COUNCIL MEETING

September 29-30, 2022

Hilton Union Square
Grand Ballroom
San Francisco, CA
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 reimburer.

• 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 a 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.
Meeting Conduct Policy

Background

The American College of Emergency Physicians (ACEP) is committed to providing a safe, productive and harassment-free environment at its Scientific Assemblies, educational meetings, conferences, and other ACEP-sponsored events. These events are designed to enable clinicians and researchers to convene for informational and educational sessions regarding the latest advances in treatment and care, and to promote learning, professional development, and networking opportunities. ACEP meetings also allow attendees to learn about and debate the latest scientific advances and to enjoy the company of professional colleagues in an environment of mutual respect. ACEP promotes equal opportunities and treatment for all participants. All participants are expected to treat others with respect and consideration, follow venue rules, and alert staff or security when they have knowledge of dangerous situations, violations of this Meeting Conduct Policy, or individuals in distress.

Prohibited Behavior

ACEP prohibits any form of harassment, sexual or otherwise, as set forth in its Non-Discrimination and Harassment Policy. Accordingly, some behaviors are specifically prohibited, whether directed at other attendees, ACEP staff, speakers, exhibitors, or event venue staff:

• Harassment or discrimination based on race, religion, gender, sexual orientation, gender identity, gender expression, disability, ethnicity, national origin, or other protected status.
• Sexual harassment or intimidation, including unwelcome sexual attention, stalking (physical or virtual), or unsolicited physical contact.
• Yelling at, threatening, or personally insulting speakers (verbally or physically).

Participants asked to stop engaging in hostile or harassing behavior are expected to comply immediately.

Application of Rules

These conduct rules apply to all attendees and participants at any ACEP-sponsored event, as well as ACEP-sponsored meeting social events (for example,
opening and closing parties at Scientific Assembly). All who register to participate, attend, speak at, or exhibit at an ACEP event agree to comply with this Policy.

Reporting Prohibited Behavior

Harassment or other violations of this Meeting Conduct Policy should be reported immediately to ACEP Meetings staff either in person, in writing by email at conduct@acep.org or other means of reporting. ACEP may involve event security and/or local law enforcement, as appropriate based on the specific circumstances. Event attendees and participants must also cooperate with any ACEP investigation into reports of a violation of this Meeting Conduct Policy by providing all relevant information requested by ACEP.

Potential Consequences

- ACEP reserves the right to remove any participant whose social attentions become unwelcome to another and who persists in such attentions after their unwelcome nature has been communicated.
- ACEP also reserves the right to remove any participant or attendee who appears inebriated and who engages in conduct that interferes with the ability of other attendees to participate in and enjoy the conference.
- ACEP may remove any individual from attendance or other participation in any ACEP-sponsored event, without prior warning or refund, if in its reasonable judgment, ACEP determines a violation of this Meeting Conduct Policy has occurred.
- If ACEP, in its reasonable judgment, determines that an individual has violated this Meeting Conduct Policy, ACEP may also prohibit the individual from attending or participating in future ACEP events.
- ACEP will also report on the outcome of any investigation to individuals who have reported a violation of this Meeting Conduct Policy.
2022 Council Meeting
September 29-30, 2022
Pre-Meeting Events Occur Wednesday Evening, September 28, 2022
Hilton San Francisco Union Square, Grand Ballroom B
San Francisco, CA

TIMED AGENDA

Thursday, September 29, 2022
Coffee, water, soft drinks available – Grand Ballroom A 7:30 am

1. Call to Order
   A. Meeting Dedication
   B. Pledge of Allegiance
   C. National Anthem
   Dr. Gray-Eurom 8:00 am

2. Introductions
   Dr. Gray-Eurom 8:10 am

3. Welcome from CA Chapter President
   Dr. Winston 8:12 am

4. Tellers, Credentials, & Election Committee
   A. Credentials Report
   B. Meeting Etiquette
   Dr. Kraus 8:14 am

5. Changes to the Agenda
   Dr. Gray-Eurom 8:16 am

6. Council Meeting Website Overview
   Mr. Joy 8:16 am

7. EMF Challenge
   Dr. Wilcox 8:21 am

8. NEMPAC Challenge
   Dr. Jacoby 8:23 am

9. Review and Acceptance of Minutes
   A. Council Meeting – October 23-24, 2021
   Dr. Gray-Eurom 8:25 am

10. Approval of Steering Committee Actions
    A. Steering Committee Meeting – January 24, 2022
    B. Steering Committee Meeting – May 1, 2022
    Dr. Gray-Eurom

11. Call for and Presentation of Emergency Resolutions
    Dr. Gray-Eurom

12. Steering Committee’s Report on Late Resolutions
    A. Reference Committee Assignments of Allowed Late Resolutions
    B. Disallowed Late Resolutions
    Dr. Gray-Eurom 8:30 am

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. Gray-Eurom 8:35 am

14. Candidate Opening Statements
    A. Board of Directors Candidates (2 minutes each)
    B. President-Elect Candidates (5 minutes each)
    Dr. Gray-Eurom 8:40 am

9:00 am
Thursday, September 29, 2022 (Continued)

15. Reference Committee Assignments          Dr. Gray-Eurom          9:15 am

**BREAK**  
9:20 am – 9:30 am

16. Reference Committee Hearings –  
   A – Governance & Membership – Franciscan A-B  
   B – Advocacy & Public Policy – Yosemite A-B  
   C – Emergency Medicine Practice – Franciscan C-D

**Boxed Lunches Available – Yosemite C**  
11:00 am – 12:30 pm

17. Reference Committee Executive Sessions  
   A – Franciscan A-B  
   B – Yosemite A-B  
   C – Franciscan C-D

**BREAK – Return to main Council meeting room – Grand Ballroom B**  
12:30 pm – 12:45 pm

18. Town Hall Meeting – Grand Ballroom B  
   Dr. Costello  
   A. Strange Changes: Practice Innovations, Payment Impacts, and Predicting the Future

19. Candidate Forum for the President-Elect Candidates – Grand Ballroom B  
   2:00 pm – 2:30 pm

**BREAK – Return to Reference Committee meeting rooms**  
2:30 pm – 2:45 pm
   Franciscan A-B, Yosemite A-B, Franciscan C-D

20. Candidate Forum for Board of Directors Candidates  
   Candidates rotate through Reference Committee meeting rooms.

**BREAK – Return to main Council meeting room – Grand Ballroom B**  
4:30 pm – 4:45 pm

21. Speaker’s Report  
   Dr. Gray-Eurom  
   4:45 pm

22. In Memoriam  
   Dr. Gray-Eurom  
   5:00 pm
   A. Reading and Presentation of Memorial Resolutions
   Dr. Costello
   *Adopt by observing a moment of silence.*

23. ABEM Report  
   Dr. Keim  
   5:15 pm

24. Secretary-Treasurer’s Report  
   Dr. Goodloe  
   5:25 pm

25. EMRA Report  
   Dr. Cai  
   5:30 pm

26. EMF Video Report  
   5:35 pm

27. NEMPAC Video Report  
   5:40 pm

28. President’s Address  
   Dr. Schmitz  
   5:45 pm

**RECESS**  
6:05 pm

*Candidate Reception ● 6:15 pm – 7:15 pm ● Imperial Ballroom A*
Friday, September 30, 2022

Coffee, water, soft drinks available – Grand Ballroom A

1. Call to Order Dr. Gray-Eurom 8:00 am
2. Tellers, Credentials, & Elections Committee Report Dr. Kraus 8:00 am
3. Electronic Voting
   A. Electronic Voting Testing Dr. Kraus 8:05 am
   B. Demographic Data Collection
4. Executive Directors Report Ms. Sedory 8:30 am
5. Submitting Amendments Electronically Dr. Gray-Eurom 8:50 am
6. Reference Committee Reports
   A. Reference Committee ___
   B. Reference Committee ___ 8:55 am
7. Awards Luncheon – Continental Ballroom 4 12:00 pm
   A. Welcome Dr. Gray-Eurom 12:45 pm
      1. Recognition of Past Speakers and Past Presidents
      2. Recognition of Chapter Executives
   B. ACEP Awards Announcements Dr. Schmitz 12:55 pm
   C. Reading and Presentation of Commendation Resolutions Dr. Gray-Eurom/Dr. Costello
      Adopt by acclamation.
   D. Council Award Presentations Dr. Gray-Eurom/Dr. Costello
      1. Council Service Milestone Awards – 5, 10, 15, 20, 25, 30, 35+ Year Councillors
      2. Council Teamwork Award
      3. Council Horizon Award
      4. Council Champion in Diversity & Inclusion Award
      5. Council Curmudgeon Award
      6. Council Meritorious Service Award

Luncheon Adjourns – Return to main Council meeting room – Grand Ballroom B 1:30 pm

8. Tellers, Credentials, & Elections Committee Report Dr. Kraus 1:40 pm
9. Reference Committee Reports Continue
   C. Reference Committee ___ 1:45 pm
10. President-Elect’s Address Dr. Kang 4:45 pm
11. Installation of President Dr. Schmitz/Dr. Kang 5:05 pm
12. Tellers, Credentials, & Elections Committee Report Dr. Kraus 5:10 pm
13. Elections
   A. Board of Directors Dr. Kraus 5:10 pm
   B. President-Elect
14. Announcements Dr. Gray-Eurom 5:40 pm

ADJOURN 5:45 pm

Next Annual Council Meeting ● October 7-8, 2023 ● Philadelphia, PA
2022 Council Meeting

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<td>• William B. Felegi, DO, FACEP</td>
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<td>• Jeffrey M. Goodloe, MD, FACEP</td>
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<td>• Gabor D. Kelen, MD, FACEP</td>
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<td>• Jeffrey F. Linzer, Sr., MD, FACEP</td>
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<td>• Kristin B. McCabe-Kline, MD, FACEP</td>
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<td>• Henry Z. Pitzele, MD, FACEP</td>
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<td>• Ryan A. Stanton, MD, FACEP</td>
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<td>Frisco, TX</td>
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<td>Orange Park, FL</td>
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<td>New Orleans, LA</td>
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<td>Palm Coast, FL</td>
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<td>Simpsonville, SC</td>
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<td>Bing Pao, MD, MD, FACEP</td>
<td>Michael Ruzek, DO, FACEP</td>
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<th>Ashley Tarchione, MD</th>
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<tr>
<td>Commerce Township, MI</td>
<td>(EMRA REP to Steering Committee)</td>
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Procedures for Councillor and Alternate Seating

Councillor Credentialing

All certified councillors and alternates must be officially credentialed at the annual meeting.

1. A master list of all certified councillors and alternates will be maintained at councillor credentialing.

2. If a councillor is not certified on the master list, the following steps will be followed:

   a. Only the component body (chapter president or executive staff, section chair or staff, EMRA president or staff, AACEM president or staff, CORD president or staff, SAEM president or staff, ACOEP president or staff), also known as sponsoring body, can certify a member to be credentialed as a councillor. The component body must also identify whom the new councillor will replace. No councillor will be certified without final confirmation from the component body.

   b. If the chapter president, section chair, EMRA president, AACEM president, CORD president, SAEM president, ACOEP president, or staff executive of the component body is not available, seating will be denied. Only a certified alternate councillor may be seated on the Council floor.

   c. If no certified councillor or alternate of a component body is present at the meeting, a member of that sponsoring 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.

As stated in the Bylaws, Article VIII – Council, 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 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.”

Only councillors or alternates certified by the component body may be seated on the Council floor. Only the appropriate individual from a component body may authorize seating of their non-certified councillors. All of the College’s past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor. A past president, past Council speaker, or past Chair is only permitted to vote when serving as a certified councillor.

If the appropriate individual from the component body is not present to authorize seating of a non-certified councillor or alternate, then the request for seating must be made directly to the chair of the Tellers, Credentials, & Elections Committee.
Seating of Past Presidents, Past Council Speakers, and Past Chairs of the Board

1. Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor.

2. Each past president, Council speaker, and past Chairs of the Board sitting with their delegation should be credentialed and are required to wear the appropriate identification giving them access to the Council floor.

3. Past leaders have the full privilege of the floor, including the proposal of motions and amendments, except that they may not vote unless serving as a regular voting councillor or alternate.

Voting Cards and Electronic Voting

1. Each credentialed councillor will receive a voting card with their name and component body.

2. Voting will be conducted by either voting card, online electronic voting, keypads (if applicable), or voice votes at the discretion of the Speaker.

3. The Tellers, Credentials, & Elections Committee will periodically check the Council delegations to ensure that only the authorized voting cards and keypads (if applicable) are used.

Seating Exchange Between Credentialed Councillors and Alternates

1. No exchange between a councillor and alternate is permitted during the Council meeting while a motion is on the floor of the Council. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

2. To make an exchange, the councillor should leave their voting card and keypad on the table. The alternate may then proceed to take the seat of the designated councillor, unless debate is occurring on the Council floor. No exchange is permitted until final action is taken on a particular issue.

