentorship of Site Principal Investigator Chadd Nesbit, MD/John O’Neill, MD), *Validation of Point-of-Care TBI Detection System for Head Injured Patients (B-AHEAD III Trial)*,Brainscope Company, Inc., December 9, 2014-January 1, 2016, $37,545/$37,545


33. Site Principal Investigator, *Continuous Chest Compressions*, Resuscitation Outcomes Consortium, April 1, 2015-June 30, 2015, $6,876/$6,876

34. Site Principal Investigator, *Registry*, Resuscitation Outcomes Consortium, April 1, 2015-June 30, 2015, $2,053/$2,053

35. Site Principal Investigator, *Amiodarone (PM101), Lidocaine or Neither for Out-of-Hospital Cardiac Arrest Due to Ventricular Fibrillation or Tachycardia (ALPS: Amiodarone, Lidocaine or Placebo Study)*, Resuscitation Outcomes Consortium, April 1, 2015-December 10, 2015, $6,876/$6,876


37. Site Co-Investigator (Mentorship of Site Principal Investigator Charles Feronti, DO), *Retrospective Study of Treatment Patterns and Outcomes for Patients Receiving Factor Xa Inhibition Who Required Urgent Reversal of Anticoagulation in the Setting of Serious/Life-Threatening Bleeding Or Urgent/Emergency Surgery in the United States*, Portola Pharmaceuticals, Protocol Number 15-507, December 22, 2015-October 1, 2016, $16,000/$16,000


39. Site Co-Investigator (Mentorship of Site Principal Investigator Charles Feronti, DO), *Multicenter Trial of Rivaroxaban for Early Discharge of Pulmonary Embolism from the Emergency Department (MERCURY PE)*, Janssen Research and Development, LLC, NCT02584660, February 2016-May 2017, $20,517.50/$20,517.50

41. Site Co-Investigator (Site Principal Investigator John O’Neill, MD), *Use of Eye Movement Tracking to Detect Oculomotor Abnormality in Traumatic Brain Injury Patient (DETECT)*, Oculogica, Inc., NCT02776462, December 1, 2016-November 30, 2017, $32,500

42. Site Co-Investigator (Site Principal Investigator John O’Neill, MD), *A Phase III, Multi-Center, Double Blind, Randomized, Active Controlled Clinical Trial to Evaluate the Non-Inferiority Comparing Cetirizine Injection 10 mg to Diphenhydramine Injection, 50 mg, for the Treatment of Acute Urticaria*, JDP Therapeutics, Inc., NCT02935699, December 14, 2016-April 12, 2018, $26,310

43. Site Co-Investigator (Site Principal Investigator John O’Neill, MD), *A Randomized Double-Blind, Placebo-Controlled Dose Ranging Study Evaluating the Safety, Pharmacokinetics and Clinical Benefit of FLU-IGIV in Hospitalized Patients with Serious Influenza A Infection*, Emergent BioSolutions, Inc., NCT03315104, December 14, 2017-October 15, 2019, $30,200

44. Site Principal Investigator, *Primary Palliative Care for Emergency Medicine*, NIH/National Center for Complementary & Integrative Care 1 UG3 AT009844, June 19, 2018-present, $49,024/$49,024

45. Site Co-Investigator (Site Principal Investigator Charles Feronti, DO), *Emergency Department Gathering and AlphaStroke Refinement (EDGAR)*, Forest Devices, Inc., September 25, 2018-present, $28,905

46. Site Principal Investigator, *Using Short Stay Units (SSU) Instead of Routine Admission to Improve Patient Centered Health Outcomes for Acute Heart Failure (AHF) Patients*, Agency for Healthcare Research and Quality, 5R01HS025411-02, September 26, 2018-present, $4,970/$4,970

47. Site Principal Investigator, *The ACCESS Trial: ACCESS to The Cardiac Catheterization Laboratory in Patients Without ST-Elevation Myocardial Infarction Resuscitated from Out-of-Hospital Ventricular Fibrillation Cardiac Arrest*, NIH/NHLBI, 5U01HL133818-03, February 22, 2019-November 30, 2019, $5,000


49. Principal Investigator, *Innovation Participation Grant*, Pennsylvania Medical Society, 201900228, October 1, 2019-September 30, 2020, $80,000/$80,000
Publications

Published Full Length Papers (*Peer Reviewed)


*18. Arvind Venkat, “Surrogate Medical Decision Making on Behalf of the Never Competent, Profoundly Intellectually Disabled Patient Who Is Acutely Ill,” Journal of Clinical Ethics, Volume 23, Number 1, Spring 2012, 71-78


24. The ProCESS/ARISE/ProMISe Methodology Writing Committee on behalf of the ProCESS Investigators, the ARISE Investigators for the ANZICS Clinical Trials Group and the ProMISe Investigators, “Harmonizing International Trials of Early Goal-Directed Resuscitation for Severe Sepsis and Septic Shock: Methodology of ProCESS, ARISE and ProMISe,” Intensive Care Medicine, Volume 39, Number 10, October 2013, 1760-1775


27. Arvind Venkat, Julianna Becker, "The Effect of Statutory Limitations on the Authority of Substitute Decision Makers on the Care of Patients in the Intensive Care Unit: Case Examples and Review of State Laws Affecting Withdrawing or Withholding Life-Sustaining Treatment," Journal of Intensive Care Medicine, Volume 29, Number 2, March-April 2014, 71-80


*42. Brian S. Marcus, Jestin N. Carlson, Gajanan G. Hegde, Jennifer Shang, Arvind Venkat, “Comparison of Viewpoints of Health Care Professionals With or Without Involvement with Formal Ethics Processes on the Role of Ethics Committees and Hospitals in the Resolution of Clinical Ethical Dilemmas,” *Clinical Ethics*, Volume 10, Number 1-2, March-June 2015, 22-33


40


*61. Joel M. Geiderman, Kenneth V. Iserson, Catherine A. Marco, John E. Jesus, Arvind Venkat, “Conflicts of Interest in Emergency Medicine,” Academic Emergency Medicine, Volume 24, Number 12, December 2017, 1517-1526


*Other Communications (*Peer Reviewed)*


*11. Arvind Venkat, “Universal Factors Affecting Emergency Department Crowding” Archives of Trauma Research, Volume 1, Number 4, Winter 2013, 187


38. Arvind Venkat, “Executive Privilege,” PACEP News, Summer 2019, 1, 3


42. Arvind Venkat, “Executive Privilege,” PACEP News, Winter 2020, 1, 3

Book Chapters


2. KK Venkat, Arvind Venkat, "The End-Stage Renal Disease Patient on Dialysis," Challenging and Emerging Conditions in Emergency Medicine, ed: Arvind Venkat, Wiley-Blackwell Publishing, West Sussex, United Kingdom, 2011, pages 74-95


Textbook Edited


Published Abstracts (*Peer Reviewed)


*15. Neal Handly, Jiexun Li, David A. Thompson, Arvind Venkat, David M. Chuirazzi, "Derivation of Hospital Admission Prediction Models Based on Coded Chief Complaint, Demographic, Patient Acuity and Emergency Department (ED) Operational Data Available at ED Triage," Society for Academic Emergency Medicine Annual Meeting, June 4, 2011, Boston, MA (lightning oral presentation)


*18. Neal Handly, Arvind Venkat, Jiexun Li, David A Thompson, David M. Chuirazzi, "Failure to Validate Hospital Admission Prediction Models Adding Coded Chief Complaint to Demographic, Emergency Department Operational and Patient Acuity Data Available at ED Triage," Society for Academic Emergency Medicine Annual Meeting, May 9, 2012, Chicago, IL (lightning oral presentation)


*25. Janice Pringle, Tamara Slain, Arvind Venkat, Sherry Rickard-Aasen, “This is an emergency, preparing for a safe landing: Lessons from an overdose prevention project located in an emergency department,” American Public Health Association 141st Annual Meeting and Expo, November 4, 2013, Boston, MA (poster presentation)


*32. Arvind Venkat, Sherry Rickard-Aasen, Gary Shank, Janice Pringle, “A Qualitative Analysis of the Incorporation of Screening, Brief Intervention and Referral to Treatment (SBIRT) into the Normal Workflow of the Emergency Department for Patients with At-Risk Behavior Related to Drug and Alcohol Abuse,” Society for Academic Emergency Medicine Annual Meeting, May 16, 2014, Dallas, TX (poster presentation)


*43. Nicole Pleskovic, Arvind Venkat, Albert Presto, Gajanan G. Hegde, Jennifer Shang, Sunder Kekre, Paige E. Dewhirst, Deborah A. Gentile, “Association Between Outdoor Air Pollution and Acute Exacerbations of Respiratory Disease in Pittsburgh,” American Academy of Allergy, Asthma and Immunology Annual Meeting, March 5, 2016, Los Angeles, CA (poster presentation)


*46. Jeffrey Caterino, Steven Bernstein, Cielito Reyes-Gibby, Maria Guyette, Arvind Venkat, Aveh Bastani, Christopher Baugh, Christopher Coyne, Adam Klotz, David Adler, Troy Madsen, Jason Wilson, Daniel Henning, Tammie Quest, Nathan Shapiro, Corita Grudzen, “Presentation and Treatment of Patients with Acute Cancer Presenting to the Emergency Departments of the Comprehensive ONCologic Emergencies Research Network (CONCERN-1),” Society for Academic Emergency Medicine Annual Meeting, May 19, 2017, Orlando, FL (lightning oral presentation)


*48. Rahul Ladhania, Amelia M. Haviland, Jesse M. Pines, Rahul Telang, Arvind Venkat, “Impact of Acquiring Medicaid Coverage Under the Affordable Care Act on Emergency Department Utilization by Previously Uninsured Adults,” World Congress of the International Health Economics Association, July 8-11, 2017, Boston, MA (oral presentation)


*57. Adam Christensen, Jestin Carlson, Mark Zocchi, Karla Marsh, Chloe McCoy, Jesse Pines, Rebecca Kornas, Arvind Venkat, “Procedural Experience with Intubation: Results from a National Emergency Medicine Group,” American College of Emergency Physicians Scientific Assembly, November 3, 2019, Austin, TX (oral presentation)


Presentations

Local

A. Intra-institutional


2. Arvind Venkat, An Overview of Ethics for the Practicing Neurologist, ACGME Lecture, Department of Neurology, Allegheny General Hospital, September 19, 2008, Pittsburgh, PA

3. Arvind Venkat, An Overview of Ethics for the Practicing Intensivist, ACGME Lecture, Division of Pulmonary/Critical Care, Department of Medicine, Allegheny General Hospital, October 16, 2008, Pittsburgh, PA

4. Arvind Venkat, An Overview of Ethics for the Practicing Nephrologist, ACGME Lecture, Division of Nephrology, Department of Medicine, Allegheny General Hospital, October 30, 2008, Pittsburgh, PA

5. Arvind Venkat, An Overview of Ethics for the Practicing Obstetrician/Gynecologist, ACGME Lecture, Department of Obstetrics and Gynecology, Allegheny General Hospital, October 31, 2008, Pittsburgh, PA
6. Arvind Venkat, *An Overview of Ethics for the Practicing Traumatologist*, ACGME Lecture, Trauma Conference, Division of Trauma Surgery, Department of Surgery, Allegheny General Hospital, November 17, 2008, Pittsburgh, PA


8. Arvind Venkat, *An Overview of Ethics for the Practicing Internist*, Medical Grand Rounds, Department of Medicine, Allegheny General Hospital, March 4, 2009, Pittsburgh, PA

9. Arvind Venkat, *An Overview of Ethics for the Practicing Gastroenterologist*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, March 12, 2009, Pittsburgh, PA


11. Arvind Venkat, *An Overview of Ethics for the Trauma Nurse*, Trauma Nursing Education Day, Allegheny General Hospital, July 9 and 29, 2009, Pittsburgh, PA

12. Arvind Venkat, *An Overview of Ethics for the Medical Student*, Medical Ethics Lecture for Rotating Fourth-Year Drexel University College of Medicine Students at Allegheny General Hospital, Department of Medicine, 2009-2011

13. Arvind Venkat, *Update on Ethics for the Practicing Nephrologist*, ACGME Lecture, Division of Nephrology, Department of Medicine, Allegheny General Hospital, October 1, 2009, Pittsburgh, PA


17. Arvind Venkat, *Update on Ethics for the Practicing Gastroenterologist*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, May 7, 2010, Pittsburgh, PA
18. Arvind Venkat, *Update on Ethics for the Practicing Neurosurgeon*, ACGME Lecture, Department of Neurosurgery, Allegheny General Hospital, September 15, 2010, Pittsburgh, PA

19. Arvind Venkat, *Clinical Ethics for the Practicing Gastroenterologist*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, January 3, 2011, Pittsburgh, PA

20. Arvind Venkat, *Dealing with Stress in Medical Practice*, Lecture for rotating third-year medical students from the Temple University School of Medicine, Allegheny General Hospital, May 13, 2011, Pittsburgh, PA (recurrent annually)

21. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Department of Medicine, Allegheny General Hospital, August 26, 2011, Pittsburgh, PA

22. Arvind Venkat, *Ethical Dilemmas in Gastroenterology*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, September 15, 2011, Pittsburgh, PA

23. Arvind Venkat, *Ethical Dilemmas in Nephrology*, ACGME Lecture, Division of Nephrology, Department of Medicine, Allegheny General Hospital, September 15, 2011, Pittsburgh, PA


25. Arvind Venkat, *Ethical Dilemmas in Neurology*, ACGME Lecture, Department of Neurology, Allegheny General Hospital, February 17, 2012, Pittsburgh, PA

26. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, July 27, 2012, Pittsburgh, PA


28. Arvind Venkat, *Ethics and Gastroenterology*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, September 13, 2012, Pittsburgh, PA

30. Arvind Venkat, *Clinical Ethics*, ACGME Lecture, Department of Medicine, Allegheny General Hospital, November 6, 2012, Pittsburgh, PA

31. Arvind Venkat, *An Overview of Ethics for the Practicing Physician*, 4th Year Medical Student Capstone Course, Temple University School of Medicine Clinical Campus – Allegheny General Hospital, May 1, 2013, Pittsburgh, PA (recurrent annually)


33. Arvind Venkat, *Ethics and Neurosurgery*, ACGME Lecture, Department of Neurosurgery, Allegheny General Hospital, July 30 and August 13, 2013, Pittsburgh, PA

34. Arvind Venkat, *Ethics and Palliative Care*, Palliative Care Module, Internal Medicine Residency Program, Department of Medicine, Allegheny General Hospital, August 5, 2013-June 30, 2016 (curriculum series)

35. Arvind Venkat, *Clinical Ethics for the Practicing Gastroenterologist*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, August 13, 2013

36. Arvind Venkat, *Clinical Ethics for the Practicing Nephrologist*, ACGME Lecture, Division of Nephrology, Department of Medicine, Allegheny General Hospital, September 26, 2013

37. Arvind Venkat, *Clinical Ethics for the Practicing Hand Surgeon*, ACGME Lecture, Division of Hand Surgery, Department of Orthopedic Surgery, Allegheny General Hospital, October 9, 2013

38. Arvind Venkat, *An Overview of Clinical Ethics for the Practicing Pulmonary/Critical Care Physician*, ACGME Lecture, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Allegheny General Hospital, March 20, 2014


40. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Cardiology, Department of Medicine, Allegheny General Hospital, July 15, 2014, Pittsburgh, PA

42. Arvind Venkat, *Ethics for the Practicing Gastroenterologist*, ACGME Lecture, Divisions of Gastroenterology, Department of Medicine, Allegheny General Hospital, October 6, 2014


44. Arvind Venkat, *Influenza – The Dangers and The Opportunities*, Nursing Grand Rounds, Allegheny General Hospital, November 18, 2014

45. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Allegheny General Hospital, November 25, 2014

46. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Allegheny General Hospital, December 19, 2014


48. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Department of Medicine, Allegheny General Hospital, May 22, 2015

49. Arvind Venkat, *Futility*, Department of Social Work Services, Allegheny General Hospital, June 17, 2015


52. Judy Black, Deborah Olszewski, Margaret Meals, Thomas Maher, Arvind Venkat (Moderator), *Advanced Planning Documents: Application in the Acute Care Setting*, System Ethics Grand Rounds, Allegheny Health Network, October 13, 2015, Pittsburgh, PA

53. Arvind Venkat, *Ethical Issues in Nephrology*, ACGME Lecture, Division of Nephrology, Department of Medicine, Allegheny General Hospital, March 3, 2016, Pittsburgh, PA
54. Arvind Venkat, *Ethical Issues in Gastroenterology*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, March 7, 2016, Pittsburgh, PA


57. Amer Aldeen, Arvind Venkat, *Research and Education*, US Acute Care Solutions Orientation, August 16, 2016, Canton, OH


59. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, November 15, 2016, Pittsburgh, PA

60. Arvind Venkat, *Futility*, ACGME Lecture, Division of Pulmonary and Critical Care Medicine, Department of Medicine, Allegheny General Hospital, April 3, 2017, Pittsburgh, PA


62. Arvind Venkat, *Update on Clinical Ethics*, ACGME Lecture, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, April 11, 2017, Pittsburgh, PA

63. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Nephrology, Department of Medicine, Allegheny General Hospital, April 11, 2017, Pittsburgh, PA


65. Deborah Olszewski, Arvind Venkat, *Review of Pennsylvania Laws on Surrogate Decision Making*, Division of Palliative Care, Department of Medicine, May 3, 2018, Pittsburgh, PA
66. Arvind Venkat, *Writing Orders on Limitations of Life-Sustaining Treatment*, Cardiovascular Institute, Department of Nursing, Allegheny General Hospital, November 13, 2018, Pittsburgh, PA

67. Arvind Venkat, Ethics Panelist, *Morbidity and Mortality Conference*, Division of Pulmonary and Critical Care Medicine, Department of Medicine, Allegheny General Hospital, December 17, 2018, Pittsburgh, PA

68. Arvind Venkat, *Ethical Issues in Gastroenterology*, Division of Gastroenterology, Department of Medicine, Allegheny General Hospital, January 7, 2019, Pittsburgh, PA

B. Extra-Institutional

1. Arvind Venkat, *Care of the HIV-Positive Patient in the Emergency Department in the Era of Highly Active Antiretroviral Therapy*, Joint University of Pittsburgh/Allegheny General Hospital Departments of Emergency Medicine Grand Rounds, Allegheny General Hospital, March 6, 2008, Pittsburgh, PA

2. Arvind Venkat, *Ethical Dilemmas in Emergency and Critical Care*, Joint University of Pittsburgh/Allegheny General Hospital Departments of Emergency Medicine Grand Rounds, Center for Emergency Care, University of Pittsburgh, September 25, 2008, Pittsburgh, PA

3. Arvind Venkat, *Care of the HIV-Positive Patient in the Emergency Department in the Era of Highly Active Antiretroviral Therapy*, Emergency Medicine Grand Rounds, Department of Military and Emergency Medicine, Uniformed Services University of the Health Sciences, October 22, 2009, Bethesda, MD


6. Arvind Venkat, *An Overview of Ethics for the Practicing Internist*, ACGME Lecture, Department of Medicine, Western Pennsylvania Hospital, March 8, 2010, Pittsburgh, PA


10. Arvind Venkat, *Care of the Adult Patient with Cystic Fibrosis in the Emergency Department*, Joint University of Pittsburgh/Allegheny General Hospital Departments of Emergency Medicine Grand Rounds, Center for Emergency Care, University of Pittsburgh, October 14, 2010, Pittsburgh, PA


12. Arvind Venkat, *Clinical Ethics in Practice*, Department of Medical Education, Paul L. Foster School of Medicine, April 18, 2012, El Paso, TX

13. Arvind Venkat, Julianna Becker, *The Effect of Statutory Limitations on the Authority of Substitute Decision Makers on the Care of Patients in the Intensive Care Unit: Case Examples and Review of State Laws Affecting Withdrawing or Withholding Life-Sustaining Treatment*, Health Law, Regulations and Transactions, Duquesne University School of Law, April 24, 2012, Pittsburgh, PA


18. Arvind Venkat, *Ethical Dilemmas in Emergency Medicine*, Department of Emergency Medicine Grand Rounds, Central Michigan University College of Medicine, May 9, 2013, Saginaw, MI

19. Arvind Venkat, *Care of the HIV-Positive Patient in the Emergency Department in Era of Highly Active Antiretroviral Therapy*, Department of Emergency Medicine Grand Rounds, Central Michigan University College of Medicine, May 9, 2013, Saginaw, MI
20. **Arvind Venkat**, *Procedures for Organ Donor Management – Case Studies*, Joint Clinical Training Session, Center for Organ Recovery and Education, June 27, 2013, Pittsburgh, PA