3. If a councillor is leaving the floor of the Council, and there will not be an alternate replacement, the councillor must return the voting card and keypad (if applicable) to staff at councillor credentialing. Once the councillor returns, the voting card and keypad (if applicable) will be returned to the councillor. If debate is occurring on the Council floor, the councillor should wait until final action has been taken on a particular issue before returning to the seat on the Council floor.
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
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</thead>
<tbody>
<tr>
<td>Alternate Councillors</td>
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<td>Reserved Chapter Staff</td>
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<tr>
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<td>Alternate Councillors</td>
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<tr>
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<tr>
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Past Presidents, Past Council Speakers, and Past Chairs of the Board Seating

Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor (see seating chart). The 2022 councillor seating chart includes the following:

<table>
<thead>
<tr>
<th>State</th>
<th>Membership Details</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>9 councillors + 2 past leaders attending not serving as councillors = 11 seats</td>
</tr>
<tr>
<td>California</td>
<td>33 councillors + 6 past leaders attending not serving as councillors = 39 seats</td>
</tr>
<tr>
<td>Colorado</td>
<td>7 councillors + 2 past leader attending not serving as a councillor = 9 seats</td>
</tr>
<tr>
<td>Connecticut</td>
<td>5 councillors + 2 past leader attending not serving as a councillor = 7 seats</td>
</tr>
<tr>
<td>Florida</td>
<td>20 councillors + 2 past leader attending not serving as a councillor = 22 seats</td>
</tr>
<tr>
<td>Georgia</td>
<td>9 councillors + 1 past leader attending not serving as councillor = 10 seats</td>
</tr>
<tr>
<td>Government Services</td>
<td>11 councillors + 1 past leader attending not serving as councillor = 12 seats</td>
</tr>
<tr>
<td>Indiana</td>
<td>6 councillors + 1 past leader attending not serving as councillor = 7 seats</td>
</tr>
<tr>
<td>Louisiana</td>
<td>5 councillors + 1 past leader attending not serving as councillor = 6 seats</td>
</tr>
<tr>
<td>Maryland</td>
<td>7 councillors + 1 past leader attending not serving as councillor = 8 seats</td>
</tr>
<tr>
<td>Michigan</td>
<td>20 councillors + 3 past leaders attending not serving as councillors = 23 seats</td>
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<tr>
<td>New Jersey</td>
<td>10 councillors +1 past leader attending and not serving as councilor = 11 seats</td>
</tr>
<tr>
<td>New Mexico</td>
<td>3 councillors + 2 past leader attending and not serving as councillor = 5 seats</td>
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<tr>
<td>New York</td>
<td>30 councillors + 1 past leader attending not serving as a councillor = 31 seats</td>
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<tr>
<td>North Carolina</td>
<td>11 councillors + 1 past leaders attending not serving as councillors = 12 seats</td>
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<tr>
<td>Ohio</td>
<td>16 councillors + 1 past leaders attending not serving as councillors = 17 seats</td>
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<tr>
<td>Texas</td>
<td>21 councillors + 2 past leaders attending not serving as a councillor = 23 seats</td>
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<tr>
<td>Virginia</td>
<td>10 councillors + 2 past leaders not serving as a councillor = 12 seats</td>
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<tr>
<td>Washington</td>
<td>8 councillors + 2 past leaders attending not serving as a councillor = 10 seats</td>
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<td>Chapter/Section</td>
<td>Position</td>
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<tr>
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<td>ALASKA CHAPTER</td>
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</tbody>
</table>
2022 COUNCILLORS & ALTERNATE COUNCILLORS

Councillor  
Peter Erik Sokolove, MD, FACEP
Councillor  
Susanne J Spano, MD, FACEP, FACEP
Councillor  
Katherine Laurinda Staats, MD, FACEP
Councillor  
Lawrence M Stock, MD, FACEP
Councillor  
Thomas Jerome Sugarman, MD, FACEP
Councillor  
Gary William Tamkin, MD, FACEP
Councillor  
David Terca, MD, FACEP
Councillor  
Patrick Um, MD, FACEP
Councillor  
Lori D Winston, MD, FACEP
Councillor  
Anna L Yap, MD
Councillor  
Randall J Young, MD, FACEP
Alternate  
Harrison Alter, MD, FACEP
Alternate  
Reb JH Close, MD, FACEP
Alternate  
Fred Dennis, MD, MBA, FACEP
Alternate  
William E Franklin, DO, MBA, FACEP
Alternate  
Douglas Everett Gibson, MD, FACEP
Alternate  
Leslie Mukau, MD, FACEP
Alternate  
Susan E Ondak, MD
Alternate  
Mitesh B. Patel, MD, FACEP
Alternate  
Hunter M Pattison, MD
Alternate  
Alex Schmalz, MD
Alternate  
Melanie T Stanzer, DO, FACEP
Alternate  
Camilla Sulak, MD
Alternate  
Andrea M Wagner, MD, FACEP
Alternate  
Bradley Alan Zlotnick, MD, FACEP

COLORADO CHAPTER  
Councillor  
Jasmeet Singh Dhaliwal, MD, MPH, MBA
Councillor  
Ramnik S Dhaliwal, MD, JD
Councillor  
Laura Edgerley-Gibb, MD, FACEP
Councillor  
Anna Engeln, MD, FACEP
Councillor  
Douglas M Hill, DO, FACEP
Councillor  
Rebecca L Kornas, MD, FACEP
Councillor  
Carla Elizabeth Murphy, DO, FACEP
Alternate  
Rachelle M Klammer, MD, FACEP
Alternate  
Bradley D Shy, MD, FACEP
Alternate  
James D Thompson, MD, FACEP

CONNECTICUT CHAPTER  
Councillor  
Thomas A Brunell, MD, FACEP
Councillor  
Michael L Carius, MD, FACEP
Councillor  
Daniel Freess, MD, FACEP
Councillor  
Elizabeth Schiller, MD, FACEP
Councillor  
David E Wilcox, MD, FACEP

CORD  
Councillor  
Jason Cass Wagner, MD, FACEP

DELAWARE CHAPTER  
Councillor  
Emily M Granitto, MD, FACEP
Councillor  
Kathryn Groner, MD, FACEP
Alternate  
John T Powell, MD, MHCDS, FACEP
### DISTRICT OF COLUMBIA CHAPTER

**Councillor**
- Christopher T Clifford, MD
- James D Maloy, MD, MPH
- Rita A Manfredi-Shutler, MD, FACEP

### EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

**Councillor**
- Angela Cai, MD, MBA
- Nicholas Paul Cozzi, MD
- Amanda Kay Irish, MD, MPH
- Breanne M Jaqua, DO, MPH
- Maggie Moran, MD
- Abbey M Smiley, MD
- Sophia Spadafore, MD
- Ashley Tarchione, MD
- Jacob Mark Altholz, MD
- Blake Denley, MD
- Evelyn Huang, MD
- Erin R Karl, MD
- Kenneth Taeyoung Kim, MD
- Yevgeniy Maksimenko, MD
- Vishnu R Muppala, MD, MPH

### FLORIDA CHAPTER

**Councillor**
- Andrew I Bern, MD, FACEP
- Damian E Caraballo, MD, FACEP
- Jordan GR Celeste, MD, FACEP
- Andrzej T Dmowski, MD, FACEP
- Vidor E Friedman, MD, FACEP
- Shayne M Gue, MD, FACEP
- Saundra A Jackson, MD, FACEP
- Steven B Kailes, MD, FACEP
- Amy S Kelley, MD, FACEP
- Dakota R Lane, MD
- Ryan T McKenna, DO, FACEP
- Ashley Norse, MD, FACEP
- David John Orban, MD, FACEP
- Sanjay Pattani, MD, FACEP
- Tracy G Sanson, MD, FACEP
- Todd L Slesinger, MD, FACEP
- Zachary C Terwilliger, MD
- Stephen C Viel, MD, MBA, FACEP
- L Kendall Webb, MD, FACEP
- Cristina Zeretzke, MD, FACEP
- Danvanilla Q Barnes, MD
- Edward A Descallar, MD, FACEP
- Andrew Martin, MD
- Caroline Marie Molins, MD, FACEP
- David Charles Seaberg, MD, CPE, FACEP
- Frank C Smeeks, MD, FACEP

### GEORGIA CHAPTER

**Councillor**
- Matthew R Astin, MD, FACEP
2022 COUNCILLORS & ALTERNATE COUNCILLORS

Councillor 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 DW "Chip" Pettigrew, III, MD, FACEP
Councillor James L Smith, Jr, MD, FACEP
Councillor Johnny L Sy, DO, FACEP
Councillor Matthew J Watson, MD, FACEP
Alternate Talitha A Ashby, MD
Alternate Shamie Das, MD, MBA, MPH, FACEP
Alternate Mark A Griffiths, MD, FACEP
Alternate Brendan Hawthorn, MD, FACEP
Alternate Benjamin Lefkove, MD, FACEP
Alternate Matthew Rudy, MD, FACEP
Alternate Carmen D. Sulton, MD, FACEP
Alternate Michelle P Wan, MD
Alternate John L Wood, MD, FACEP

GOVT SERVICES CHAPTER
Councillor Joshua S da Silva, DO
Councillor Christine A DeForest, DO, FACEP
Councillor Roderick Fontenette, MD, FACEP
Councillor Katrina N Landa, MD, FACEP
Councillor Micaela A LaRose, MD
Councillor Linda L Lawrence, MD, CPE, FACEP
Councillor David S McClellan, MD, FACEP
Councillor Torree M McGowan, MD, FACEP
Councillor Justine K Stremick, MD
Councillor Sean Stuart, DO
Councillor Danielle Wickman, MD
Alternate Joshua Stierwalt, MD

HAWAII CHAPTER
Councillor John M Gallagher, MD, FACEP
Councillor Lisa Jacobson, MD, FACEP

IDAHO CHAPTER
Councillor Sierra Pearl Debenham, MD
Councillor Ken John Gramyk, MD, FACEP
Alternate Nicholas J Kroll, MD, FACEP

ILLINOIS CHAPTER
Councillor Amit D Arwindekar, MD, FACEP
Councillor Christine Babcock, MD, FACEP
Councillor E Bradshaw Bunney, MD, FACEP
Councillor Cai Glushak, MD, FACEP
Councillor John W Hafner, MD, FACEP
Councillor Adnan Hussain, MD, FACEP
Councillor Janet Lin, MD, FACEP
Councillor Howard K Mell, MD, MPH, CPE, FACEP
Councillor Henry Pitzele, MD, FACEP
Councillor Yanina Purim-Shem-Tov, MD, MS, FACEP
Councillor Willard W Sharp, MD, FACEP
## 2022 COUNCILLORS & ALTERNATE COUNCILLORS

Councillor | Lauren M Smith, MD  
Councillor | Deborah E Weber, MD, FACEP  
Alternate | Halleh Akbarnia, MD, FACEP  
Alternate | Shu Boung Chan, MD, FACEP  
Alternate | Kristen M Donaldson, MD, MPH, FACEP  
Alternate | Elisabeth M Giblin, MD  
Alternate | George Z Hevesy, MD, FACEP  
Alternate | Jason A Kegg, MD, FACEP  
Alternate | Napoleon B Knight, Jr, MD, FACEP  
Alternate | Pavitra Kotini-Shah, MD  
Alternate | Julie A Lewis, MD  
Alternate | Christopher M McDowell, MD, FACEP  
Alternate | Laura D Napier, MD, FACEP

### INDIANA CHAPTER

Councillor | Michael D Bishop, MD, FACEP(E)  
Councillor | Timothy A Burrell, MD, MBA, FACEP  
Councillor | Daniel W Elliott, MD, FACEP  
Councillor | Kyle D English, MD, FACEP  
Councillor | Emily M Fitz, MD, FACEP  
Councillor | Lindsay Zimmerman, MD, FACEP  
Alternate | Sara Ann Brown, MD, FACEP  
Alternate | Daniel Slubowski, MD  
Alternate | Lauren Stanley, MD, FACEP

### IOWA CHAPTER

Councillor | Ryan M Dowden, MD, FACEP  
Councillor | Stacey Marie Marlow, MD, JD, FACEP  
Councillor | Rachael Sokol, DO, FACEP  
Alternate | Thomas E Benzoni, DO, FACEP  
Alternate | Hans Roberts House, MD, FACEP  
Alternate | Nicholas Holden Kluesner, MD, FACEP

### KANSAS CHAPTER

Councillor | Howard Chang, MD, FACEP  
Councillor | John F McMaster, MD, FACEP  
Councillor | Jeffrey G Norvell, MD, MBA, RDMS, FACEP

### KENTUCKY CHAPTER

Councillor | David Wesley Brewer, MD, FACEP  
Councillor | Christopher W Pergrem, MD, FACEP  
Councillor | Melissa Platt, MD, FACEP  
Councillor | Hugh W Shoff, MD, FACEP  
Alternate | Steven Joseph Stack, MD, MBA, FACEP

### LOUISIANA CHAPTER

Councillor | James B Aiken, MD, FACEP  
Councillor | Deborah D Fletcher, MD, FACEP  
Councillor | Jamie Hoitien Do Kuo, MD  
Councillor | Phillip Luke LeBas, MD, FACEP  
Councillor | Michael D Smith, MD MBA CPE, FACEP  
Alternate | Julius (Jay) A Kaplan, MD, FACEP  
Alternate | Randy L Pilgrim, MD, FACEP
## 2022 COUNCILLORS & ALTERNATE COUNCILLORS

### MAINE CHAPTER
- **Councillor** Thomas C Dancoes, DO, FACEP
- **Councillor** Garreth C Debiegun, MD, FACEP
- **Councillor** Charles F Pattavina, MD, FACEP
- **Alternate** Nathan G Donaldson, DO, FACEP
- **Alternate** Brandon E Giberson, DO
- **Alternate** James B Mullen, III, MD, FACEP
- **Alternate** Laurel Parker, MD, FACEP

### MARYLAND CHAPTER
- **Councillor** Michael C Bond, MD, FACEP
- **Councillor** Sydney E DeAngelis, MD, FACEP
- **Councillor** Karen Dixon, MD, FACEP
- **Councillor** Jonathan Lewis Hansen, MD, FACEP
- **Councillor** Kathleen D Keeffe, MD, FACEP
- **Councillor** Edana Denise Mann, MD, FACEP
- **Councillor** Richard Gentry Wilkerson, MD, FACEP
- **Alternate** Arjun S Chanmugam, MD, FACEP
- **Alternate** Timothy P Chizmar, MD, FACEP
- **Alternate** Kyle Fischer, MD, MPH, FACEP
- **Alternate** Kerry Forrestal, MD, FACEP
- **Alternate** Gregory N Jasani, MD

### MASSACHUSETTS CHAPTER
- **Councillor** Brien Alfred Barnewolt, MD, FACEP
- **Councillor** Stephen K Epstein, MD, MPP, FACEP
- **Councillor** Kathleen Kerrigan, MD, FACEP
- **Councillor** Matthew B Mostofi, DO, FACEP
- **Councillor** Mark D Pearlmutter, MD, FACEP
- **Councillor** Jesse Rideout, MD, FACEP
- **Councillor** Michele Schroeder, MD
- **Councillor** James Joseph Sullivan, Jr, MD
- **Councillor** Brian Sutton, MD, FACEP
- **Councillor** Joseph C Tennyson, MD, FACEP
- **Alternate** Alice Bukhman, MD
- **Alternate** Deesha Sarma, MD

### MICHIGAN CHAPTER
- **Councillor** Michael J Baker, MD, FACEP
- **Councillor** Abigail Brackney, MD, FACEP
- **Councillor** Sara S Chakel, MD, FACEP
- **Councillor** Nicholas Dyc, MD, FACEP
- **Councillor** Michael W Fill, DO, FACEP
- **Councillor** Gregory Gafni-Pappas, DO, FACEP
- **Councillor** Michael Vincent Gratson, MD, FACEP
- **Councillor** Robert T Malinowski, MD, FACEP
- **Councillor** Therese G Mead, DO, FACEP
- **Councillor** Emily M Mills, MD, FACEP
- **Councillor** James C Mitchiner, MD, MPH, FACEP
- **Councillor** Diana Nordlund, DO, JD, FACEP
- **Councillor** David T Overton, MD, FACEP
- **Councillor** Luke Christopher Sasaki, MD, FACEP
- **Councillor** Jennifer B Stevenson, DO, FACEP
# 2022 Councillors & Alternate Councillors

<table>
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<tr>
<th>MINNESOTA CHAPTER</th>
<th>Councillor</th>
<th>Andrew Taylor, DO, FACEP</th>
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<td>Councillor</td>
<td>Larisa MayTraill, MD, FACEP</td>
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<td>Kathleen Cowling, DO, MS, MBA, FACEP</td>
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<td>Alternate</td>
<td>Trevor Eckenswiller, DO</td>
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<td>Alternate</td>
<td>Antony P Hsu, MD, FACEP</td>
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<td>Rose Tian Kuo, MD</td>
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Councillor
Joseph P Tagliaferro, III, DO, FACEP
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**Oregon Chapter**

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**PUERTO RICO CHAPTER**

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**RHODE ISLAND CHAPTER**

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**TENNESSEE CHAPTER**

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**TEXAS CHAPTER**

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<td>Karolyn K Moody, DO, MPH, FACEP</td>
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2022 COUNCILLORS & ALTERNATE COUNCILLORS

Alternate Karina Sanchez, MD
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.
# Councillor Handbook

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I. COMPOSITION OF THE COUNCIL

Introduction

This handbook is updated annually to help councillors understand how they can best be prepared to participate in the annual meeting. The councillor who knows how the Council functions, who takes the time to understand issues affecting the College and the specialty, and who makes a point of talking with individual candidates for office about their objectives is a model representative.

What is the Council?

The Council is a body composed of emergency physicians who directly represent the 53 chartered chapters of the American College of Emergency Physicians, the Emergency Medicine Residents’ Association (EMRA), the Association of Academic Chairs in Emergency Medicine (AACEM), the American College of Osteopathic Emergency Physicians (ACOEP), the Council of Emergency Medicine Residency Directors (CORD), the Society for Academic Emergency Medicine (SAEM), and the College’s sections of membership. The Council meets annually, just prior to the ACEP annual meeting. The Council may meet more often, but special meetings must be duly called as specified in the ACEP Bylaws.

The number of councillors who represent a chapter in a given year is determined by the number of ACEP members in that chapter on December 31 each year. Each chapter is represented by at least one councillor; an additional councillor is allowed for each 100 members in the chapter. EMRA is allocated eight voting councillors; AACEM, ACOEP, CORD, and SAEM, are each allocated one voting councillor; and each section of membership is allocated one voting councillor.

What Does the Council Do?

The Council elects the Board of Directors, Council officers, and the president-elect of the College. The Council shares responsibility with the Board of Directors for initiating policy, and councillors shape the strategic plan of the College by providing comments on behalf of the constituencies they represent. The Council also provides a participatory environment where policies already established or under consideration by the Board of Directors can be debated.

So that the Board of Directors can manage change for the good of the membership, the specialty, and the public, the Council serves as a sounding board and communication network. Councillors are expected to be aware of environmental changes, see association goals as essential to the continued vitality of the specialty, and understand the rationale behind decisions made by the Board of Directors.

The Council officers (speaker and vice speaker) chair the annual meeting and participate in all meetings of the Board of Directors as representatives of the Council.

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

Councillors are certified by their component body (chapter, EMRA, AACEM, ACOEP, CORD, SAEM, or section) no later than 60 days before the annual meeting. Component bodies are also referred to as sponsoring bodies in the Bylaws.

Comprehensive materials are distributed to councillors at least 30 days before the annual meeting. These materials contain the meeting agenda, current strategic plan, minutes of the previous annual meeting, and annual committee reports. All resolutions submitted by the deadline are also provided with background information and cost implications developed by staff.

Councillors are expected to review the materials carefully and to meet with the leadership of the component bodies they represent to discuss issues that will be addressed at the annual meeting. The component body leadership may want to instruct the councillor on how to vote on various resolutions, but the councillor should be open to receiving additional information at the meeting and then make the best decision on behalf of the College.
How Does the Council Conduct its Business?

Regular business or business casual attire is appropriate for the Council meeting.

Most of the work of the Council is conducted in Reference Committee hearings. The hearings provide a system for gathering information and expediting business. Each resolution submitted to the Council is referred to a Reference Committee, which holds a hearing to gather information from all interested councillors and other College members. The Reference Committees then recommend a specific course of action for the Council on each resolution. Reference Committees are composed of councillors selected by the Council officers. Guidelines for reference committee hearings are provided on pages 5-7. All Reference Committee meetings are open to the membership, except for the executive session. When the executive session is called, the chair will inform the audience of the time frame of the session.

As previously stated, the Council elects the Board of Directors, Council officers, and the president-elect; initiates policy; and shapes the strategic plan of the College. The Council also identifies issues for study and evaluation by the Board and the committees of the Board. There is usually a tremendous amount of business to be conducted during the two-day meeting and several tools are used to facilitate that business.

The Bylaws of the College specifies basic procedures that must be followed by the Council. These procedures include how nominations and elections must be conducted, how resolutions must be submitted and handled, and how the Bylaws may be amended. The most current Bylaws are provided with the Council meeting materials.

Standing Rules for the conduct of the meeting change little, if any, from one year to the next and cover general procedures such as how debate, credentialing, and elections will be handled. The Standing Rules are amendable only by resolution. The most current Standing Rules are provided with the Council meeting materials.

Except when superseded by the Bylaws or the Standing Rules, the rules in The Standard Code of Parliamentary Procedure 4th edition (also known as Sturgis) govern the Council in all applicable cases. A chart describing parliamentary rules is provided on pages 16-17.

A councillor is not expected to memorize the Bylaws, Standing Rules, or Sturgis; however, a quick review of these documents will give the first-time councillor a basic understanding of how business is conducted on the floor of the Council. The most important rule that a councillor should remember is that a “point of personal privilege” is always in order. If a councillor does not understand what is happening, the point of personal privilege should be used to request clarification. An orientation session is always held the night before the Council meeting and the basics of parliamentary procedure are reviewed.

What is a Resolution?

New policies and changes to existing policy are recommended to the Council in the form of resolutions. Resolutions usually pertain to issues affecting the practice of emergency medicine, advocacy and regulatory issues, Bylaws amendments, Council Standing Rules amendments, and College Manual amendments.

“Resolutions” are considered formal motions that if adopted will become official Council policy and will apply not only to the present meeting but also to future business of the Council.

Resolutions must be submitted in writing by at least two members on or before 90-days prior to the annual Council meeting. These resolutions are known as “regular resolutions.” Resolutions may also be submitted by chapters, sections, committees, or the Board of Directors. Resolutions sponsored by a chapter or section must be accompanied by an endorsement of the sponsoring body. Resolutions sponsored by national ACEP committees must first be approved by the Board of Directors for submission to the Council. Upon approval by the Board, the resolution will then include the endorsement of the committee and the Board. Regular resolutions will be referred to an appropriate Reference Committee for consideration.
Amendments to Resolutions

All motions for substantial amendments to resolutions must be submitted to the speaker in writing prior to being introduced verbally. When appropriate, the amendment will be projected on a screen for viewing by the Council.

Late Resolutions

Resolutions submitted after the 90-day submission deadline, but not less than 24 hours prior to the beginning of the annual Council meeting, are known as “late resolutions.” Late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual Council meeting. The Steering Committee is empowered to decide whether a late submission is justified. Late submission is justified when events giving rise to the resolution occur after the filing deadline for resolutions. If a majority of the voting members of the Steering Committee vote to waive the filing and transmittal requirements, the resolution is presented to the Council at its opening session and assigned to a Reference Committee. When the Steering Committee votes unfavorably, the reason for such action shall be reported to the Council at its opening session. Disallowed late resolutions are not considered by the Council unless the Council, by a majority vote of councillors present and voting, overrides the Steering Committee’s recommendation.

Emergency Resolutions

Resolutions submitted less than 24 hours prior to, or after the beginning of the annual Council meeting, are known as “emergency resolutions.” Emergency resolutions are limited to substantive issues that could not have been considered by the Steering Committee prior to the Council meeting because of their acute nature, or resolutions of commendation that become appropriate during the course of the Council meeting. Emergency resolutions must be submitted in writing to the speaker who will then present the resolution to the Council for its consideration. The originator of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the councillors to determine the importance of the resolution. Without debate, a 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, upon acceptance by the Council, it will be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution will be debated on the floor of the Council at a time chosen by the speaker.

What if I Have Questions About the Council?

Questions about the Council should be directed to national ACEP staff in the Office of the Executive Director. They work closely with the Council officers in planning and executing the annual meeting and helping members to develop resolutions for consideration by the Council.

How are Nominations and Elections Conducted?

Each year the Council elects four members to the Board of Directors to terms of three years. The Council speaker and vice-speaker, who serve two-year terms, are elected by the Council every other year. The Council also elects the president-elect of the College annually for a one-year term.

Nomination procedures and the composition of the nominating committees are specified in the Bylaws. Councillors may submit nominations from the floor at the annual meeting, but nominations are closed on the first day of the annual meeting. Closing the nominations assures that all candidates will have the opportunity to share their viewpoints during an open forum with councillors. The elections are the last item of business on the second day of the Council meeting. The Tellers, Credentials, & Elections Committee, which is appointed by the Council officers, conducts the elections. A majority of votes cast is required for election. Election procedures are described in the Council Standing Rules and the Bylaws.

With the exception of the president-elect, the Board of Directors elects its own officers (chair, vice president, and secretary-treasurer) each year during the first Board meeting after the Council meeting.

Each year a Candidate Forum is held. This year the Candidate Forum for the president-elect candidates will be held from 2:00 – 2:30 pm in the main Council meeting room, following the Town Hall meeting. The Candidate
Forum for the Council officer candidates and Board of Directors candidates will be held from 2:45 pm – 4:30 pm in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee will moderate each session with the candidates. Candidates will answer questions and declare their views on issues facing emergency medicine. An informal reception will be held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and the reception that follows.

The Candidate Campaign Rules prohibit the scheduling of candidate receptions by any component body during the annual Council meeting. This position was adopted by the Council and the Board of Directors.

What is the Steering Committee?

The Council officers appoint the Steering Committee. The Steering Committee conducts the business of the Council between annual meetings. Attempts are made to limit service on the committee to two years, with about half of the committee membership replaced each year. Care is taken to assure adequate geographic representation on the committee.

The Steering Committee may identify resolution topics to stimulate discussion of key issues by the Council, plans the Council agenda, and advises and assists the officers with meeting logistics. The Steering Committee has the authority, rarely invoked, to take positions on behalf of the Council subject to ratification by the Council at the next annual meeting.

2022 Council Steering Committee

Kelly Gray-Eurom, MD, MMM, FACEP, Chair
Melissa W. Costello, MD, FACEP, Vice Chair
Eileen F. Baker, MD, PhD, FACEP (OH)
Lisa M. Bundy, MD, FACEP (AL)
Carrie de Moor, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
William D. Falco, MD, MS, FACEP (WI)
Carlton Heine, MD, FACEP (WA)
Steven B. Kailes, MD, FACEP (FL)
Phillip Luke LeBas, MD, FACEP (LA)
Kristin McCabe-Kline, MD, FACEP (FL)
Christina Millhouse, MD, FACEP (SC)
Bing Pao, MD, FACEP (CA)
Michael Ruzek, DO, FACEP (NJ)
Gary Starr, MD, MBA, FACEP (MN)
Thomas J. Sugarman, MD, FACEP (CA)
Larisa M. Traill, MD, FACEP (MI)

III. COUNCIL REFERENCE COMMITTEES

The duty of a Reference Committee is to hold hearings, deliberate on various resolutions and proposals, and recommend a particular course of action on each to the Council.