25. Arvind Venkat, James Valeriano, Michael Hansen, *Brain Death – Neurologic, Medical and Ethical Considerations*, Joint University of Pittsburgh/Allegheny General Hospital Departments of Emergency Medicine Grand Rounds, Allegheny General Hospital, April 23, 2014, Pittsburgh, PA


30. Arvind Venkat, *Ethical Dilemmas in Emergency Medical Services*, Cranberry EMS Continuing Education Conference, August 8, 2015, Cranberry, PA

32. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, Forbes Regional Hospital Pre-Hospital Response Team Education Day, December 18, 2015, Monroeville, PA

33. Arvind Venkat, *EMS Ethics*, Grove City EMS Conference, February 5, 2016, Grove City, PA

34. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, Forbes Regional Hospital Emergency Medical Services Continuing Education Day, February 10, 2016, Monroeville, PA

35. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, North Strabane Emergency Medical Services Continuing Education, April 27, 2016, Canonsburg, PA

36. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, Cranberry Township Emergency Medical Services Continuing Education, August 14, 2016, Cranberry Township, PA

37. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, Sharon Regional Health System Acute Emergency and Critical Care Symposium, September 23, 2016, Sharon PA

38. Arvind Venkat, *Care of Individuals with Autism Spectrum Disorder in the Pre-Hospital Setting*, Clarion Emergency Medical Services Symposium, November 4, 2016, Clarion, PA


42. Arvind Venkat, *Living Wills, DNR, and POLST*, Mount Nittany Medical Center, April 19, 2017, State College, PA

44. Arvind Venkat, *Advance Planning Documents and Actionable Medical Orders in Emergency Care*, Department of Emergency Medicine Grand Rounds, Ohio Valley Medical Center, October 26, 2017, Wheeling, WV


46. Joann Migyanka, Arvind Venkat, *Care of the Patient with Autism Spectrum Disorder in the Pre-Hospital Setting*, Butler County We Belong Conference, March 7, 2018, Butler, PA

47. Arvind Venkat, *Care of the Patient with Autism Spectrum Disorder in the Emergency Department*, Department of Emergency Medicine Grand Rounds, Central Michigan University, June 8, 2018, Saginaw, MI


49. Arvind Venkat, *Advance Planning Documents and POLST in the ED*, Department of Emergency Medicine Grand Rounds, Central Michigan University, June 8, 2018, Saginaw, MI

50. Arvind Venkat, *Dialysis Emergencies*, Department of Emergency Medicine Grand Rounds, Genesys Regional Medical Center, October 24, 2018, Grand Blanc, MI


52. Arvind Venkat, *Care of the Renal Transplant Patient in the Emergency Department*, Department of Emergency Medicine Grand Rounds, Medical University of South Carolina, October 17, 2019, Charleston, SC


54. Arvind Venkat, *Medical Ethics in the Modern Age: Advance Directives and Actionable Medical Orders*, Faculty Development Series, Albert Einstein Medical Center, February 5, 2020, Philadelphia, PA

55. Arvind Venkat, *Care of the Renal Transplant Patient in the Emergency Department*, Department of Emergency Medicine Grand Rounds, Central Michigan University, May 7, 2020, Saginaw, MI

*State/Regional*


3. Arvind Venkat, Panelist, *Panel Discussion: Ethics in Donation Case Review*, Center for Organ Recovery & Education 4th Annual Pennsylvania Hospital Collaborative Community of Practice Conference: Sharing the Links to Life - From Referral to Recovery and Beyond, September 27, 2011, Pittsburgh, PA

4. Arvind Venkat, *Ethical Dilemmas in Emergency Medical Services*, EMS Update 2013, Emergency Medical Services Institute, March 21-23, 2013, Seven Springs, PA


18. **Arvind Venkat**, *Do Not Resuscitate and POLST: How to Handle in the Field*, EMS Update 2015, Emergency Medical Services Institute, March 27, 2015, Seven Springs, PA

19. Joann Migyanka, **Arvind Venkat**, *Care of Individuals with Autism Spectrum Disorder During Disasters and Times of Crisis*, 2015 Disaster Human Services Conference, Department of Human Services, Commonwealth of Pennsylvania, August 13, 2015, West Chester University, Philadelphia, PA

20. **Arvind Venkat**, *Screening, Brief Intervention and Referral to Treatment in the Emergency Department*, Western Pennsylvania Residents Day, Pennsylvania College of Emergency Physicians, September 24, 2015, Pittsburgh, PA

22. Fernando Mirarchi, Arvind Venkat, *Point-Counterpoint: Should We Be Discussing End-of-Life Care in the Emergency Department?*, Scientific Assembly, Pennsylvania College of Emergency Physicians, April 8, 2016, Valley Forge, PA


33. Arvind Venkat, Care of the Bariatric Surgery Patient in the ED, Michigan State University College of Osteopathic Medicine State Wide Campus System Emergency Medicine Education Day, September 19, 2018, Troy, MI

34. Shelly McGonigal, Arvind Venkat, Ethical Dilemmas and the Impact on Quality and Safety, Hospital and Health System Association of Pennsylvania 2018 Patient Safety & Quality Symposium, October 3, 2018, Lancaster, PA

35. Maria Guyette, Arvind Venkat, Directors’ Forum – Department of Health Regulations, Scientific Assembly, Pennsylvania College of Emergency Physicians, April 10, 2019, King of Prussia, PA

36. Arvind Venkat, President’s Inaugural Address, Scientific Assembly, Pennsylvania College of Emergency Physicians, April 12, 2019, King of Prussia, PA


41. Arvind Venkat, President’s Farewell Address, Annual Membership Meeting, Pennsylvania College of Emergency Physicians, April 3, 2020 (Zoom Meeting due to Covid-19)

National/International


2. Arvind Venkat, Jan Seski, Rita Schwab, Ethical Considerations in Developing a Bloodless Medicine Center – What Have We Learned, 2012 Society for the Advancement of Blood Management Annual Meeting, September 21, 2012, Pittsburgh, PA


5. Gus Garmel, Arvind Venkat, Brigitte Baumann, *Fulfilling the Residency Scholarly Project Requirement: Solutions from Both Program and Research Directors*, 2014 Society for Academic Emergency Medicine Annual Meeting, May 14, 2014, Dallas, TX (SAEM ON DEMAND Continuing Medical Education Selection)


The 2020 American College of Emergency Physicians Awards Program honors leadership and excellence. The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College’s award programs.

**John G. Wiegenstein Leadership Award**
David C. Seaberg, MD, CPE, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

**James D. Mills Outstanding Contribution to Emergency Medicine Award**
John J. Rogers, MD, CPE, FACEP

Presented to an active, life, or honorary member for significant contributions to emergency medicine. The award honors the late James D. Mills Jr., MD, second president of the College.

**Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy**
Steven J. Stack, MD, MBA, FACEP

Presented to a member who has made a significant contribution to achieving the College’s health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP’s Executive Director from 1982 to 2003.

**Judith E. Tintinalli Award for Outstanding Contribution in Education**
Tracy G. Sanson, MD, FACEP

Recognizes a member who has made a significant contribution to the educational aspects of emergency medicine.
ACEP HONORS 2020 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

**John A. Rupke Legacy Award**
Peter M. Fahrney, MD, FACEP(E)

Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.

**Award for Outstanding Contribution in Research**
Alan E. Jones, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

**Award for Outstanding Contribution in EMS**
James M. Atkins, MD

Presented to an individual who has made an outstanding contribution of national significance or application in Emergency Medical Services. The award is not limited to ACEP members.

**Disaster Medical Sciences Award**
Irving “Jake” Jacoby, MD, FACEP

Recognizes individuals who have made outstanding contributions of national/international significance or impact to the field of disaster medicine.

**Council Meritorious Service Award**
Michael McCrea, MD, FACEP

Recognizes consistent contributions to the growth and maturation of the ACEP Council.
Community Emergency Medicine Excellence Award
Adnan Hussain, MD

Recognizes individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice.

Innovative Change in Practice Management Award
Rahul Sharma, MD, MBA, FACEP

This annual award is given to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

Pamela P. Bensen Trailblazer Award
Sharon E. Mace, MD, FACEP

The Pamela P. Bensen Trailblazer Award is presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).

Diane K. Bollman Chapter Advocate Award
Bob Ramsey, CAE

The Diane K. Bollman Chapter Advocate Award is presented to a current or recent (within the past 12 months) ACEP chapter executive or chapter staff member who has made a significant contribution to advancing emergency care and the objectives of an ACEP chapter and the College. The award is named after Diane K. Bollman, who served as the executive director of the Michigan College of Emergency Physicians for 25 years and was an honorary member of ACEP.
Honorary Membership Award
Pat Hughes, CMP

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award
Jane D. Scott, ScD, MSN

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award
Hugh Dean Wilkerson, JD, MBA, CAE

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Policy Pioneer Award
Amy M. Cho, MD

The Policy Pioneer Award is presented to early- and mid-career members who have made outstanding contributions to the College’s health policy and advocacy initiatives.
2020 ACEP COUNCIL AWARDS

Council Service Milestone Award
(Staff will identify all who qualify)

**Purpose:** To commemorate accumulated years of service as a Councillor or Alternate Councillor.

**Award:** The Award is a pin indicating years of service given at 5-year service intervals.

**Criteria:** Any member who has served as a Councillor or Alternate councillor. Recipients will be automatically recognized by ACEP staff via the Councillor database.

**Presentation:** The award is given to individuals at council registration. Recipients will be briefly recognized at the Council luncheon.

Council Meritorious Service Award
Michael McCrea, MD, FACEP

**Purpose:** Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.

**Criteria:** The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. He nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

Council Horizon Award
Theresa Tran, MD, FACEP

**Purpose:** Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.

**Criteria:** The nominee should have made an outstanding contribution to the Council of important resolutions, significant contributions to Council discussions, etc.

Council Champion in Diversity & Inclusion Award
Andrea L. Green, MD, FACEP

**Purpose:** The award celebrates and promotes diversity of experience and thought, the merit of inclusivity, and the value of equity. It is presented to a councillor, group of councillors, or component body that has demonstrated a sustained commitment to fostering a diversity of contributions and an environment of inclusivity that directly enhances the work of the Council and provides excellence to ACEP.

**Criteria:** The nominee should exemplify service to the College through the promotion of diversity and inclusion. The nominee must demonstrate evidence of having a commitment to the promotion of a diverse leadership and/or membership and/or initiatives related to diversity and inclusion through mentorship, programmatic activities, professional development, and other contributions specifically purposed to promote the mission, support the policies, and enhance the work of the Council and the specialty of emergency medicine.
2020 ACEP COUNCIL AWARDS

Council Teamwork Award

Purpose: Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

Criteria: Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

Council Curmudgeon Award

William K. Mallon, MD, FACEP

Purpose: To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.

Criteria: The Curmudgeon Award will be presented to current or former Council participants (ie, Councillor or Alternate Councillor, President, Speaker, ACEP staff, etc.) that have embodied the essence of the description above.
ACEP Strategic Plan for 2020-2023

Goal 1 – Improve the Delivery System for Acute Care

Objective A  Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Objective B  Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Objective C  Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Objective D  Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Objective E  Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective F  Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Objective G  Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Objective H  Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A  Improve the practice environment and member well-being.

Objective B  Increase total membership and retain graduating residents.

Objective C  Provide robust communications and educational offerings, including novel delivery methods.

Objective D  Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Objective E  Ensure optimal organizational infrastructure and governance to support membership, including increased resources from non-dues revenue.

Objective F  Provide and enhance leadership development and recognition and strengthen liaison relationships with other emergency medicine organizations.

Objective G  Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Objective H  Strengthen job security and opportunity for individual members at all stages of their career.
EMERGENCY MEDICINE FOUNDATION REPORT

OCTOBER 2020

- EMF approved $100,000 in funding from the EMF Endowment fund to support COVID-19 research made possible through the generous donations of ACEP members.

- EMF raised $62,000 in additional funds to support COVID-19 emergency medicine research from the Medtronic Giving Connection and McDonald’s Corporation.

- **EMF received 72 COVID-19 proposals and has awarded $163,967 to the following emergency physicians to conduct COVID-19 emergency medicine research:**

  Investigator: John Purakal, MD, MSc
  Institution: Duke University - Division of Emergency Medicine
  *Social Determinants of Health and COVID-19 Infection in North Carolina: A Geospatial and Qualitative Analysis*
  $50,000

  Investigator: Janice Blanchard, MD, PhD
  Institution: George Washington University
  *An Evaluation of Stressors related to COVID-19 In Emergency Medicine Physicians*
  $38,777

  Investigators: Amyna Husain, DO and Daniel Hindman, MD, MPH
  Institution: Johns Hopkins University School of Medicine
  *Pediatric Patient Characteristics and Their Associations with Screening, Receipt of COVID-19 Testing and Management within the Johns Hopkins Health System Enterprise*
  $24,920

  Investigator: Felipe Teran, MD, FACEP
  Institution: University of Pennsylvania
  *Prognostic Value of Point of Care Cardiac and Lung Ultrasound in COVID-19 – CLUSCO Study*
  $50,000

- **EMF has created a new Health Disparities grant for $50,000 that will be announced at ACEP20 and awarded in the next EMF Grant Cycle.**

**FY 20-21 EMF GRANT AWARDS**

**Mid-Career Research Development Grant**
Daniel Tsze, MD, MPH
Columbia University College of Physicians and Surgeons
*Dose-Finding Study of Intranasal Midazolam for Procedural Sedation in Children*
$250,000
Early Career Research Development Grant
Lauren Abbate, MD, PhD
University of Colorado/Rocky Mountain Regional VA Medical Center
*Weight Management and Exercise Prescription Program for Older Veterans with Knee Pain*
$150,000

Pilot Research Grant
Ari Friedman, MD, PhD
University of Pennsylvania
*Assessing the Impact of Urgent Care Clinics on Emergency Departments*
$50,000

EMF/CORD Emergency Medicine Education Research Grant
Lori Stolz, MD
UC Health, University of Cincinnati
*Climbing the Learning Curve for First Trimester Pregnancy Bedside Ultrasound Image Interpretation*
$25,000

Annemarie Cardell, MD
Maimonides Medical Center
*Building a Smart Airway Trainer: A Patient Specific 3D Printed Intubation Simulator with Embedded Force Sensors*
$25,000

EMF/CORD Emergency Medicine Education Starter Grant
Ashley Rider, MD
Stanford University
*The relationship between leader identity and team performance: a mixed-methods analysis using interprofessional in situ simulation in the emergency department*
$10,000

Matthew Malone, MD
The Ohio State University
*Virtual Reality Simulation to Assess EPA 10 in Fourth Year Medical Students*
$10,000

EMF/EMRA Resident Research Grant
Peter Serina, MD, MPH
Northwestern University
*Development and validation of the Admission for Geriatric patients in the Emergency Department (AGED)*
$10,000

Ryan Coute, DO
University of Alabama at Birmingham
*Disability-adjusted Life Years Due to In-hospital Cardiac Arrest in the United States (Coute)*
$10,000

Alexander Janke, MD
Yale School of Medicine
$10,000

JJ Hoff, MD
Duke University Hospital

**Shame and Error in EMS: A Qualitative Analysis of Culture and Attitudes in Prehospital Emergency Care**
$10,000

**EMF/SAEMF Medical Student Research Grant**

Eshani Goradia, BA
Stony Brook University

*Comparison of the effects of a bromelain and collagenase based enzymatic agent on inflammation and eschar debridement in a partial thickness porcine model*
$5,000

Kristy Blackwood, BA
Alpert Medical School at Brown University

*Firearm Violence and Safety Training in Undergraduate Medical Education: Evaluation of First Year Clinical Skills Curricular Intervention*
$5,000

Kendall Burdick, BA
University of Massachusetts

*Geographic and Temporal Analysis of Pediatric Trauma Access Disparities in the United States*
$5,000

David Helfer, BS
University of Pennsylvania

*Risk Prediction of Acute Coronary Lesions Following Out-of-Hospital Cardiac Arrest*
$5,000

**EMF/NAEMSP EMS RESEARCH GRANT**

Rebecca Cash, PhD, MPH, NRP
Massachusetts General Hospital

*Epidemiology of Prehospital Obstetric Emergencies in the United States*
$5,000

**Fisher and Paykel EMF Grant: Pending Final Award: $150,000**

**Washington State Medical Association-Better Prescribing Better Treatment Program Impact**

Logan Ramsey, MD
University of Cincinnati

*Better Prescribing, Better Treatment: Innovation to Improve Opioid Prescribing Patterns for Acute Pain*
$14,975

**TOTAL FY20-21 EMF GRANT AWARDS - $779,975**
Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

and

The ACEP 911 Legislative Network

September 2020
NEMPAC celebrates 40 years of success in 2020. A small, forward thinking group of ACEP members founded NEMPAC back in 1980 to help ACEP promote our legislative goals and express the concerns of emergency medicine to Members of Congress. Back then, the founders determined they would need to raise $10,000 to make a difference on the issue of independent contractor status for emergency physicians. Today, due to the increased costs of running for office and the many issues that ACEP can influence in Congress, our goal is to raise more than $1 million annually.

Just like our Board today, NEMPAC’s founders were from all parts of the country and were “party” blind when it came to selecting candidates worthy of NEMPAC support. And just like today, NEMPAC is the only national PAC solely dedicated to representing our bi-partisan interests in the nation’s capital.

Over the years, NEMPAC has opened doors, educated new and veteran lawmakers, and helped emergency medicine identify friends and champions in the U.S. Congress. This access created opportunities to express our well-reasoned viewpoints on the issues of the day for 40 years. This election cycle has been particularly challenging as our nation faces the greatest public health crisis in decades. With ACEP members on the front lines of managing the COVID-19 pandemic, our advocacy efforts have pivoted from efforts earlier this year to find a balanced, reasonable solution to surprise medical billing, to COVID-19 related issues such as obtaining PPE, temporary liability protections and mental health resources for health care professionals managing the pandemic and due process rights. Recently, we have focused our efforts on preventing devastating Medicare reimbursement cuts due to take effect in 2021. Our work continues in seeking solutions for the opioid and mental health crisis, addressing gun violence and injury prevention, protecting the prudent layperson standard, and funding for EM research and graduate medical education, to name a few.

Today, by combining and carefully allocating donations from thousands of individual emergency physicians, NEMPAC has grown to be one of most recognized and credible health care PACs in the nation and is THE VOICE of emergency medicine in the political process.

The Council Challenge has been in place for more than 25 years. Councilors now contribute more than $300,000 annually to NEMPAC, which is more than one-quarter of our total raised annually.

2020 Election Cycle Fundraising Highlights

- 2019 Amount Raised: $1,022,031 in 2019 exceeding $1 million goal set by ACEP Board of Directors. This was our third best fundraising year in NEMPAC’s history.
- 2020 Amount Raised as of Sept 10, 2020: $512,602 (Note that NEMPAC suspended actively soliciting our members March - July due to the COVID-19 pandemic. Funds were only collected through installment giving plans previously established and through the NEMPAC check-off on the ACEP dues statement).
- Over this two-year election cycle to date, 4,394 ACEP members supported NEMPAC. We remain the fourth largest physician specialty PAC in the nation with a 13% participation rate of members donating in this election cycle. We expect this number to increase by the November elections as we conduct the Council Challenge and member wide solicitation campaigns over the next 60 days.

The number of “Give-A-Shift” ($1,200 and above) donors continues to grow exponentially. In 2004, 70 ACEP members contributed at the “Give-A-Shift” level. Currently, 649 ACEP members are donating at the “Give-a-Shift” level. (Note: Some are due to renew during the Council Challenge. A complete listing of all VIP donors will be included in the 2020 NEMPAC Election Report and is available on the NEMPAC website.)

- 4 Chairman’s Club ($5000)
- 20 Platinum ($2500)
- 29 15 Year Give a Shift
- 79 Ten Year Give-a-Shift
- 129 Five Year Give-a-Shift
- 239 Regular Give-a-Shift
- 88 Transitioning Give-a-Shift
- 61 Resident Give-a-Shift
NEMPAC Guidelines for Contributions to Candidates in the 2020 Election Cycle

NEMPAC serves a vital role in advancing ACEP’s legislative agenda and in broadening ACEP’s visibility with Congress. As contributions to the PAC have increased, NEMPAC has become involved in more congressional races and expanded ACEP’s influence. In the 2018 election cycle, NEMPAC contributed nearly $2.2 million to candidates, party committees, leadership PACs, and independent expenditure campaigns. NEMPAC’s fundraising success in this cycle of $2,145,072 raised in hard and soft dollars allowed NEMPAC to be active in more races and to make larger contributions to individual candidates than in past cycles.

In the 2020 election cycle, NEMPAC’s donations are trending at 55% Democrat/ 45% Republican.

Senate candidates: $199,000
Senate party committees: $68,500
House candidates: $919,500
House party committees: $198,500

Total as of September 10, 2020: $1,385,500

**Evaluation Categories**

2020 evaluation criteria follow past NEMPAC practice of focusing on a candidate’s support of ACEP’s key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignment, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support. In addition, an initial list of NEMPAC Champions will be identified by the NEMPAC Board and staff. The champions will receive maximum financial support and additional resources that NEMPAC can provide.