It may not be possible for each councillor to be fully informed or to have an opinion on every resolution. Therefore, the Reference Committee is designated to investigate and deliberate on the issues. By dividing the proposals between several Reference Committees, the Council can transact more business than if the entire Council had to discuss all of the pros and cons of each resolution.

Members of the Reference Committees are appointed by the speaker. They are chosen on the basis of their activities in the College and their expertise on particular issues. They are not chosen because of their stand on particular issues.

Asynchronous Testimony

Resolutions that have been submitted by the deadline and assigned to a Reference Committee will be available for asynchronous testimony on the ACEP website not less than 30 days prior to the Council meeting. It is anticipated asynchronous testimony will be available on August 29, 2022, and it is open to all members of the College. Asynchronous testimony will close at 12:00 noon on Monday, September 19, 2022.

Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this asynchronous testimony, all members acknowledge and agree to abide by ACEP’s Meeting Conduct Policy.
Please include the following information when commenting:

1. Whether you are commenting on behalf of yourself or your component body (i.e., chapter, section, AACEM, CORD, EMRA, or SAEM).
2. Whether you are commenting in support of the resolution, opposed to the resolution, or suggesting an amendment.
3. Any additional information to support your position.

Comments should be concise so as to not exceed an equivalent of 2 minutes of oral testimony. Comments from the asynchronous testimony will be used to develop preliminary Reference Committee reports.

The asynchronous platform is the only method to introduce testimony until the live Reference Committee meetings in San Francisco. Opinions posted elsewhere will not be considered in the Reference Committee deliberations. Proper Council decorum is expected within the asynchronous testimony platform. All comments should be addressed to the Reference Committee Chair or the Speaker. Do not direct any communications to another member, including those who have posted before you, with whom you may or may not agree. The Council Speaker and Vice Speaker will do their best to monitor testimony and encourage corrections to any breaches.

**Procedures**

The preliminary Reference Committee reports will be the starting point for the Reference Committee hearings on September 29, 2022. The testimony heard in Reference Committee will be added to the asynchronous testimony to form the consent report submitted to Council.

Reference Committee hearings are open to all members of the College, its committees, and invited guests of the Reference Committee. Members of the College, its committees, and/or invited guests are privileged to present written testimony or to speak to the committee on the resolution under consideration. Upon recognition by the chair, non-members may be permitted to speak. The chair is privileged to call upon anyone attending the hearing if, in his/her opinion, the individual called upon may have information that would be helpful to the committee.

The Reference Committee hearings will be held concurrently and are scheduled from 9:30-12:30 on Thursday, September 29, 2022. Written testimony may be submitted to the Reference Committee if time overlaps occur.

**Proceedings**

Equitable hearings are the responsibility of the Reference Committee chair. The committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, etc. The Reference Committee hearing is the proper forum for discussion of controversial items of business. While it is recognized that the concurrence of Reference Committee hearings may create difficulties in this respect, as does service by councillors on other Reference Committees, the submission of written testimony can alleviate these problems. In the event of extensive written testimony, the Reference Committee chair will report to the Reference Committee the number of written testimony received in favor and in opposition to the resolution. The Reference Committee chair has the discretion to read any written testimony, especially testimony that provides information not previously presented in other written or in-person testimony. All written testimony will be made available electronically to the Council unless determined by the Speaker to contain inaccurate information or inappropriate comments. The reading of any written testimony shall not exceed the time limits set by the chair for providing testimony on any particular resolution.

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a “pressing need” for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue. **Determination of a “pressing need” will be left to the discretion of the chair.** The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee. Reference Committees may
take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to
designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.
If an individual arrives to present testimony before or after the time the resolution was scheduled for
discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When
presenting testimony, the individual should state their name, component body, and whether speaking in
support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify
a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular
expertise for their testimony.

Following the open hearing and after all testimony is given, the Reference Committee will go into executive
session to deliberate and construct its final report. It may call into such executive session anyone whom it
may wish to hear or question. Others are permitted to be in attendance, but may not address the committee
unless requested by the chair for clarification of testimony or to answer questions by committee members.

Reports

Reference Committee reports comprise the bulk of the official business of the Council. The reports need to be
constructed swiftly and succinctly after completion of the hearing so that they can be processed and made
available to the councillors as far in advance of formal presentation as possible. Reference Committees have
wide latitude in facilitating expression of the will of the majority on the matters before them and in giving
credence to the testimony they hear. They may amend resolutions, consolidate kindred resolutions by
constructing substitutes, and recommend the usual parliamentary procedures for disposition of the business
before them, such as adoption, not for adoption, amendment, and referral. Minority reports from Reference
Committees are in order.

When the Reference Committee presents its report to the Council, each report or resolution that has been
accepted by the Council as its business is the matter which is before the Council for disposition together with
the committee’s recommendation in that regard. If a number of closely related items have been considered by
the committee and consolidation or substitution is proposed by the committee, the substitute resolution will be
the matter before the Council for discussion.

Each item referred to a Reference Committee will be placed on a consent agenda grouped by the
recommended action and is reported to the Council as follows:

1. identify the resolution by number and title
2. state concisely the committee’s recommendation
3. comment, as appropriate, on the testimony presented at the hearing
4. incorporate evidence supporting the recommendation of the committee

Each Reference Committee will make recommendations on each resolution assigned to it in a written report.
The speaker will open for discussion each resolution or matter which is the immediate subject of the
Reference Committee report. The effect is to permit full consideration of the business at hand, unrestricted to
any specific motion for its disposal. Any appropriate motion for amendment or disposition may be made from
the floor. In the absence of such a motion, the speaker will state the question and provide the recommendation
of the Reference Committee. If the recommendation is referral or amended language, the primary motion on
the table is the recommendation of the Reference Committee.

Examples of our common variants employing the procedure are:

1. The Reference Committee recommends that a resolution not be adopted. The speaker places the
resolution before the Council for discussion. In the absence of other motions from the floor, the speaker
places the question on adoption of the resolution, making it clear that the Reference Committee has
recommended that it not be adopted (a negative vote).

2. The Reference Committee recommends amending a resolution by adding, striking out, inserting, or
substituting. The matter that is placed before the Council for discussion is the amended version as
presented by the Reference Committee together with the recommendation for its adoption. It is then in
order for the Council to apply to this Reference Committee version amendments in the usual fashion. Such procedure is clear and orderly and does not preclude the possibility that an individual may wish to restore the matter to its original unamended form. This may be accomplished quite simply by moving to amend the Reference Committee version by restoring the original language.

3. The Reference Committee recommends referral of a resolution to the Board of Directors, Council Steering Committee, or Bylaws Interpretation Committee of the College. The speaker places the motion to refer before the Council for discussion. Adoption of the motion to refer removes the matter from consideration by the Council. If the motion to refer is not adopted, the resolution comes before the body for discussion. The Council is then free to adopt, not adopt, or amend the resolution.

4. The Reference Committee recommends consolidation of two or more kindred resolutions into a single resolution, or it recommends adoption of one of these items in its own right as a substitute for the rest. The matter before the Council consideration is the recommendation of the Reference Committee or the substitute or consolidate version. A motion to adopt this substitute is the main motion. If the Reference Committee’s version is not adopted the entire group of proposals has been rejected but it is in order for any councillor to then propose consideration and adoption of any one of the original resolutions or reports.
IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES.

Summary of Council Actions on Reference Committee Reports

<table>
<thead>
<tr>
<th>Original Resolution</th>
<th>Reference Committee’s Recommendation</th>
<th>Speaker Action (Failing Council Action)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To adopt or to not adopt</td>
<td>Puts question on adoption, clearly stating the Reference Committee’s recommendation</td>
<td></td>
</tr>
<tr>
<td>2. To refer</td>
<td>Puts question on referral</td>
<td></td>
</tr>
<tr>
<td>3. To adopt</td>
<td>Puts question on adoption of the committee’s substitute resolution</td>
<td></td>
</tr>
<tr>
<td>4. To adopt</td>
<td>Puts question on adoption of the committee’s substitute resolution</td>
<td></td>
</tr>
</tbody>
</table>

Committee Substitute Resolution (combining several like resolutions)

**Definition of Council Action**

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 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) resolution in original or amended form.
### V. PRINCIPLE RULES GOVERNING MOTIONS

<table>
<thead>
<tr>
<th>Order of precedence (^1)</th>
<th>Can interrupt</th>
<th>Requires second?</th>
<th>Debatable</th>
<th>Amendable</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied (in addition to withdraw)? (^4)?</th>
</tr>
</thead>
</table>

#### Privileged Motions

1. Adjourn
   - No
   - Yes
   - Yes\(^3\)
   - Yes\(^3\)
   - Majority
   - None
   - Amend

2. Recess
   - No
   - Yes
   - Yes\(^3\)
   - Yes\(^3\)
   - Majority
   - None
   - Amend\(^3\)

3. Question of privilege
   - Yes
   - No
   - No
   - None
   - None
   - None
   - None

#### Subsidiary Motions

4. Postpone temporarily (table)
   - No
   - Yes
   - No
   - No
   - Majority\(^2\)
   - Main motion
   - None

5. Close debate
   - No
   - Yes
   - No
   - No
   - 2/3
   - Debatable motions
   - None

6. Limit debate
   - No
   - Yes
   - Yes\(^3\)
   - Yes\(^3\)
   - 2/3
   - Debatable motions
   - Amend\(^3\)

7. Postpone definitely (to a certain time)
   - No
   - Yes
   - Yes\(^3\)
   - Yes\(^3\)
   - Majority
   - Main motion
   - Amend\(^3\), close debate, limit debate

8. Refer to committee
   - No
   - Yes
   - Yes\(^3\)
   - Yes\(^3\)
   - Majority
   - Main motion
   - Amend\(^3\), close debate, limit debate

9. Amend
   - No
   - Yes
   - Yes
   - Yes
   - Majority
   - Rewordable motions
   - Close debate, limit debate, amend

#### Main Motions

10. a. The main motion
    - No
    - Yes
    - Yes
    - Yes
    - Majority
    - None
    - Restorative, subsidiary

   b. Restorative main motions
      - Amend a previous action
        - No
        - Yes
        - Yes
        - Yes
        - Majority
        - Main motion
        - Subsidiary, restorative
      - Ratify
        - No
        - Yes
        - Yes
        - Yes
        - Majority
        - Previous action
        - Subsidiary
      - Reconsider
        - Yes
        - Yes
        - Yes
        - No
        - Majority
        - Main motion
        - Close debate, limit debate
      - Rescind
        - No
        - Yes
        - Yes
        - No
        - Majority
        - Main motion
        - Close debate, limit debate
      - Resume consideration
        - No
        - Yes
        - No
        - No
        - Majority
        - Main motion
        - None

---

\(^1\) Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

\(^2\) Requires two-thirds vote when it would suppress a motion without debate.

\(^3\) Restricted.

\(^4\) Withdraw may be applied to all motions.
## VI. INCIDENTAL MOTIONS

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt</th>
<th>Requires second?</th>
<th>Debatable</th>
<th>Amendable</th>
<th>Vote Required?</th>
<th>Applies to what motions applied (in addition to withdraw)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2/3*</td>
<td>Decision of chair</td>
</tr>
<tr>
<td>Suspend Rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Requests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of Order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Any error</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Main motion</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
</tr>
</tbody>
</table>

* Per the Council Standing Rules.
VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

Definition

The Council considers items in the form of resolutions. Resolutions set forth background information and propose a course of action.

Submission and Deadline

Resolutions can be submitted by e-mail or U.S. mail. Receipt of resolutions will be acknowledged by e-mail or phone.

All resolutions should be submitted to:

Sonja Montgomery, CAE
Governance Operations Director
American College of Emergency Physicians
PO Box 619911
Dallas, TX 75261-9911
E-mail: smontgomery@acep.org
Phone: 800-798-1822 x3202 or 469-499-0282
Fax: 972-580-2816

Bylaws and regular resolutions are due 90 days before the annual Council meeting. The 2022 Council meeting will be held on Thursday, September 29, and Friday, September 30, 2022. Therefore, the deadline for resolutions for the 2022 Council meeting is July 2, 2022.

Each resolution must be submitted by at least two members of the College. In the case of a chapter or section, a letter of endorsement must accompany such resolution from the president or chair representing the sponsoring body. If submitting by e-mail, the letter of endorsement can be either attached to the e-mail or embedded in the body of the e-mail.

All resolutions from national ACEP committees must be submitted to the Board of Directors for review prior to the resolution deadline. This usually occurs at the June Board of Directors meeting. If the Board accepts the submission of the resolution, then the resolution carries the endorsement of the committee and the Board of Directors.

Questions

Please contact Sonja Montgomery, CAE, smontgomery@acep.org, at ACEP Headquarters, 800-798-1822, extension 3202 or 469-499-0282, for further information about preparation of resolutions.

Format

The title of the resolution must appropriately reflect the intent. Resolutions begin with "Whereas" statements, which provides the basic facts and reasons for the resolution, and conclude with "Resolved" statements, which identifies the specific proposal for the requestor's course of action.

Whereas Statements

Background, or “Whereas” information provides the rationale for the "resolved" course of action. The whereas statement(s) should lead the reader to your conclusion (resolved).

In writing whereas statements, begin by introducing the topic of the resolution. Be factual rather than speculative and provide or reference statistics whenever possible. The statements should briefly identify the problem, advise the timeliness or urgency of the problem, the effect of the issue, and indicate if the action called for is contrary to or will revise current ACEP policy. Inflammatory statements that reflect poorly on the organization will not be permitted.
Resolved Statements

Resolved statements are the only parts of a resolution that the Council and Board of Directors act upon. Conceptually, resolves can be classified into two categories – policy resolveds and directives. A policy resolved calls for changes in ACEP policy. A directive is a resolved that calls for ACEP to take some sort of action. Adoption of a directive requires specific action but does not directly affect ACEP policy.

A single resolution can both recommend changes in ACEP policy and recommend actions about that new policy. The way to accomplish this objective is to establish the new policy in one resolved (a policy resolved), and to identify the desired action in a subsequent resolved (a directive).

Regardless of the type of resolution, the resolved should be stated as a motion that can be understood without the accompanying whereas statements. When the Council adopts a resolution, only the resolved portion is forwarded to the Board of Directors for ratification. The “resolved” must be fully understood and should stand alone.

Bylaws Amendments

In writing a resolved for a Bylaws amendment, be sure to specify an Article number as well as the Section to be amended. Show the current language with changes indicated as follows: new language should be bolded (dark green type, bold, and underline text), and language to be deleted should be shown in red, strike-through text (delete). Failure to specify exact language in a Bylaws amendment usually results in postponement for at least one year while language is developed and communicated to the membership.

General Resolutions

The president, and not the Council, is responsible for determining the appropriate level of committee involvement for resolutions adopted by the Council. Additionally, the Council and ACEP, cannot “direct” action by another organization, although the College can recommend a course of action to other organizations through the ACEP president or through ACEP representatives to that organization.

Council Actions on Resolutions

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 provided 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. A resolution cannot be referred to other College committees.
- **Not Adopt:** Defeat (or reject) the resolution in original or amended form.

Board Actions on Resolutions

According to the Bylaws, Article VIII – Council, 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, including amendments to the College Manual, and other actions or appropriations enacted by the Council. The Board of Directors shall act on all resolutions adopted by the Council 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 either 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.

Sample Resolutions

Three resolutions are provided as examples of well-written proposals.

Resolution 9(06) shows how to propose an amendment to the Bylaws. New language is shown in bold with underlining and deleted language is shown in strike-out format. The use of colors in the electronic file (red for strike-out and green for new language) is also helpful.

**RESOLUTION 9(06)**

WHEREAS, The College Bylaws provides for an Executive Committee of the Board of Directors; and
WHEREAS, The speaker has informally served on the Executive Committee; and
WHEREAS, The Executive Committee would benefit from having more formal and standard composition, including the membership of the speaker and the chair of the Board of Directors; and
WHEREAS, The College would benefit from having an Executive Committee appointed every year; therefore be it

RESOLVED, That the ACEP Bylaws, Article XI – Committees, Section 2 – Executive Committee, be amended to read:

**ARTICLE XI – COMMITTEES**

Section 2 – Executive Committee

The Board of Directors may appoint an Executive Committee **The Board of Directors shall have an Executive Committee**, consisting of the president, president-elect, vice president, secretary-treasurer, and the 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.
Resolution 23(06) shows how communication between the College and another organization can be stated.

**RESOLUTION 23(06)**

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 nursing, within the scope of nursing practice, is also a recognized subspecialty with its own unique knowledge base and skill set that is certifiable by examination, resulting in a Certified Emergency Nurse (CEN); and

WHEREAS, Unlike in emergency medicine, where specialized training and experience are required for a physician to take an emergency medicine board examination, any nurse practicing in an emergency department (ED) is able to sit for the CEN exam; and

WHEREAS, In many EDs throughout the country, the majority of emergency nurses working are not CEN certified; and

WHEREAS, The range of acuity of the emergency patients seen in emergency departments by emergency nurses can be from non-urgent to critically ill; and

WHEREAS, The expectation of patients who utilize emergency departments for their emergency medical care is that there is seamless, high quality medical and nursing care provided; therefore be it

RESOLVED, That the American College of Emergency Physicians works with the Emergency Nurses Association (ENA) to facilitate the development by ENA of a position paper defining a standard of emergency nursing care that includes obtaining CEN certification and outlines a timetable for an emergency nurse to attain such certification; and be it further

RESOLVED, That the American College of Emergency Physicians works with ENA, the American Hospital Association (AHA) and related state hospital organizations to provide resources, support, and incentives for emergency nurses to be able to readily attain CEN certification.

Resolution 16(99) shows how statistics can be used to lead the reader to your conclusion.

**RESOLUTION 16(99)**

WHEREAS, According to the National Association of State Boating Law Administrators, the number of boating accidents involving alcohol increased 20% over a five-year period; and

WHEREAS, The number of deaths attributed to boating and alcohol has also increased 20% during this same time period; and

WHEREAS, A study of four states found 60% of boating fatalities had elevated blood alcohol levels and 30% were intoxicated with BAL greater than 0.1%; and

WHEREAS, The fault for boating fatalities can not be attributed to the boat operator in almost half of these deaths; and

WHEREAS, In 1991 46% of all boating deaths occurred while the boat was not even underway; and

WHEREAS, It has thus been suggested that intoxicated boat passengers are at independent risk for boating injuries; and this risk is assumed to be due to intoxicated passengers being at increased risk for falls overboard and risk taking behaviors; and

WHEREAS, Educational and enforcement measures have predominantly targeted boat operators and not boat passengers about the dangers of alcohol consumption and boating; therefore be it

RESOLVED, That the American College of Emergency Physicians promote and endorse safe boating practices; and be it further

RESOLVED, That ACEP promote educating both boat passengers and operators about the dangers of alcohol intoxication while boating.
VIII.

**ACEP Parliamentary Motions Guide**  
Based on *Sturgis Standard Code of Parliamentary Procedure (4th Ed.)*

The motions below are listed in order of precedence.  
Any motion can be introduced if it is higher on the chart than the pending motion.

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>(77) Close meeting</td>
<td>I move that we adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>(75) Take break</td>
<td>I move to recess for</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>(72) Register complaint</td>
<td>I rise to a question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>(68) Lay aside temporarily</td>
<td>I move that the main motion be postponed temporarily</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Varies</td>
</tr>
<tr>
<td>(65) Close debate and vote immediately</td>
<td>I move to close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
</tr>
<tr>
<td>(62) Limit or extend debate</td>
<td>I move to limit debate to …</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>2/3</td>
</tr>
<tr>
<td>(58) Postpone to certain time</td>
<td>I move to postpone the motion until …</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>(55) Refer to committee</td>
<td>I move to refer the motion to …</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>(47) Modify wording of motion</td>
<td>I move to amend the motion by …</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>(32) Bring business before assembly (a main motion)</td>
<td>I move that …</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
</tbody>
</table>

Jim Slaughter, Certified Professional Parliamentarian – Teacher & Professional Registered Parliamentarian  
336/378/1899 (W)  336/378-1850 (Fax)  P.O. Box 41027, Greensboro NC 27404-1027  
web site: [www.jimslaughter.com](http://www.jimslaughter.com)

1 As modified by the ACEP Council Standing Rules
### Incidental Motions
- No order of precedence. Arise incidentally and decided immediately.

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<tbody>
<tr>
<td>(82) Submit matter to assembly</td>
<td>I appeal from the decision of the chair</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2/3</td>
</tr>
<tr>
<td>(84) Suspend rules</td>
<td>I move to <strong>suspend the rule</strong> requiring</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
</tr>
<tr>
<td>(87) Enforce rules</td>
<td><strong>Point of order</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>(90) Parliamentary question</td>
<td><strong>Parliamentary inquiry</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>(94) Request to withdraw motion</td>
<td>I wish to withdraw my motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>(96) Divide motion</td>
<td>I request that the motion be divided ...</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>(99) Demand rising vote</td>
<td>I call for a <strong>division of the assembly</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>

### Restorative Main Motions
- No order of precedence. Introduce only when nothing else pending.

| (36) Amend a previous action        | I move to amend the motion that was ... | No          | Yes  | Yes     | Yes    | Varies |
| (38) Reconsider motion              | I move to **reconsider** ...            | Yes         | Yes  | Yes     | No     | Majority |
| (42) Cancel previous action         | I move to **rescind**...                | No          | Yes  | Yes     | No     | Majority |
| (44) Take from table                | I move to **resume consideration** of ... | No          | Yes  | No      | No     | Majority |

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336/378/1899 (W)  336/378-1850 (Fax)  P.O. Box 41027, Greensboro NC 27404-1027  
web site: [www.jimslaughter.com](http://www.jimslaughter.com)
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 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 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, except for commendation and memorial resolutions. 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 resolution sponsors and cosponsors must be confirmed at least 45 days in advance of the Council meeting.

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.

**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. All resolutions assigned to a Reference Committee shall be placed on a Unanimous Consent Agenda. 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 not for adoption for each resolution listed. 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. 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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Revised January 2021

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 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.

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 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.

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 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 or the chair of the Board with not less than 48 hours 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.
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. 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, ACEP Code of Ethics, other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within 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, any additional ACEP review body listed in these Procedures, and 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 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 complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing guidelines and timetables that will 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.

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 Committee, the Bylaws Committee, or other committee designee, 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 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, or other committee designee, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics 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, 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 Ethics Complaint Review Panel or the Bylaws Committee will review the President’s action. The President’s action can be overturned by a majority vote of the applicable ACEP review body.

5. Within ten (10) business days after the determination specified in Section-C.4.b. or Section C.4.c. of these Procedures, forwards the complaint to the respondent by 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 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 applicable ACEP review body, including 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 the Bylaws Committee appointed to review the complaint, as appropriate.

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

1. Reviews the written record of any complaint that alleges a violation of the ACEP Code of Ethics or other 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. Applicable version of the ACEP Code of Ethics or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Code of Ethics or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Ethics Complaint Review Panel renders a decision to impose disciplinary action, based on the written record.
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 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. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Bylaws Committee renders a decision to impose disciplinary action, based solely on the written record.
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.
F. **Right of Respondent to Request a Hearing**

If the Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the Executive Director will send to the respondent a written notice by USPS Certified Mail of the right to request a hearing. This notice will list the respondent’s hearing rights as set forth in Section G. below. The respondent’s request for a hearing must be submitted in writing to the Executive Director within thirty (30) days of receipt of the notice of right to a hearing. In the event of no response, the applicable ACEP review body will implement its final decision.

G. **Hearing Procedures**

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by 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 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.
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, 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, 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. 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 Hearing Panel’s decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the 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 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 does not conform with the College’s ethical standards; it may detail the manner in which 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. Upon written request by a
member of ACEP, ACEP may confirm the censure; however, contents of the letter will not
be provided.

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 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.

b. 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 ACEP President.
At the end of the twelve (12) month period of suspension, the suspended member 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.

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 announced in an appropriate ACEP publication. The published announcement
shall also state which ACEP policy or Bylaws provision was violated by and shall inform
ACEP members that they may request further information about the disciplinary 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: 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.

b. Disclosure to Non-Members: If a non-member 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.

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the
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 Complaint Review Panel, the Bylaws Committee, or the Board 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
ACEP 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 Complaint Review Panel, the Bylaws Committee, or the Board 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.

6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.

7. The Ethics Complaint Review Panel or the Bylaws Committee’s decision 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 Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.

9. 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.
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. 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, ACEP Code of Ethics, other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within 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, any additional ACEP review body listed in these Procedures, and 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 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 complainant’s intent to file a complaint. Includes a copy of ACEP’s Procedures providing guidelines and timetables that will 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.
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 Committee, the Bylaws Committee, or other committee designee, 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 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, or other committee designee, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics 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, 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 Ethics Complaint Review Panel or the Bylaws Committee will review the President’s action. The President’s action can be overturned by a majority vote of the applicable ACEP review body.
5. Within ten (10) business days after the determination specified in Section-C.4.b. or Section C.4.c. of these Procedures, forwards the complaint to the respondent by 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 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 applicable ACEP review body, including 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 the Bylaws Committee appointed to review the complaint, as appropriate.

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

1. Reviews the written record of any complaint that alleges a violation of the ACEP Code of Ethics or other 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. Applicable version of the ACEP Code of Ethics or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Code of Ethics or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Ethics Complaint Review Panel renders a decision to impose disciplinary action, based on the written record.
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 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. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Bylaws Committee renders a decision to impose disciplinary action, based solely on the written record.
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.
F. Right of Respondent to Request a Hearing

If the Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the Executive Director will send to the respondent a written notice by USPS Certified Mail of the right to request a hearing. This notice will list the respondent’s hearing rights as set forth in Section G. below. The respondent’s request for a hearing must be submitted in writing to the Executive Director within thirty (30) days of receipt of the notice of right to a hearing. In the event of no response, the applicable ACEP review body will implement its final decision.

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by 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 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.
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, 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, 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. 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 Hearing Panel’s decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the 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 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 does not conform with the College’s ethical standards; it may detail the manner in which 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. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided.

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 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.

b. 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 ACEP President. At the end of the twelve (12) month period of suspension, the suspended member 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.

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 announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary 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: 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.
   b. Disclosure to Non-Members: If a non-member 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.

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the 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 Complaint Review Panel, the Bylaws Committee, or the Board 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 ACEP 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 Complaint Review Panel, the Bylaws Committee, or the Board 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.

6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.

7. The Ethics Complaint Review Panel or the Bylaws Committee’s decision 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 Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.

9. 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.
The 50th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:04 am Central time on Saturday, October 23, 2021, by Speaker Gary R. Katz, MD, MBA, FACEP.

Seated at the table were: Gary R. Katz, MD, MBA, FACEP, speaker; Kelly Gray-Eurom, MD, MMM, FACEP, vice speaker; Susan E. Sedory, MA, CAE, Council secretary and executive director; and Jim Slaughter, JD, CPP, parliamentarian.

Dr. Katz provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance and singing the National Anthem. He then welcomed new councillors, new alternate councillors, first time attendees, and guests.