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments by the NEMPAC Board of Trustees determine which overall approach is most compatible with ACEP’s legislative and regulatory agenda.

An internal spreadsheet is maintained by NEMPAC staff which tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislative considered by congress, campaign activity and election ratings and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

Most recently during their September 2020 meeting, the NEMPAC Board of Trustees approved a modified candidate budgeted based on revised fundraising projections and additional legislative priorities during the COVID-19 pandemic.

NEMPAC Chair, Dr. Peter Jacoby, will be providing an updated and extensive NEMPAC presentation during the virtual council meeting that will discuss criteria from the internal spreadsheet mentioned above as well as additional statistics and new initiatives warranted during the pandemic to ensure that NEMPAC remained a strong voice for emergency medicine in the political process. A complete list of criteria and candidates can also be found on the NEMPAC website.
2020 Election Cycle Activity

Staff and ACEP member attended nearly 1000 fundraisers and meet and greets in the 2020 election cycle (January 1, 2019 – through Sept. 10, 2020) – about 15% were attended by ACEP members.

Since COVID-19/work at home in March 2020, we have transitioned to virtual events including briefings with candidates and incumbent members and national party committees.

NEMPAC hosted and co-hosted more than 60 events for candidates and incumbents (including virtual events during COVID-19). Many of these events were with a coalition of physician/dental PACs.

We developed a NEMPAC candidate questionnaire for screening new candidates in 2020 elections. This tool along with collaboration with state chapter leaders, helped the NEMPAC Board and staff evaluate and agree to support 16 new candidates, 10 of whom are physicians.

In response to COVID-19 challenges, we began series of NEMPAC Virtual Happy Hours for VIP donors (Give a Shift and above) beginning in April 2020 continuing bi-monthly with special guests including, Rep. Raul Ruiz, MD, FACEP (D-CA), Election expert and political pundit, Nathan Gonzales, Sen. Bill Cassidy (R-LA), Rep. Raja Krishnamoorthi (D-IL), and physician congressional candidates including Drs. Hiral Tipirneni (D-AZ), ACEP member Richard McCormick (R-GA), Manny Sethi (R-TN) and Bill Clifford (R-KS). These events will continue throughout the fall.

We repurposed NEMPAC administrative funds dedicated to recognition of donors (NEMPAC VIP reception at LAC for example) for a Charity PAC Match program. 10% of all donations made June through September will be donated to a charity of a donor’s choice among three (EMF, GETUSPPE, American Foundation for Suicide Prevention).

Created a 2020 Voter Resource Center for ACEP members:  https://p2a.co/S1vqRnq/

The 911 Legislative Network

Along with NEMPAC, the 911 Legislative Network plays a significant role in promoting ACEP’s legislative agenda to Congress. When ACEP recognized that it was competing for federal legislators’ time and attention in an environment burgeoning with important legislative issues, ACEP’s Federal Government Affairs Committee and the Board of Directors voted to create a technically sophisticated grassroots network. Launched in April 1998, the 911 Legislative Network encourages ACEP members to cultivate relationships with their federal legislators for long term, ongoing lobbying and educational efforts. The goal is to have emergency physicians across the country available as resources and healthcare issue experts for federal legislators. As “citizen lobbyists,” 911 Network members carry ACEP’s concerns directly to policy makers and staff to explain how legislation or regulation affects medical care provided in an emergency department. ACEP provides the tools and the training to help 911 Legislative Network members effectively communicate with their legislators.

Through various strategies including adding NEMPAC donors and members that have responded to ACEP all-member action alerts to the Network (with option to opt out), and recruiting Residents and Medical Students, overall participation in 911 Network is nearly 6,000. (it was 3,905 in June of 2019).

We successfully met goal of meeting all new members of congress elected to 116th Congress through new members coffees in the district, support through NEMPAC, meet and greets in Washington DC post-election, lobbyists visits and LAC Hill visits.

ACEP’s Virtual Hill Day resulted in 474 emergency physicians from 45 states participating in 306 conference call meetings with federal legislators and/or their healthcare staff, with close to half of the meetings being held with members of Congress themselves or senior staff. ACEP was one of the first groups in DC to conduct a virtual fly-in of this magnitude and is now being looked to as a model for future such meetings.
911 Network Member of the Year
Each year, a “911 Network Member of the Year” is selected from among the most active advocates in the Network based on an accrued point system which includes attending events, hosting ED visits, responding to action alerts and recruiting new members to the Network. The 2020 Winner is Dr. Cameron Webb from Washington State.

As leaders of ACEP, it is important that members of the Council participate in the 911 Legislative Network. Councillors are well informed about the issues facing emergency medicine and ACEP’s efforts to promote the specialty. This makes members of the Council the perfect spokes persons to carry ACEP’s message to their legislators. ACEP’s goal is to achieve 100% Councillor participation in the ACEP 911 Network.

You can join here: [https://www.acep.org/federal-advocacy/federal-advocacy-overview/911grassrootsadvocacy/](https://www.acep.org/federal-advocacy/federal-advocacy-overview/911grassrootsadvocacy/)

NEMPAC and the 911 Legislative Network help promote the specialty of emergency medicine. We thank the Councillors for their past support and encourage all members of the Council to contribute to NEMPAC and sign up for the 911 Legislative Network. Your participation will help ensure the future of our specialty and our patients.
American Board of Emergency Medicine

Report to the 2020 American College of Emergency Physicians Council

October 2020
American Board of Emergency Medicine

Report to the 2020 American College of Emergency Physicians Council

Purpose

The purpose of this report is to provide the 2020 ACEP Council an overview of the various changes to ABEM certification.

General

ABEM is revising continuing certification to improve learning opportunities and decrease the high-stakes nature of certification. These revisions provide an additional advantage in accelerating knowledge translation in our specialty in a novel way. ABEM has changed its certification program in response to physician requests and feedback. The most recent iteration of its certification program is the culmination of a deliberate, specialty-centric development process that integrated substantial physician input. ABEM has continuously been revising its certification program to meet the needs of the physician, the specialty, and the public (Attachment 1). As Attachment 1 demonstrates, ABEM certification has been constantly evolving.

ABEM acknowledges that although many physicians welcome this latest evolution in certification, there are some physicians who would prefer that no change be made. ABEM has attempted to optimize fairness and consistency in this transition. Unfortunately, granting the exceptions requested by some physicians could create greater inconsistencies and threaten the balance and fairness that ABEM has designed.

The changes to ABEM’s certification program reduce the number of requirements needed to stay certified. In addition, the revised program should reduce stress by eliminating the high-stakes ConCert Examination. Nonetheless, uncertainty about an individual physician’s requirements and misperceptions about the implications of the changes create a sense of complexity. ABEM is pleased to assist physicians with understanding their requirements as a result of this transition. To help physicians understand their requirements, ABEM designed a new tool, ✓ABEM Reqs, which is available on the ABEM website. This easy-to-use feature allows physicians to view their certification requirements based on when their current board certification expires.

ABEM certification signifies that a physician has met rigorous standards. ABEM certification is highly regarded and has value as a credential. ABEM, working with ACEP and other Emergency Medicine organizations, has been able to leverage the strength of ABEM certification to eliminate several medical merit badge requirements. Others view ABEM certification as proof that a physician has demonstrated up-to-date knowledge in the specialty.

ABEM has always required recertification since the inception of the specialty—this is a source of pride for the specialty. Throughout its history, ABEM has been consistent and fair in the manner in which it administers certification. By granting exceptions during the phase-in process, ABEM would create complex subgroups with differing formats of certification for physicians, which would undercut the consistency and rigorous application of national standards.
The phase-in process is designed to provide ABEM-certified physicians access to MyEMCert quickly to shorten the transition and create uniformity in physicians’ certification requirements. Given the need to transition ABEM certification to a more continuous process, ABEM will allow recertification to occur via MyEMCert two years earlier than ABEM initially projected. As recently as the 2019 Council meeting, ABEM announced that the earliest year a physician could become recertified using MyEMCert would be 2022, and that it would require completing eight MyEMCert modules in two years. By transitioning to a 5-year certification cycle, ABEM is able to offer recertification using MyEMCert sooner.

Key Elements

Gathering Your Ideas
Prior to the latest changes to certification, ABEM solicited extensive feedback from physicians. ABEM conducted a nationwide summit of all major organizations, including ACEP. ACEP was represented by (now) ABEM President, William P. Jaquis, M.D., and (then) Executive Director, Dean Wilkerson, M.B.A., J.D., CAE. ABEM also conducted focus groups with the majority of ACEP state chapters. Finally, ABEM sent a survey to 36,000 ABEM-certified physicians, 12,800 of whom responded.

Responsive to Unique Needs
The program responds to the unique needs of emergency physicians. Emergency physicians are different—we work extremely varied schedules and 365 days of the year. The program addresses the need for flexibility and making staying certified easier. Emergency physicians are also exposed to a wider range of patient conditions than most other specialties. The new program considers the tremendous breadth of knowledge emergency physicians are expected to understand. MyEMCert will accelerate the translation of knowledge in the specialty in a way that is unique to Emergency Medicine.

Custom Built to Physician Feedback
ABEM redesigned this program based on emergency physician feedback. Physicians wanted MyEMCert to start as soon as possible—ABEM found a way. As mentioned above, beginning in spring 2021, ABEM-certified physicians will have the option of fulfilling continuing certification requirements by completing four MyEMCert modules (online and open book) in lieu of the ConCert Exam. A short video describing MyEMCert modules is available on the ABEM website. The ConCert Exam will no longer be available after 2022.

The switch to MyEMCert prioritizes relevant content, saves emergency physicians time and money, and better accommodates their schedules. Starting in 2021, ABEM will move to five-year certification and implement an annual fee structure. The move from 10-year to 5-year certification—while simultaneously moving to an annual fee structure—does not come with any increased fees and actually decreases the number of required activities and indirect costs (see FAQ #13 in Attachment 2).

Flexibility
As mentioned before, emergency physicians often work nontraditional office hours. MyEMCert gives emergency physicians the flexibility to answer questions at a time and in a setting of their choosing.
Commonly Asked Questions

Physicians will have questions about any change. The following questions have been the most common. ABEM wishes to clarify misconceptions that may help physicians be more at ease with this transition.