Dr. Katz announced that the Council meeting was being live streamed to remote participants. Remote participants do not have the ability to be recognized to speak or send messages to the Council, however, councillors participating remotely will be able to vote. The Reference Committee hearings and the Candidate Forum will also be live streamed to the remote participants.

Kathleen Kerrigan, MD, FACEP, president of the Massachusetts Chapter, welcomed councillors and other meeting attendees.

Dr. Katz provided an overview of the voting software for the Council meeting and a voting practice was conducted. Electronic councillor credentialing was conducted to determine the number of councillors currently participating remotely.

Chadd K. Kraus, DO, DrPH, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 277 councillors of the 446 eligible for seating had been credentialed, including 244 participating in person and 33 participating remotely. A roll call was not conducted because limited access to the Council floor was monitored by the committee and unique credentials were provided to each councillor participating remotely.

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

Peter J. 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 2021 Council meeting and through remote participation:

<table>
<thead>
<tr>
<th>Chapter/Org - Councillor</th>
<th>Attended Mtg</th>
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<tr>
<td><strong>AACEM</strong></td>
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<tr>
<td>Theodore A Christopher, MD, FACEP</td>
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<td><strong>Alabama Chapter</strong></td>
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<td>Melissa Wysong Costello, MD, FACEP</td>
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<td>Muhammad N Husainy, DO, FACEP</td>
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<td>Bobby R Lewis, MD, DMD, FACEP</td>
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<td>Annalise Sorrentino, MD, FACEP</td>
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<td><strong>Alaska Chapter</strong></td>
<td>Nicholas Papacostas, MD, FACEP</td>
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<td><strong>Arizona Chapter</strong></td>
<td>Patricia A Bayless, MD, FACEP</td>
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<td>Bradley A Dreifuss, MD, FACEP</td>
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<td><strong>Arkansas Chapter</strong></td>
<td>J Shane Hardin, MD, PhD, FACEP</td>
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<td><strong>California Chapter</strong></td>
<td>Harrison Alter, MD, FACEP</td>
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<td>Zahir I Basrai, MD</td>
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<td>Rodney W Borger, MD, FACEP</td>
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<td>Vikram Raj, DO</td>
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<td>Lori D Winston, MD, FACEP</td>
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<td><strong>Colorado Chapter</strong></td>
<td>Jasmeet Singh Dhaliwal, MD, MPH, MBA</td>
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<td>Name</td>
<td>Connecticut Chapter</td>
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<td>Anna Engeln, MD, FACEP</td>
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<td>L Kendall Webb, MD, FACEP</td>
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<td>Cristina Zeretzke, MD, FACEP</td>
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<td>Matthew R Astin, MD, FACEP</td>
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<td>Andrea Austin, MD, FACEP</td>
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<td>Lindsay Zimmerman, MD, FACEP</td>
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### Iowa Chapter
- Ryan M Dowden, MD, FACEP: Yes, Yes
- Nicholas Holden Kluesner, MD, FACEP: Yes, Yes
- Rachael Sokol, DO, FACEP: Yes, Yes

### Kansas Chapter
- Howard Chang, MD, FACEP: Yes, Yes
- John M Gallagher, MD, FACEP: Yes, Yes
- John F McMaster, MD, FACEP: Yes, Yes
- Jeffrey G Norvell, MD, MBA, RDMS, FACEP: Yes, Yes

### Kentucky Chapter
- David Wesley Brewer, MD, FACEP: Yes, Yes
- Christopher W Pergrem, MD, FACEP: Yes, Yes
- Melissa Platt, MD, FACEP: Yes, Yes
- Hugh W Shoff, MD, FACEP: Yes, No

### Louisiana Chapter
- James B Aiken, MD, FACEP: Yes, Yes
- Deborah D Fletcher, MD, FACEP: Yes, Yes
- Phillip Luke LeBas, MD, FACEP: Yes, Yes
- Randy L Pilgrim, MD, FACEP: Yes, Yes
- Michael D Smith, MD MBA CPE, FACEP: Yes, Yes

### Maine Chapter
- Thomas C Dancoes, DO, FACEP: Yes, Yes
- James B Mullen, III, MD, FACEP: Yes, Yes
- Charles F Pattavina, MD, FACEP: Yes, Yes

### Maryland Chapter
- Michael C Bond, MD, FACEP: Yes, Yes
- Arjun S Chanmugam, MD, FACEP: Yes, No
- Sydney E DeAngelis, MD, FACEP: Yes, Yes
- Kyle Fischer, MD, MPH, FACEP: Yes, No
- Jonathan Lewis Hansen, MD, FACEP: Yes, Yes
- Robert Clifford Linton, II, MBA, MD, FACEP: Yes, No
- Edana Denise Mann, MD, FACEP: Yes, No

### Massachusetts Chapter
- Brien Alfred Barnewolt, MD, FACEP: Yes, Yes
- Stephen K Epstein, MD, MPP, FACEP: Yes, Yes
- Kathleen Kerrigan, MD, FACEP: Yes, No
- Matthew B Mostofi, DO, FACEP: Yes, Yes
- Mark D Pearlmutter, MD, FACEP: Yes, Yes
- Jesse Rideout, MD, FACEP: Yes, Yes
- Michele Schroeder, MD: Yes, No
- James Joseph Sullivan, Jr, MD: Yes, Yes
- Brian Sutton, MD, FACEP: Yes, No
- Joseph C Tennyson, MD, FACEP: Yes, Yes

### Michigan Chapter
- Michael J Baker, MD, FACEP: Yes, Yes
- Sara S Chakel, MD, FACEP: Yes, Yes
- Nicholas Dyc, MD, FACEP: Yes, Yes
- Gregory Gafni-Pappas, DO, FACEP: Yes, Yes
- Michael Vincent Gratson, MD, FACEP: Yes, Yes
- Rami R Khoury, MD, FACEP: Yes, Yes
- Warren F Lanphear, MD, FACEP: Yes, Yes
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<td>Navin Ariyaprakai, MD, EMT-P, FAEMS, FACEP</td>
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Jenice Baker, MD, FACEP Yes Yes
Rachelle Ann Freeman, MD, FACEP Yes Yes
Patrick Blaine Hinfey, MD, FACEP Yes Yes
Steven M Hochman, MD, FACEP Yes Yes
Marjory E Langer, MD, FACEP Yes Yes
Jessica M Maye, DO, FACEP Yes Yes
J Mark Meredith, MD, FACEP Yes Yes
Amy Ondeyka, MD, FACEP Yes Yes
Michael Ruzek, DO, FACEP Yes Yes

New Mexico Chapter
David A Cheever, MD Yes Yes
Tatsuya Norii, MD, FACEP Yes No
Tony B Salazar, MD, FACEP Yes Yes

New York Chapter
Brahim Ardolic, MD, FACEP Yes Yes
Joseph Basile, MD, FACEP Yes Yes
Nicole Berwald, MD, FACEP Yes Yes
Kirby Black, MD, FACEP Yes Yes
Erik Blutinger, MD, MSc Yes Yes
Robert M Bramante, MD, FACEP Yes Yes
Jay Miller Brenner, MD, FACEP Yes Yes
Bernard P Chang, MD, PhD, FACEP Yes Yes
Brandon Joseph Chavez, DO Yes Yes
Joshua R Codding, MD Yes Yes
Lauren J Curato, DO, FACEP Yes Yes
Mark Curato, DO, FACEP Yes Yes
Mathew Foley, MD, FACEP Yes Yes
Keith Grans, MD, FACEP Yes Yes
Sanjey Gupta, DO, FACEP Yes Yes
Abbas Husain, MD, FACEP Yes Yes
Marc P Kanter, MD, FACEP Yes Yes
Stuart Gary Kessler, MD, FACEP Yes Yes
Daniel Lakoff, MD, FACEP Yes Yes
Penelope Lema, MD, FACEP Yes Yes
Laura D Melville, MD Yes Yes
Joshua B Moskovitz, MD, MBA, MPH, FACEP Yes Yes
Nestor B Nestor, MD, FACEP Yes Yes
David L Ng, MD, FACEP Yes Yes
Louise A Prince, MD, FACEP Yes Yes
Jeffrey S Rabrich, DO, FACEP Yes Yes
Livia M Santiago-Rosado, MD, FACEP Yes Yes
Sarah E Secor-Jones, DO, FACEP Yes Yes
Virgil W Smaltz, MD, FACEP Yes Yes
Asa Viccellio, MD, FACEP Yes Yes
Luis Carlos Zapata, MD, FACEP Yes Yes

North Carolina Chapter
Thomas N Bernard, III, MD, FACEP Yes No
Scott W Brown, MD, FACEP Yes Yes
Gregory J Cannon, MD, FACEP Yes Yes
Jennifer Casaletto, MD, FACEP Yes Yes
Thomas Lee Mason, MD, FACEP Yes Yes
Eric E Maur, MD, FACEP Yes Yes
Abhishek Mehrotra, MD, MBA, FACEP Yes Yes
Bret Nicks, MD, MHA, FACEP Yes No
Sankalp Puri, MD, FACEP Yes Yes
Sean S Ray, MD, FACEP  Yes  Yes
Stephen A Small, MD, FACEP  Yes  Yes

North Dakota Chapter
K J Temple, MD, FACEP  Yes  No

Ohio Chapter
Andrew Aten, MD  Yes  Yes
Laura Michelle Espy-Bell, MD, FACEP  Yes  Yes
B Bryan Graham, DO, FACEP  Yes  Yes
Purva Grover, MD, FACEP  Yes  No
Thomas W Lukens, MD, PhD, FACEP  Yes  Yes
Catherine Anna Marco, MD, FACEP  Yes  Yes
Ryan Marino, MD, FACEP  Yes  Yes
Daniel R Martin, MD, MBA, FACEP  Yes  Yes
Michael McCrea, MD, FACEP  Yes  Yes
Ashley Diana McMellen, MD  Yes  Yes
Crystal Williams Nock, MD  Yes  Yes
John R Queen, MD, FACEP  Yes  Yes
Matthew J Sanders, DO, FACEP  Yes  No
Imran Shaikh, MD, FACEP  Yes  Yes
Ryan Squier, MD, FACEP  Yes  Yes
Nicole Ann Veitinger, DO, FACEP  Yes  Yes

Oklahoma Chapter
Cecilia Guthrie, MD, FACEP  Yes  No
Jeffrey Johnson, MD, FACEP  Yes  Yes
Chad A Phillips, MD  Yes  No

Oregon Chapter
Samuel H Kim, MD, FACEP  Yes  Yes
John C Moorhead, MD, FACEP  Yes  Yes
Chris F Richards, MD, FACEP  Yes  Yes
Christian Smith, MD  Yes  Yes
Christopher Strear, MD, FACEP  Yes  Yes

Pennsylvania Chapter
Monisha Bindra, DO, MPH, FACEP  Yes  Yes
Merle Andrea Carter, MD, FACEP  Yes  Yes
Karen M Custodio, DO  Yes  Yes
Eleanor Dunham, MD, FACEP  Yes  Yes
Todd Fijewski, MD, FACEP  Yes  No
Maria Koenig Guyette, MD, MPPM, FACEP  Yes  No
Clairisse Hafey, DO  Yes  No
Ronald V Hall, MD, FACEP  Yes  Yes
Richard Hamilton, MD, FACEP  Yes  Yes
F Richard Heath, MD, FACEP  Yes  No
Annaheta Kalantari, DO, FACEP  Yes  Yes
Chadd K Kraus, DO, DrPH, CPE, FACEP  Yes  Yes
Hannah M Mishkin, MD, FACEP  Yes  Yes
Dhimitri Nikolla, DO  Yes  Yes
Shawn M Quinn, DO, FACEP  Yes  Yes
Jennifer L Savino, DO, FACEP  Yes  No
Robert J Strony, DO, MBA, FACEP  Yes  Yes
Theresa Ann Walls, MD, MPH  Yes  Yes
Elizabeth Barrall Werley, MD, FACEP  Yes  Yes
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<td>Matthew D Bitner, MD, FACEP</td>
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<td>Diana L Fite, MD, FACEP</td>
<td>Yes</td>
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<td>Robert D Greenberg, MD, FACEP</td>
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<td>Robert Hancock, Jr, DO, FACEP</td>
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<td>Doug Jeffrey, MD, FACEP</td>
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<td>Alexander J Kirk, MD, FACEP</td>
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<td>Heidi C Knowles, MD, FACEP</td>
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<td>Edward Kuo, MD, FACEP</td>
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<td>Jason A Lesnick, MD</td>
<td>Yes</td>
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<td>Laura N Medford-Davis, MD, FACEP</td>
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<td>Craig Meek, MD, FACEP</td>
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<td>Sterling Evan Overstreet, MD, FACEP</td>
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<td>Heather S Owen, MD, FACEP</td>
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<td>Anant Patel, DO, FACEP</td>
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<td>Daniel Eugene Peckenpaugh, MD, FACEP</td>
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<td>R Lynn Rea, MD, FACEP</td>
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<td>Richard Dean Robinson, MD, FACEP</td>
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<td>Theresa Tran, MD, FACEP</td>
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<td>Gerard A Troutman, MD, FACEP</td>
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<td>James M Williams, DO, FACEP</td>
<td>Yes</td>
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<td></td>
<td>Sandra Williams, DO, MPH, FACEP</td>
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<tr>
<td>Utah Chapter</td>
<td>Jim V Antinori, MD, FACEP</td>
<td>Yes</td>
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<td>Stephen Carl Hartsell, MD, FACEP</td>
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<td>David Brent Mabey, MD</td>
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<td>Alison L Smith, MD, MPH, FACEP</td>
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<td>Chapter</td>
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<tr>
<td><strong>Vermont Chapter</strong></td>
<td>Alexandra Nicole Thran, MD, FACEP</td>
<td>Yes</td>
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<tr>
<td><strong>Virginia Chapter</strong></td>
<td>Trisha Danielle Anest, MD, MPH, FACEP</td>
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<td>Kenneth Hickey, MD, FACEP</td>
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<td>James R Humble, MD</td>
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<td>Bruce M Lo, MD, MBA, RDMS, FACEP</td>
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<td>Joseph Mason, MD, FACEP</td>
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<td>Cameron K Olderog, MD, FACEP</td>
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<td>Todd Parker, MD, FACEP</td>
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<td>Joran Sequeira, MD, FACEP</td>
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<td>Jesse Duane Spangler, MD</td>
<td>Yes</td>
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<td>Theodore I Tzavaras, MD</td>
<td>Yes</td>
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<td><strong>Washington Chapter</strong></td>
<td>Stephen H Anderson, MD, FACEP</td>
<td>Yes</td>
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<td>Roderick W Beaver, MD</td>
<td>Yes</td>
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<td>Herbert C Duber, MD, MPH, FACEP</td>
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<td>Joshua R Frank, MD, FACEP</td>
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<td>Carlton E Heine, MD, PhD, FACEP</td>
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<td>Elizabeth A McMurtry, DO, FACEP</td>
<td>Yes</td>
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<td>Susan Amy Stern, MD</td>
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<td>Jessica J Wall, MD, FACEP</td>
<td>Yes</td>
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<td><strong>West Virginia Chapter</strong></td>
<td>David Benjamin Deuell, DO, FACEP</td>
<td>Yes</td>
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<td></td>
<td>Christopher S Goode, MD, FACEP</td>
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<td><strong>Wisconsin Chapter</strong></td>
<td>Bradley Burmeister, MD</td>
<td>Yes</td>
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<td>Jeffrey J Pothof, MD, FACEP</td>
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<td>Michael Dean Repplinger, MD, PhD, FACEP</td>
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<td></td>
<td>Jamie Schneider, MD</td>
<td>Yes</td>
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<td>Brian Sharp, MD, FACEP</td>
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<td>Christopher Torkilsen, DO</td>
<td>Yes</td>
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<tr>
<td><strong>Wyoming Chapter</strong></td>
<td>Carol Lea Wright Becker, MD, FACEP</td>
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**Sections of Membership**