1. I recently passed the ConCert exam and thought my certification was good for 10 years. Why isn’t it?

   Recertification is not exclusively linked to ConCert. ConCert is only one of 12 requirements during a 10-year certification. When certification is renewed is not linked to when you pass the ConCert, but when your current certification expires. Passing the ConCert Exam means that you completed one requirement to become recertified.

2. I was planning to retire in less than ten years. What exception can be made so that I do not need to retake the exam prior to my retirement?

   In order to ensure consistency and fairness, ABEM cannot make any exceptions to certification requirements and certification lengths. Every physician will be transitioned to the new certification process with their next period of recertification, whenever that may be.

3. Why wasn’t I informed of the change to the five-year certification before I took the ConCert Exam?

   ABEM has communicated the continuing certification process and resulting requirements as promptly as possible. ABEM completed and approved the new continuing certification program on July 23, 2020, and shared the information within six business days. The Board went through a meticulous process to revamp its continuous certification process to better meet the unique needs of emergency physicians. So far, the overall response from ABEM-certified physicians has been positive.

4. Why is my certification period being shortened?

   ABEM is not shortening the period of certification for any physician. ABEM is honoring the end date of every certificate it has already issued.

For additional FAQs, see Attachment 2.
ABEM Certification: A Constant Evolution

Introduction

ABEM has had some form of continuing certification since it was approved in 1979 as the 23rd American Board of Medical Specialties (ABMS)–recognized medical specialty board. Over time, continuing certification has evolved due to two main factors: 1) requirements emanating from the American Board of Medical Specialties (ABMS); and 2) physician suggestions.

Recertification

ABEM has always required recertification. Recertification was initially based on meeting ABEM medical licensure requirements and passing a recertification examination. The first ABEM multiple choice question recertification examination was administered over 30 years ago (1989).

Maintenance of Certification (MOC)

The seminal report *To Err is Human*, published by the Institute of Medicine in 1999, prompted the ABMS to determine that lifetime certification based on a single examination was felt to be insufficient assurance of physician competency. Recognizing the need to show constant involvement in activities that demonstrate learning and improved patient care, the ABMS introduced its MOC program in 2000. Each member board agreed to develop an MOC program that followed a four-part design including these components:

- Professional Standing (later changed to Professionalism and Professional Standing)
- Lifelong Learning and Self-Assessment
- Assessment of Cognitive Expertise (later changed to Assessment of Knowledge, Judgment, and Skills)
- Assessment of Practice Performance (later changed to Improvement in Medical Practice).

The ABEM MOC Program 2004 – 2020

When the ABMS decided that all member boards would implement an MOC program, ABEM created a program that:

- Transitioned the “recertification” examination to the Continuous Certification (ConCert) Examination. ConCert introduced improvements to the recertification exam including:
  - ConCert was computer based
  - It was offered over a one-week period each year, providing physicians with greater flexibility in scheduling
  - ConCert was administered in professional testing centers located throughout the United States and Canada, reducing physician travel time and costs
- Introduced the LLSA, which involved reading articles and taking an online, open-book test.
- Added the Improvement in Medical Practice (IMP) component, which was designed to recognize practice improvement efforts in which emergency physicians were already engaged. IMP involved attesting to completion of a quality improvement effort using a plan-do-study-act (PDSA)–like cycle. Initially, it also included periodic participation in a Patient Experience of Care Survey.
• Enhanced the professional standing component to be continuous, rather than required once every ten years.

Continuous Improvement
Since the inception of the ABEM MOC program, ABEM has constantly refined the requirements and improved the activities available for physicians to meet requirements. The ABEM Continuing Certification Committee meets every six months and examines every aspect of continuing certification. ABEM frequently receives feedback from certified physicians via multiple avenues.

Since its implementation in 2004, ABEM has made several modifications to ABEM Continuing Certification (modifications listed below).

Continuing Certification 2020
Changes to continuing certification, both implemented and planned for implementation in 2021 include:

• MyEMCert. Core elements of MyEMCert include:
  o Online, open-book modules
  o Modules are topic specific
  o Immediate feedback, providing scores, correct answers, and rationales
  o Content that keeps physicians informed about key advances in the specialty
• Five-year certification period
  o Begins in 2021 with all newly issued certificates
• Annual fee begins in 2021
  o Approximately the same cost as currently paid on an annualized basis
  o Physicians who have paid more than the annualized amount will receive a refund
  o Begins with all newly issued certificates
• Transitional ConCert
  o Online
  o Open book (UpToDate® available as a resource)
  o Taken alone
  o Available twice per year through 2022, when ConCert will be discontinued

Modifications to ABEM Continuing Certification (2004 – 2019)

• ABEM originally planned to base up to 40 percent of ConCert’s content on LLSA readings, on the grounds that certified physicians would then have a significant head start when preparing to take the examination. However, physicians felt that this would quickly become an unmanageable burden. They would have to study material from up to ten previous LLSA tests based on as many as 200 articles. In response, ABEM removed the link between designated LLSA readings and ConCert questions.
• Starting with the 2009 LLSA test, the number of test questions was reduced from 40 to 20-30, based on concerns physicians expressed about the time and effort needed to prepare for and take the tests.
• Examinees who took the ConCert reported that they felt rushed to complete the exam. Scheduled breaks were not provided during the four hours of the exam. In 2009, the examination was split into two separately timed sections to allow adequate break time.
The number of annual LLSA readings was reduced from 16-20 to 10-15 in 2010, based in part on concerns physicians expressed about the effort needed to review the articles.

Physicians were able to take LLSAs in the year in which they become certified or renew certification starting in 2011. This allowed physicians to take an LLSA each year during the certification cycle.

The Practice Improvement (PI) requirement of the Improvement in Medical Practice (IMP) component of MOC was modified in 2011 to include an exception to the rule that the pre-measurement and post-measurement required for an improvement activity must include at least ten of the physician’s patients. The exception allowed diplomates to include fewer of their patients in each measurement involving low-frequency, high-acuity conditions.

Starting in 2011, options for physicians to regain certification were simplified. Specifically, formerly certified physicians who missed a small number of requirements could regain certification by making up missed requirements within five years. If more than five years had passed after their certification expired, or if too many requirements were missed, the physician would be required to pass the ConCert and Oral Certification examinations to regain certification.

In 2011, ABEM, in conjunction with ACEP and AAEM, began offering CME credit for successfully completing an LLSA test.

Starting in 2012, ABEM implemented a five-business day “grace period” for completing recertification requirements. Although certificates still expire on December 31, ABEM does not convert certificates to expired status for not having met all continuing certification requirements until after the grace period ends. In 2016, the grace period was extended to ten business days.

The frequency with which certified physicians were required to report and verify their medical licensure was reduced from every time they initiated action within the MOC website to every six months. This change was implemented in late 2013.

The requirement that physicians complete their required LLSA tests prior to registering for ConCert was eliminated in 2013.

Previously, passing ConCert immediately renewed a physician’s certification, which “reset” the certification date. If a physician took the examination sooner than the tenth year of certification, they would have paid the full price of certification for an abbreviated duration. In 2013, a change was implemented that allows physicians to take the exam up to five years before their certification expiration date. These changes removed the financial disincentive to take the exam early, with the result that an increasing number of physicians have taken the exam one or two years early to ensure that they have time to retake it, if necessary, before their certification expires.

Originally, each year’s LLSA was based primarily on designated topic areas of the EM Model for that year. The list of topics was intended to recycle every nine years. It became a challenge to find a sufficient number of high-quality articles on designated topics each year. ABEM recognized that there might be more current, important articles published in any given year. Starting with the 2014 LLSA, the annual readings come from all areas of the EM Model.

The requirement that certified physicians complete an average of eight self-assessment CME credits per year was removed in 2016. Participating in learning activities that include a self-assessment dimension is still important. However, physicians meet this goal just by completing their required ABEM LLSAs, all of which meet the definition of a self-assessment activity.
More options for meeting the ABEM LLSA requirement were offered to physicians starting in 2016, when EMS and Medical Toxicology LLSAs were made available to all ABEM-certified physicians. In June 2017, a Pediatric Emergency Medicine LLSA also became available.

Starting with the 2017 EM LLSA, ABEM began providing specific rationales for each test question once the physician passed the test. This change is intended to enhance the value of ABEM LLSA tests as learning activities.

The patient safety LLSA requirement was removed in 2017. Patient safety material is included in regular ABEM LLSAs, so a specific requirement was no longer needed.

In 2019, ABEM removed the requirement that certified physicians participate in a patient experience of care survey (the Communication / Professionalism (C/P) requirement of the IMP component). Physician feedback was one of the drivers of this change.
5-Year Continuing Certification Cycle and Annual Fee

FREQUENTLY ASKED QUESTIONS (FAQS)

1. **How long is the current certification period?** Your current certification will remain valid until the expiration date on your certificate. Starting in 2021, after your current certification expires, when you renew your certification, you will be issued a certificate that will be valid for 5 years. This takes place after your current certification expiration date, not necessarily in 2021. Starting in 2021 physicians who receive initial certification will also receive a certificate that is valid for a 5-year period.

2. **Why did ABEM change the certification cycle from a 10-year to a 5-year certification cycle?** A number of factors contributed to the decision to change the certification cycle.

   - Instituting the 5-year cycle with the launch of MyEMCert and the annual fee will minimize the number of disruptions and help to simplify the continuing certification process. Five-year certification cycles foster a more continuous approach to keeping up with medical knowledge and key advances in the specialty and demonstrating ability to meet certification standards.
   - Public and patient groups do not view the 10-year certification process as sufficient for certification. They assume certification programs are much shorter.
   - The ABMS Vision Commission report recommends moving to a continuing certification process. A 5-year cycle, while not continuous, moves in the direction of continuing certification.
   - Changing to a 5-year cycle now allows physicians with certifications expiring in 2021 to recertify using MyEMCert. Previously, this group was not allowed because they would have had to complete more MyEMCert modules than would be available.

3. **Will the date my current certification expires change now that there is a 5-year certification cycle?** No. All current board certification expiration dates remain the same. Beginning in 2021, when you next renew your certification, you will be issued a 5-year certificate. This takes place after your current certification expiration date.

4. **I am confused about what my options are for renewing certification. What should I do?** To check what activities you need to complete to renew your certification, please use the ✓ ABEM Reqs tool in the Stay Certified section of the ABEM website. Enter your certification end date to view your requirements. If you still have questions, please contact ABEM at staycertified@abem.org or call 517.332.4800.