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<tr>
<th>Section</th>
<th>Name</th>
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<tbody>
<tr>
<td><strong>AAWEP Section</strong></td>
<td>Elizabeth Dubey, MD, FACEP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Air Medical Transport Section</strong></td>
<td>Samuel J Slimmer, MD, FACEP</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td><strong>Careers in Emergency Medicine Section</strong></td>
<td>Constance J Doyle, MD, FACEP</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td><strong>Critical Care Medicine Section</strong></td>
<td>Nicholas M Mohr, MD, FACEP</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Cruise Ship Medicine Section</strong></td>
<td>Ruben Dario Parejo, MD</td>
<td>Yes</td>
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</tbody>
</table>
Democratic Practice Section
David Hall, MD, FACEP

Disaster Medicine Section
Justin W Fairless, DO, NRP, FAEMS, FACEP

Diversity & Inclusion Section
Ugo A Ezenkwele, MD, FACEP

Dual Training Section
Vinay Mikkilineni, MD

EM Practice Mgmt and Health Policy Section
Robert M McNamara, MD

Emergency Medical Informatics Section
Zachary Joseph Jarou, MD, MBA

Emergency Medicine Locum Tenens Section
Pamela Andrea Ross, MD, FACEP

Emergency Medicine Research Section
Richard Gentry Wilkerson, MD, FACEP

Emergency Medicine Workforce Section
Leslie Mukau, MD, FACEP

Emergency Telehealth Section
David C Ernst, MD, FACEP

Emergency Ultrasound Section
Kenton L Anderson, MD, FACEP

EMS-Prehospital Care Section
Michael O’Brien, MD, FAEMS, FACEP

Event Medicine Section
Paul E Pepe, MD, FAEMS, FACEP

Forensic Medicine Section
Monika Pitzele, MD, FACEP

Freestanding Emergency Centers Section
Lonnie R Schwirtlich, MD, FACEP

Geriatric Emergency Medicine Section
Shan W Liu, MD, FACEP

International Emergency Medicine Section
Jessica Valeria Bravo Gutierrez, MD

Medical Directors Section
C Ryan Keay, MD, FACEP

Medical Humanities Section
Zayir Malik, Malik, MD
<table>
<thead>
<tr>
<th>Section</th>
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<tbody>
<tr>
<td>Observation Services Section</td>
<td>Alexei Wagner, MD</td>
</tr>
<tr>
<td>Pain Management Section</td>
<td>Eric M Ketcham, MD, MBA, FACEP</td>
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<tr>
<td>Palliative Medicine Section</td>
<td>David Wang, MD</td>
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<tr>
<td>Pediatric Emergency Medicine Section</td>
<td>Eric R Schmitt, MD, MPH, FACEP</td>
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<tr>
<td>Quality Improvement and Patient Safety Section</td>
<td>Robert Sands Redwood, MD, MPH, FACEP</td>
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<tr>
<td>Rural Emergency Medicine Section</td>
<td>Stephen John Jameson, MD, FACEP</td>
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<td>Social Emergency Medicine Section</td>
<td>Laura Janneck, MD, FACEP</td>
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<td>Sports Medicine Section</td>
<td>Calvin E Hwang, MD, FACEP</td>
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<td>Tactical Emergency Medicine Section</td>
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<tr>
<td>Toxicology Section</td>
<td>Jennifer Hannum, MD, FACEP</td>
</tr>
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<td>Trauma &amp; Injury Prevention Section</td>
<td>Gregory Luke Larkin, MD, FACEP</td>
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<tr>
<td>Undersea &amp; Hyperbaric Medicine Section</td>
<td>Stephen Hendriksen, MD, FACEP</td>
</tr>
<tr>
<td>Wellness Section</td>
<td>Susan T Haney, MD, FACEP</td>
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<tr>
<td>Wilderness Medicine Section</td>
<td>Brendan Harry Milliner, MD</td>
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<tr>
<td>Young Physicians Section</td>
<td>Nnenna Cynthia Ejesieme, DO</td>
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</table>

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

<table>
<thead>
<tr>
<th>Past Presidents</th>
<th>Members</th>
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<tbody>
<tr>
<td>Nancy J. Auer, MD, FACEP (WA)</td>
<td>Rebecca B. Parker, MD, FACEP (IL)</td>
</tr>
<tr>
<td>Brooks F. Bock, MD, FACEP (CO)</td>
<td>Andrew Sama, MD, FACEP (NY)</td>
</tr>
<tr>
<td>Angela F. Gardner, MD, FACEP (TX)</td>
<td>Robert W. Schafermeyer, MD, FACEP (NC)</td>
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<tr>
<td>Nicholas J. Jouriles, MD, FACEP (OH)</td>
<td>Sandra M. Schneider, MD, FACEP (TX)</td>
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<tr>
<td>Brian F. Keaton, MD, FACEP (OH)</td>
<td>Richard L. Stennes, MD, FACEP (CA)</td>
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<tr>
<td>George Molzen, MD, FACEP (NM)</td>
<td>Robert E. Suter, DO, MPH, FACEP (TX)</td>
</tr>
</tbody>
</table>
Past Speakers
Mark L. DeBard, MD, FACEP (OH)  John G. McManus, Jr., MD, MBA, FACEP
Peter J. Jacoby, MD, FACEP (CT)  Todd Taylor, MD, FACEP (AZ)

Past Chairs of the Board
John D. Bibb, MD, FACEP (CA)  Robert E. O’Connor, MD, MPH, FACEP (VA)
Ramon W. Johnson, MD, FACEP (CA)  David P. Sklar, MD, FACEP (NM)

The Temporary 2021 Council Meeting Standing Rules were distributed to the councillors prior to the meeting and were not read aloud.

TEMPORARY 2021 COUNCIL MEETING STANDING RULES

Because of the continuing COVID-19 pandemic, travel restrictions, and the impossibility for some councillors to attend the 2021 Council meeting in person, the following Rules governing the 2021 Council meeting are recommended for adoption, upon advice of ACEP’s General Counsel and Parliamentarian:

Rule 1. Virtual access to the Council meeting will be available via Zoom for councillors, alternate councillors, members of the Board of Directors, past presidents, past speakers, past chairs of the Board, ACEP members, invited guests, and authorized ACEP staff. There will not be an opportunity for virtual observers to be recognized to speak during the Council meeting or to submit comments through a chat feature.

Rule 2. Quorum for the Council meeting will be based on the number of credentialed councillors present at the meeting whether in person or by virtual access.

Rule 3. Voting on all matters during the Council meeting will be conducted using the Association Voting platform, which will also be accessible to councillors participating in the meeting through virtual access. Individual connectivity issues will not be the basis of a Point of Order or a challenge to any votes.

Rule 4. Virtual access to the Reference Committee hearings will be available via Zoom for councillors, alternate councillors, members of the Board of Directors, past presidents, past speakers, past chairs of the Board, ACEP members, invited guests, and authorized ACEP staff. There will not be an opportunity for virtual observers to provide oral testimony or submit comments to the Reference Committee through a chat feature. Reference Committees will include within their consideration asynchronous comments made prior to the hearing on the ACEP platform.

Rule 5. Except as expressly provided in these Temporary Rules, all other Council Standing Rules will remain in effect.

The Temporary 2021 Council Meeting Standing Rules were adopted without objection.

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

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. 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 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 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.

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The councillors reviewed and accepted the minutes of the October 24-25, 2020, Council meeting and approved the actions of the Steering Committee taken at their January 26, 2021, and April 26, 2021, meetings.

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

Dr. Katz reported that five 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. “Leon L. Haley, Jr., Award” was numbered 81 and assigned to Reference Committee A. “Defining the Job Description of an Emergency Physician” was numbered 82 and assigned to Reference Committee B.

Dr. Katz presented the Nominating Committee report.

Dr. Gray-Eurom was the only nominee for Speaker of the Council. Dr. Katz called for floor nominations. There were no floor nominees. The nominations were then closed. A vote was then conducted and Dr. Gray-Eurom was elected as the 2021-23 speaker of the Council.

Two members were nominated for Council Vice Speaker: Melissa W. Costello, MD, FACEP, and Kurtis A. Mayz, MD, JD, FACEP. Dr. Katz called for floor nominations. There were no floor nominees. The nominations were then closed.

One member was nominated for President-Elect: Aisha T. Terry, MD, MPH, FACEP. Dr. Katz called for floor nominations. Christopher S. Kang, MD, FACEP, was nominated from the floor. The nominations were then closed.

Seven members were nominated for four positions on the Board of Directors: L. Anthony Cirillo, MD, FACEP; William B. Felegi, DO, FACEP; John T. (JT) Finnell, II, MD, FACEP; Rami R. Khoury, MD, FACEP; Heidi C. Knowles, MD, FACEP; Michael Lozano, Jr., MD, MSHI, FACEP; and Joseph R. Twanmoh, MD, MBA. Dr. Katz called for floor nominations. Robert M. McNamara, MD, and Henry Z. Pitzele, MD, FACEP, were nominated from the floor. The nominations were then closed.

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

The Council recessed at 9:45 am for the Reference Committee hearings. The resolutions considered by the 2021 Council appear below as submitted.

2021 Council Resolutions

RESOLUTION 1
RESOLVED, That the American College of Emergency Physicians commends Vidor E. Friedman, MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 2
RESOLVED, That the American College of Emergency Physicians commends William P. Jaquis, MD, MSHQS, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.
RESOLUTION 3
RESOLVED, That the American College of Emergency Physicians commends Gary R. Katz, 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 Margaret Montgomery, RN, MSN, for her outstanding service and commitment to the College and the specialty of emergency medicine.

RESOLUTION 5
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Catherine Agustiady-Becker, DO, as one of the rising stars in emergency medicine; and be it further
RESOLVED; That the American College of Emergency Physicians extends to her husband, Jacob, her sons Wyatt, Theodore, and Quentin, her extended family, colleagues, and friends our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the countless patients and physicians across the country whom she served selflessly.

RESOLUTION 6
RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Heidi J. Lako-Adamson, MD, and extends condolences and gratitude to her husband, Mark, for her service to the specialty of emergency medicine and to patient care.

RESOLUTION 7
RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Joseph Litner, MD, PhD, FACEP, on the states of Washington, Mississippi, Louisiana, and the Government Services Chapter of ACEP; therefore be it
RESOLVED That the American College of Emergency Physicians and the Government Services Chapter acknowledge the huge loss and bereavement of his many colleagues and friends, but above all, extend condolences to his beloved wife of more than 40 years, Maria Hugi, MD, FACEP, and their precious children, David and Jonathan.

RESOLUTION 8
RESOLVED, That the American College of Emergency Physicians and the California Chapter extend to the family of Paul S. Auerbach, MD, MS, FACEP, gratitude for his tremendous service to emergency medicine.

RESOLUTION 9
RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Samuel C. Slimmer, Jr., MD, FACEP, who was a pioneer in the specialty and 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 extend to his son Samuel J., daughter-in-law Kelly, daughter Lara, and granddaughters Elisha and Eily gratitude for his tremendous service as one of the first emergency physicians, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 10
RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 8 – Board of Directors Action on Resolutions, be amended to read:

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.