5. **If my current ABEM certification expires in 2021 or after, and I choose to take ConCert a year early, in 2020, will my board certification be renewed for 10 years?** No. Taking ConCert does not in itself renew certification. Certification renewal is based on the expiration date of your current certificate. If your current certification expires after 2020, if you have met all of your requirements, your certification will be renewed for 5 years.

6. **Is there a difference between renewing my certification by taking ConCert versus completing MyEMCert modules?** No. If you complete your requirements by your
certification expiration date, your board certification will be renewed for 5 years, regardless of which method you use. Please use the ✓ ABEM Reqs tool in the Stay Certified section of the ABEM website.

7. **My board certification expires after 2021, and I already took ConCert; will my certification be renewed for 10 years?** No. If you have completed all of your continuing certification requirements, your board certification will remain unchanged from when it was originally issued and in effect until the expiration date. Your board certification will then be renewed for 5 years. Please use the ✓ ABEM Reqs tool in the Stay Certified section of the ABEM website to see what your requirements are.

8. **My board certification expires at the end of 2020. If I take ConCert and complete all of my other requirements, will my board certification be renewed for 10 years?** Yes. The move to a 5-year certification cycle goes into effect for physicians whose board certification expires in 2021 and after. If you pass ConCert and complete all of your requirements by your requirement date (June 30, 2021), you will be issued a 10-year certificate. You will move to the 5-year certification cycle the next time you renew your certification.

9. **I thought that if I took ConCert, my new certificate would be for valid for 10 years; why not?** By taking ConCert—no matter when your certification ends—to renew your certification, you are completing only one of several requirements needed to renew your certification; passing ConCert does not issue you a new certificate. ABEM offered the option to take ConCert early to reduce test anxiety and decertification risk caused by having to take the exam in the last year of certification. To renew your current board certification, over a 10-year period, you must have:
   - A medical license in compliance with ABEM policy
   - Attested to 2 IMP activities
   - Completed 8 LLSAs
   - Passed ConCert (or complete 4 MyEMCert modules).

   Passing ConCert does not renew your certification; meeting all requirements by the end of your certification period renews your certification.

   Beginning with certifications that expire in 2021, board certification will be renewed for 5 years after your current board certification expiration date, even if you passed ConCert early. Please use the ✓ ABEM Reqs tool in the Stay Certified section of the ABEM website to see what your requirements are.

10. **How long will I have to be able to use ConCert to renew my certification?** ConCert will be available through 2022. If your certification expiration date is in 2026 or earlier you can take ConCert to renew your certification because you are allowed to take ConCert anytime during the last 5 years of your certification cycle. Also, when your current certification expires, you will be issued a certificate that will be valid for 5 years. Please use the ✓ ABEM Reqs tool in the Stay Certified section of the ABEM website to see your requirement options.

11. **Why is ABEM discontinuing ConCert as an option to renew certification?** A June 2018 survey of all ABEM-certified physicians showed that over 90 percent of physicians would prefer to recertify using MyEMCert, not ConCert. Maintaining both MyEMCert and ConCert would divert ABEM resources and result in higher certification costs for all physicians. Therefore, ConCert will be discontinued after 2022.
12. **My certification expires in 2027; do I have to wait until the second five years of my current certification to take MyEMCert modules?** No. Physicians with certificates that expire between 2027-2029 can take MyEMCert modules in place of LLSAs to meet their first 5-year requirements.

13. **Did certification requirements increase with the change to a 5-year certification cycle?** No. To obtain a 10-year certificate, physicians were required to:
   - Complete 8 LLSAs
   - ConCert
   - 2 IMP attestations
   - Maintain all medical licenses in compliance with ABEM policy

   With the new 5-year certification cycle, physicians complete one less requirement. They must:
   - Complete 4 MyEMCert modules
   - 1 IMP attestation
   - Maintain all medical licenses in compliance with ABEM policy

   The MyEMCert, 5-year certification cycle eliminates the high-stakes, secure ConCert Exam from total requirements. Please refer to the table below.

   ![Comparison Between 10-Year and New 5-Year Certification Cycles](image)

   **5-year recertification does not start until your current certification expires.**

14. **Will the way I pay for continuing certification change?** Yes. For physicians who renew certification or achieve initial certification in 2021, an annual fee structure will be implemented. All ABEM-certified physicians will move to an annual fee at the same time...
they move to a 5-year certification cycle (after they next renew their certification). Rather than having to pay the ConCert fee up front plus costs for LLSA tests, physicians will pay an annual fee of $280, which spreads payments evenly over the certification cycle. This is virtually the same amount as physicians are now paying for continuing certification.

15. **Is the change to MyEMCert and the annual fee going to provide a financial windfall for ABEM?** No. ABEM-certified physicians currently pay an annual average of about $280 per year for continuing certification requirements (8 x $105 for LLSAs + $1,950 for ConCert = $2,790 ÷ 10 = $279 per year). The new annual fee will be $280 per year, which is nearly the same as total current costs for continuing certification. Those who took ConCert early and paid the $1,950 fee will be receiving a refund check for the difference between the old fees and the new fees during this transition. Refer to the table in FAQ 13 for details. Please note: Refunds apply only to fees paid for successful completion of the ConCert Exam and LLSA tests; they will not apply to fees paid for retaking exams or for late fees.

16. **I took ConCert early and the fees I paid are more than the fees for MyEMCert modules. This looks like a way for ABEM to make more money.** If you paid the ConCert fee under the old fee structure, ABEM will be sending you a check reimbursing you for the difference in payments. Please note: Refunds apply only to fees paid for successful completion of the ConCert Exam and LLSA tests; they will not apply to fees paid for retaking exams or for any late fees.
To be eligible to receive certification from the American Osteopathic Association (AOA) through the American Osteopathic Board of Emergency Medicine (AOBEM), a candidate must meet the following minimum requirements:

A. **Osteopathic physicians:**
   - 1. Be a graduate of a COCA-accredited College of Osteopathic Medicine.
   - 2. Obtain training complete status from an ACGME/AOA accredited/approved residency training program.

B. **Allopathic physicians – US and Canada Programs**
   - 1. Be a graduate of a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME).
   - 2. Obtain training complete status from an ACGME accredited residency training program.

Applicants for the AOBEM written exam must have graduated from, or be in their final year of, an AOA-approved or ACGME-accredited residency in Emergency Medicine.

Board eligibility commences upon the physician’s completion of residency training program in a specialty or subspecialty and terminates on December 31st of the following sixth (6th) year.

Candidates for the oral exam must be residency complete but can take the written/oral exam in any order as long as eligibility requirements are met.

**There are four components to Osteopathic Continuous Certification (OCC)**

- **Component 1**
  - Valid, active license to practice in one of the 50 states or territories

- **Component 2**
  - 60 CME hours per three-year cycle with
  - Eight COLA modules per 10-year cycle

- **Component 3**
  - Continuous Osteopathic Recertification Examination (CORE): mini exam taken at home using educational resources during a diplomates’ expiration year.
Component 4

- 2 Practice Performance Assessments in a 10-year cycle

The AOBEM is now offering a longitudinal assessment (CORE) that replaced the high-stakes 10-year examination. CORE is a combination of current practice articles along with core content and consists of approximately 40-60 questions annually. More information is available on the AOBEM website: https://certification.osteopathic.org/emergency-medicine/occ-overview/component-3/.

There are over 3,900 active diplomates certified by the AOBEM. The AOBEM also offers subspecialties in Emergency Medical Services and Medical Toxicology and a variety of conjoint certifications offered through other AOA certifying boards.
EMRA Report to the ACEP Board of Directors:

Pillar 1: Education – **EMRA helps you become the best doctor you can be**

EMRA’s goal is to be “be there for you on every shift” so we have expanded MobilEM content, advertising and collaboration over the past few weeks. The MobilEM mark and design is now registered with the US Patent and Trademark office, as well.

Our publications continue to reach beyond the stars, with new guides including the (updated) Antibiotics guide, PressorDex: Critical Care Medications, Pain Management, and the new Trauma guide. Both the Pain Management and Trauma guides can now be purchased on Amazon.com. Content is being developed for the ECG Atlas and PEM Fundamentals guide. To support physicians and PAs manage COVID patients on vents, EMRA discounted the price of the Vent Management Card (to the EMRAFamily price).

Besides publications, we have a series of resource kits available for our membership including separate kits for medical students, interns, residents, fellows and alumni! They have all been successfully been shipped in the past 1-2 months.
despite the mail delivery challenges caused by COVID-19.

The content, enthusiasm and demand for our **EMRA*Cast Podcasts** continue to grow. Over the past 2 months alone, our new hosts have released episodes pertaining to **High Flow Nasal Cannula, Double Defibrillation, and Simulation Fellowships** along with “Friday Flashbacks” aimed for rebroadcasting timely issues previously recorded for our membership. For the months of July and August alone, we had 5,500+ downloads alone.

We are EXCITED for **ACEP20** and plan to offer a series of new educational program that includes:

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<tr>
<th>Name</th>
<th>Highlights</th>
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<tr>
<td>Residency Program Fair</td>
<td>Private video chats, virtual program profiles</td>
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<tr>
<td>Job &amp; Fellowship Fair</td>
<td>Direct partnership with ACEP, revenue available to both organizations</td>
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<tr>
<td>Medical Student Forum</td>
<td>Over 700 registered, 15 stellar faculty spots; 400+ medical students attended</td>
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<tr>
<td>Leadership Academy</td>
<td>ACEP20 pre-conference event with personal coaching sessions</td>
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<tr>
<td>Resident Councillor Caucus</td>
<td>ACEP Chapters involved, second annual event</td>
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This year, **EMRA** became a platinum sponsor of the **FIX20 Conference** (hosted by FemInEM), helping to create their first-ever resident-specific workshops. The conference will feature 20 different workshops and 4 FIX IT panels.

**Pillar 2: Leadership – EMRA helps you become the best leader you can be**

To recognize a segment of the next EM generation of leaders, EMRA’s **25 Under 45 award** has drawn 200+ applications for just 25 awards! We plan to celebrate each honoree by creating professionally-crafted video packages at **ACEP20**.
We are excited to be a part of ACEP’s Diversity Mentoring Initiative – a joint initiative between the ACEP’s Diversity Inclusion & Health Equity section and EMRA D&I committee – created to promote and support leadership / career development opportunities across emergency medicine. EMRA assisted ACEP with recruiting members for the ACEP Workforce Focus Group.

This summer, we strengthened our partnership with EDPMA by coordinating announcements for action alerts, workshops and the annual Solution Summit across our membership. The EMRA/EDPMA Scholarship continues to offer scholars with funding and organizational committee opportunities, specifically for those interested in the management and business of emergency medicine practice.

EMRA and ACEP have continued to work together on providing EM providers with the latest evidence-based education and training necessary to care for our patients. For example, EMRA has committed to disseminating infectious disease clinical guidelines and best practices if ACEP is awarded a CDC Cooperative Agreement.

As our world moves even closer to virtual, EMRA remains the leading voice of EM physicians-in-training as evidenced by our communication response rates. EM Resident has a circulation of 17,000+ and 60,000+ page views for our print and digital versions, respectively. Our monthly electronic What's Up newsletter consistently sees a 55% open rate. On social media, we now have 4,500+ Facebook fans, 16,000+ Twitter followers, 2,000+ Instagram users, and 500+ LinkedIn subscribers.
Pillar 3: Advocacy – EMRA helps emergency medicine become the best specialty it can be

We joined the VotER initiative and have received mostly positive feedback from our membership for encouraging patient and provider voter registration. Our aim is to promote civic engagement, steer clear of political debate, and provide options to our patient population no matter the political climate.

Additionally, EMRA has promoted Civic Health Month throughout August in collaboration with over 130 hospitals, healthcare institutions, and clinics across the country that include entities such as PennMedicine, Oak Street Health, and Kansas Hospital Association (KHA).

In response to several delays of EM board certification examinations announced by ABEM, EMRA advocated on behalf of all EM residents for ABEM leadership to clearly delineate expectations moving forward. The result? ABEM met with reps from all EM resident organizations for gathering comments on the cancelation of the 2020 Oral Certification Examination.

Virtual Mock Interview Practice sessions are now being offered to medical students entering the 2021 Match in collaboration with CORD and CDEM. The opportunity aims to prepare EM-bound MS-IV medical students for virtual interviews in attaining highly coveted residency spots. EMRA is recruiting the interviewees (while CORD is recruiting the interviewers).

Dr. Hannah Hughes and Dr. Bo Burns recently recorded a video on “5 Tips for Effective Virtual Interviews” for EM-bound medical students, residents AND fellows!

EMRA submitted several resolutions to ACEP Council to advocate on behalf of graduating residents.

Virtual 1:1 mock interviews will be organized according to geographical regions.
threatening to lose their employment contracts, trainees looking for additional telehealth training opportunities, and physicians concerned about post-graduate training of advanced practice providers (APPs).

For our 4,000+ medical student members, we have taken on the following initiatives this year:

1. **Medical Student Forum** (part of ACEP20): 400+ MS attended
2. **Virtual Interview Tips** with our President, Dr. Hughes, and Dr. Bo Burns
3. **EMRA Hangout** session (podcast) on virtual interviewing
4. **Virtual Mock Interview** practice sessions: collaborated with CORD & CDEM
5. **Virtual Residency Program Fair**: offered for FREE to EM programs as a gesture of acknowledgment and support during these unprecedented times
6. **Personal correspondence** (via email) with hundreds of medical students anxious to learn more about the virtual application process

**Pillar 4: Sustainability – Make EMRA the best organization it can be**

Given the importance of research and advocacy - our board and staff have recently strategized new ways for upholding the high quality of EMRA member-authored surveys.

As a nod to the future, EMRA has been working on a series of new initiatives that include (1.) improving Residency Match information on our website, (2.) generating a CV Project so that our members may receive valuable guidance for CV building, and (3.) redesigning our webpage to keep pace with innovation.

In July, alone, we received the following views:

- EMRA.org: Over 100,000 page views (3rd time in 4 months)
- EMResident.org: Over 70,000 page views (all-time record)
- EMRA What’s Up/messaging: 47% open rate (on average)

*Dr. Hughes and Dr. Burns worked together on offering effective virtual interviews for EM-bound medical students, residents, and fellows*
EMRA membership continues to grow compared to even from just one year ago. Just recently, we crested 20,000 members!

![Membership Data Table]

<table>
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<th>Segment</th>
<th>% Change</th>
<th>FY 19/20</th>
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<td>(19,039)</td>
<td>(18,244)</td>
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Memorandum

To: 2020 Council

From: Christopher S. Kang, MD, FACEP
Secretary-Treasurer

Date: September 24, 2020


This report of the FY 2019-20 encompasses the College’s activities from July 1, 2019 through June 30, 2020. Additional details can be found in the June 30, 2020 Financial Statements.

Membership
Total membership increased by 2,090 to a total of 41,435 (5.31%). Regular membership increased by 372 to 21,421 (1.7%). Candidate membership increased by 1,531 to 15,686 (10.8%). International membership increased by 349 to 1,656 (26.7%). Life membership decreased by 165 to 2,632 (-5.8%). Honorary membership increased by 3 to 40 (8.1%).

Revenue
Total operating revenue was $41,427,529. Membership dues accounted for $13,793,561 (33% of the total revenue). Meetings, sale of products, and royalties generated $19,391,501 (47% of the total revenue). Grants, investments, CEDR, and other contributions accounted for $7,893,466 (19% of total revenue). Accreditation revenue accounted for $349,000 (1% of total revenue).

Expenses
Total expenses were $40,069,317. Salaries and accrued vacations were $15,816,245 (39% of expenses). Facility and meal costs were $3,534,844 (9% of expenses). Consulting and legal fees were $6,386,659 (16% of expenses). Staff benefits were $4,422,361 (11% of expenses).

Net from Operations

<table>
<thead>
<tr>
<th>Operating Revenue</th>
<th>$41,427,529*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses</td>
<td>$40,069,317</td>
</tr>
<tr>
<td>Net</td>
<td>$1,358,212</td>
</tr>
</tbody>
</table>

Operating Revenue excludes $915,506 of Restricted Contributions revenue recognized in FY20 due to new Accounting Standards Codification (ASC) 606 Revenue from Contracts with Customers that was effective for ACEP’s FY2019-20 fiscal year. Restricted Revenue will be moved to Unrestricted Contributions as programs are completed in FY2021. Restricted Revenue is included in total revenue in the FY2020 ACEP Audit Report.

Liquid Reserve
Liquid reserve represents the amount of cash on hand minus the amount due to chapters and deferred revenue.
Cash equivalents $24,487,584  
Due to chapters $2,668,568  
Deferred revenue $10,810,355  
Liquid reserve $11,008,662 (25% of operating budget)

ACEP’s policy is to have at least 15% of the operating budget in liquid reserves. The FY 2019-20 operating budget was $43,784,373 and 15% would equal $6,567,655. Therefore, we have excess liquid reserves of $4,441,006. The liquid reserve calculation excludes Restricted Contribution revenue of $915,506.

**Contributions to Equity and Staff Bonuses**

The amount available is calculated from the net revenue after realized gains and the net budget is subtracted. This year that totaled $1,982,013; 40% was allocated to the staff bonus pool and 60% was allocated to member equity. The operating revenue over expense excludes the Strategic Project Initiatives Revenue (SPI) of $27,095, the SPI expense of $543,388, and in-kind depreciation expense of $52,282.

<table>
<thead>
<tr>
<th>Adjusted Operating Revenue Over Expense</th>
<th>$1,926,738</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Positive Realized Gains Variance</td>
<td>$96,310</td>
</tr>
<tr>
<td>Less Target Budgeted Net</td>
<td>($41,035)</td>
</tr>
<tr>
<td>Adjusted Excess</td>
<td>$1,982,013</td>
</tr>
</tbody>
</table>

**Equity**

Total member’s equity is $23,111,276, of which $22,195,769 is unrestricted and $915,507 is restricted. The total contribution to equity this year was $549,625, which is a $249,192 increase over last year.

<table>
<thead>
<tr>
<th>Assets</th>
<th>$45,395,395</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liabilities</td>
<td>$22,284,119</td>
</tr>
<tr>
<td>Equity</td>
<td>$23,111,276</td>
</tr>
</tbody>
</table>

Equity per regular member is a useful means to measure growth in equity. Equity per regular member this fiscal year was $1,078, a decrease of $7.

**Staff Bonuses**

$793,086 was distributed to the staff bonus award pool, an increase of $713,357 or 994% over last year. After taxes were paid (7.65%), the bonus award pool was $736,746.

**Investment Portfolio**

Additional details can be found in the June 30, 2020, Financial Statements. The current distribution is approximately 38% in equities, 43% in fixed income investments, and 0.5% in alternatives and 18.5% in cash. The fiscal year return was -2.53% as a result of the downturn in the market due to COVID-19. Since the fund was created in 2009, the average annual return has been 8.62%.

**2019-20 Activity Highlights**

**COVID Support Efforts**

In the challenge of COVID19 ACEP forged new relationships with consumer companies and called upon existing healthcare company partners to step up and support emergency physicians in unique and meaningful ways. We led the free rooms for emergency healthcare initiatives with Marriott, Hilton, and American Express resulting in over 950,000 free rooms being used as a safe quarantine space for frontline healthcare workers.
We worked with GrubHub to provide over $250,000 in free meals to emergency physicians. Through partnership with Amazon Business, we gave members unrestricted hospital level access to supplies that support their personal safety, while providing ACEP members $50,000 in free PPE and home sanitation supplies through grant support. We formed relationships with many companies such as McDonalds, Freshly, Sittercity, and Rover to provide generous COVID19 relief discounts and freebies in support services through our member discount platform. We secured $375,000 in unrestricted grant support, allowing us to enhance COVID19 education tools, build a robust physician wellness website hub and give physicians a safe place through an online portal to share their stories of the COVID19 pandemic. We worked to extend the reach of our COVID19 educational resources through a partnership with Evidence Care and Elemeno Health, allowing us to imbed crucial information into physician EHRs and point of care tools. We partnered with #GetUsPPE to streamline efforts in PPE donations.

We have been working on behalf of our members on every front:

- Clinical Alert: COVID-19 daily updates. ACEP’s online COVID-19 repository which serves as the single source for the latest COVID specific resources.
- Field Guide to COVID-19 Care in the ED. An online tool created to compile resources on the evaluation and treatment of COVID-19.
- Virtual Hill Day to update Congress on COVID-19. Pivoting from LAC, ACEP allowed members to connect with nearly 500 members providing updates to legislators from the front lines of the pandemic.
- Legislative and Regulatory outreach. ACEP’s DC team has doggedly tracked down definitions, terms and nuances of federal legislation and regulation and continues to call upon leaders and policy makers daily.
- COVID-19 discounts and support. ACEP secured free hotel rooms, discounted childcare, food delivery, and much more.
- Emotional Support 24/7. ACEP members have access to free stress and grief coaching or counseling by phone, text, or online chat. ACEP also launched an online wellness hub to provide resources, on demand.