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 45 calendar days of the adjournment of the Council meeting. This summary shall include:

1. An executive summary of the Council meeting.
2. A summary and final text of each passed and referred resolution.

Thereafter, the Board of Directors shall provide to the College written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution. A summary of the Board of Directors’ intent, discussion, and decision for each referred resolution shall be included. These communications shall be provided at 30 calendar day quarterly intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section.

**RESOLUTION 11**
RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.1 Regular Members, paragraph 4, be amended to read:

“Regular members who have retired from medical practice for any reason, or those working less than 280 hours annually, shall be assigned to retired status.”

**RESOLUTION 12**
RESOLVED, That the ACEP Council Standing Rules “Unanimous Consent Agenda” section, paragraph two, be amended to read as follows with the proviso that the change will become effective after the 2021 Council meeting:

“All resolutions assigned to a Reference Committee, except for Bylaws resolutions, shall be placed on a Unanimous Consent Agenda.”

**RESOLUTION 13**
RESOLVED, That any member of the College in good standing is eligible to seek election for president-elect of the College; and be it further

RESOLVED, That the ACEP president-elect be determined by a vote directly by the individual emergency physician members of the College with the majority winner becoming the president-elect; and be it further

RESOLVED, Should a non-majority vote for the president-elect by the membership not be achieved in the initial election, a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the ultimate winner.

**RESOLUTION 14**
RESOLVED, That the Council Steering Committee submit a Bylaws amendment to the Council in 2022 to support the establishment of a young physician position on the Nominating Committee.

**RESOLUTION 15**
RESOLVED, That a task force or committee be appointed to consider an alternative method of determining representation of the membership with specific consideration given to addressing the following:

1. Council composition to be determined by the allocation of credits or points that each individual emergency physician members in good standing of the College will be allotted equally.
2. Each and every full member in good standing who pays full membership dues will be assigned five (5) points or credits that the individual emergency physician is free to assign in whatever breakdown the member wishes towards his/her state chapter, another state chapter, a particular section, or any combination the member wishes to assign the points/credits.
3. Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.
4. Consider maintaining a minimum number of councillor positions i.e., one (1) could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned.
5. Consider a hybrid that gives preference as seen fit; and be it further
RESOLVED, That a task force or committee assigned to review alternative methods of determining representation of the members in the Council conclude its investigation, research, and suggestions and report back to the Board with sufficient time for the Board to report the information to the Council at least one month before the resolution submission deadline for the 2022 Council meeting.

**RESOLUTION 16**
RESOLVED, That ACEP group membership policy be revised to provide individual members a 20% discount on annual ACEP membership dues for every year that the group maintains 100% membership in ACEP beginning in 2022; and be it further
RESOLVED, That ACEP state chapters be encouraged to provide annual state chapter individual dues discount for members of groups who maintain 100% ACEP membership.

**RESOLUTION 17**
RESOLVED, ACEP develop a sample employment and independent contract template specific that is fair to emergency physicians and specifically points out numerous items that can and should be part of the negotiation, understanding that when an emergency physician is asked to give up a right or agree to something that favors the employer, it is reasonable to expect or negotiate something favorable to the emergency physician in return, including but not limited to the following items:

1. Compensation and how it is determined with base or minimum amount
2. Other compensation that the employer may generate directly or indirectly as a result of emergency physician services and how much of that the emergency physician is entitled to
3. Incentives, what ones, how they are determined, who determines them, by what measure/metrics, is the data available to both parties to review, etc.
4. Percentage of gross billing or collection, how is it determined, who collects data, how accessible is this data by the emergency physician, etc.
5. Deductions that are often taken from income and how much may be reasonable i.e. medical malpractice, scheduling, etc.
6. Equitable scheduling of shifts and a reasonable differential pay or incentives for accepting less favorable shift distribution
7. Equal treatment as all members of the medical staff at the facility the emergency physician will work i.e. employer will not agree that emergency physicians have less rights than other members of the same medical staff, etc.
8. Emergency physician’s right and final say to determine whether or not to settle a claim without trial
9. Specific language as to the transparency of the operations of the group/company that the emergency physician will be joining/working with/for and what power i.e. vote percentage the emergency physician will have and when
10. Severance pay to the emergency physician should the employer contract to hire and then withdraw the contract; terminate the physician; or there is separation of the parties (emergency physician and the group)
11. Non-compete clauses or specific language that there are no non-compete clauses (NCC). If there is a non-compete clause, is it only to prevent taking over a staffing contract? What is the duration of the NCC? Is the NCC only at the same facility, same town or city? What is the geographic distance of the NCC? Is there a buy out of the NCC? How much does the employer compensate the emergency physician to agree to a non-compete clause?
12. Whether the emergency physician is required to supervise, oversee, or collaborate with non-physicians and what control the emergency physician has to select who they work with, what control they have over quality measures, assurance, and enforcement including termination of the non-physician? How much additional compensation does the emergency physician receive for this service of oversight? How is it calculated? Who measures it? How accessible is the data?
13. The emergency physician should be aware of and should consider negotiating/demanding in their particular circumstances
14. Clear language requiring the employer to provide billing information that is complete, clear and transparent to the emergency physician regarding that emergency physician’s billing on a regular i.e. monthly, quarterly, semi-annual basis, without the emergency physician having to request it and not allowing the employer to require the emergency physician to have to ask for the information
15. Other topics and points that are deemed appropriate; and be it further
RESOLVED, That the ACEP Board of Directors expeditiously appoint a task force or committee to identify
many factors to include in a sample employment document that is fair to emergency physicians that identifies as many items that can be separately negotiated, and provide favorable and unfavorable examples of each negotiating item, and to have such task force or committee submit their final recommendations to the Board within six (6) months and for ACEP to have a final document produced and out for viewing by the membership as soon as possible but no later than before the 2022 Council meeting begins.

**RESOLUTION 18**
RESOLVED, That the ACEP Conflict of Interest form include all immediate family members or intimate partners as well as non-adopted children of a current spouse; and be it further
RESOLVED, That the ACEP Conflict of Interest forms be provided to all members and relevant staff and be included in the introductory materials for the project, committee, or task force; and be it further
RESOLVED, That a question be added to the College’s Conflict of Interest form to indicate if the person completing the form is related to a non-physician provider; and be it further
RESOLVED, That every candidate for the College President, Board of Directors, or Council Officer positions, including those running from the floor, complete the ACEP Conflict of Interest (COI) form and copies of those COI statements be included in election materials and available to all councillors.

**RESOLUTION 19**
RESOLVED, That all councillors, alternate councillors, and anyone else who may speak during Council on the Council floor or otherwise complete a disclosure form prior to the Council meeting with specific questions regarding potential conflicts that may be of importance to the Council at large to be aware; and be it further
RESOLVED, That the College implement a system i.e., electronic wristband that can be scanned when person approaches any microphone, that will display on the large screens in the room where Council is taking place that will reveal pertinent elements of the disclosure form that the speaker completed prior to Council i.e., employer, position with employer, percentage of clinical time vs. non-clinical time, other sources of revenue, etc., without disclosing specific amounts or data that the Council would find too invasive.

**RESOLUTION 20**
RESOLVED, That ACEP create a 501c(3) non-profit fund to be called the “Social Emergency Medicine Association” (SEMA) as a daughter organization in the same fashion as the Emergency Medicine Foundation and the National Emergency Medicine Political Action Committee for the purpose of funding, prioritizing, and administering efforts in social emergency medicine; and be it further
RESOLVED, That the ACEP Board of Directors and staff create the Social Emergency Medicine Association, including its rules and bylaws, by the Council meeting in 2022.

**RESOLUTION 21**
RESOLVED, That ACEP convene a summit meeting inviting the societies of emergency medicine to align efforts to address diversity, equity, and inclusion within the next year; and be it further
RESOLVED, That ACEP embed diversity, equity, and inclusion into its strategic plan and the internal and external work of ACEP; and be it further
RESOLVED, That ACEP report back to the 2022 Council meeting the outcome of the summit and have a road map created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

**RESOLUTION 22**
RESOLVED, That ACEP survey its speakers and educational presenters and report on speaker/educator demographics; and be it further
RESOLVED, That ACEP set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

**RESOLUTION 23**
RESOLVED, That ACEP focus more on marketing to and educating the public on the value of emergency physicians focusing on the differences in education and training that emergency physicians go through compared to non-emergency physicians; and be it further
RESOLVED, That ACEP focus more resources on a local, state, and national level campaign of marketing to the public through TV, radio, newspaper, social media, and public service announcements.

**RESOLUTION 24**
RESOLVED, That the College give consideration to coordinating or working with, or allowing other groups
or entities that hold common values and interests to advocate for some issues important to members of the College, to conserve resources to use for higher priority issues facing the membership and the College; and be it further

RESOLVED, That the College lessen the number of initiatives it chooses to promote or pursue, but instead focus on fewer initiatives and do them very well; and be it further

RESOLVED, That the College choose the few initiatives that affect the highest percentage of its membership, is the greatest threat to our profession, our members, and patients, and is of the least divisiveness to our members.

RESOLUTION 25

RESOLVED, That ACEP undertake a new state chapter survey with questions similar to previous Report Card studies but edited to reflect current emergency medicine practice issues in 2021; and be it further

RESOLVED, That ACEP publish and widely distribute the results of a state chapter survey in a National Report Card 2022 and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

RESOLUTION 26

RESOLVED, That ACEP support federal funding of syringe services programs; and be it further

RESOLVED, That ACEP develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use in addition to naloxone and educational material; and be it further

RESOLVED, That ACEP update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips to better inform decision-making when using drugs.

RESOLUTION 27

RESOLVED, That ACEP provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize 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.

RESOLUTION 28

RESOLVED, That:

1. ACEP advocate with professional, consumer, other health organizations and all other interested parties to classify emergency departments as follows

   Type A: All patients will be seen and evaluated exclusively by either:
   a. an ABEM or AOBEM certified emergency physician; or
   b. a physician recently graduated from a Residency Review Committee approved emergency medicine residency; or
   c. an emergency medicine resident in a Residency Review Committee approved emergency medicine residency under the onsite supervision of an ABEM or AOBEM certified emergency physician faculty member; or
   d. an emergency physician (who has been practicing emergency medicine greater than 20 years and has greater than 20,000 hours of emergency medicine experience) who is a member in good standing with an emergency medicine professional organization that has a method to enforce ethical behavior of its members including documentation of meeting these practice standards.

   Type B: All patients will have their care provided by the same criteria as Type A or by a physician assistant (PA) or nurse practitioner (NP) overseen by a ABEM or AOBEM certified or emergency medicine residency trained and/or can request and be seen by an emergency medicine residency trained or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of experience.)

   Type C: Patients may be seen by a PA or NP with supervision (either onsite or by telemedicine) by an ABEM or AOBEM certified, or by an emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience) or patients may be seen by a MD or DO that does not meet the above criteria.
Type D: Patients may be seen by a PA or NP (with 10,000 hours of emergency medicine experience) and without any direct or indirect supervision by an ABEM or AOBEM certified, approved emergency medicine residency trained, or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience).

Type E: None of above criteria have been met

2. ACEP will work with other likeminded medical professional, hospital organizations, and consumer groups to make available the classification and criteria so that it is widely known to the public and media.
3. ACEP will work to promote at no or minimal charge any and all emergency departments that meet the standards and assist all members to document these standards.
4. ACEP will work with other likeminded medical professional, hospital organizations, consumer groups, and governmental organizations to create an enforcement agency to ensure classifications are accurate and up to date.

ACEP will provide a report on this process and developments to the Council and ACEP membership on an annual basis.

RESOLUTION 29
RESOLVED, That ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; and be it further
RESOLVED, That ACEP develop specific model legislative language to include downcoding in existing prudent layperson statutes; and be it further.
RESOLVED, That ACEP work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and be it further.
RESOLVED, That ACEP work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

RESOLUTION 30
RESOLVED, That ACEP develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider’s contracts unless the new policy is required by new laws or regulations; or the provider consents in writing to the specific policy change prior to its being implemented; and be it further.
RESOLVED, That ACEP advocate at the American Medical Association to promote legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

RESOLUTION 31
RESOLVED, That ACEP submit a resolution to the June 2022 AMA House of Delegates Annual Meeting promoting Arizona house bill 2622 (2021) as signed into law as model state and national legislation to protect emergency physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or government, which also includes independent and third-party contractors providing patient services at said facilities; and be it further.
RESOLVED, That ACEP promote Arizona house bill 2622 (2021) to chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

RESOLUTION 32
RESOLVED, That ACEP promote and endorse that Emergency Departments become “Firearm Free” Zones, with the exception of active duty law enforcement officers, hospital security, military police, and federal agents; and be it further.
RESOLVED, That ACEP endorse and promote screening for firearms in the emergency department; and be it further.
RESOLVED, That ACEP promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

RESOLUTION 33
RESOLVED, That ACEP support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.
RESOLUTION 34
RESOLVED, That ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

RESOLUTION 35
RESOLVED, That ACEP support the rural critical access hospital program including the conversion of struggling rural critical access hospitals to rural emergency hospitals and state and federal governments should increase rural hospital access to low-cost capital to support the conversion of these facilities and preserve access to emergency care; and be it further
RESOLVED, That ACEP support rural health services research, including financial analyses of rural hospitals to better define the optimal funding model for rural critical access hospitals and rural emergency hospitals; and be it further
RESOLVED, That ACEP support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care, including emergency care, to enable rural critical access hospitals to provide a safety net for rural patients and cost-based reimbursement should be increased beyond this 101% minimum according to the proportion of Medicare, Medicaid, and uninsured patients seen in the emergency department; and be it further
RESOLVED, That ACEP support changes in Center for Medicare and Medicaid Services regulation that would allow rural off-campus emergency departments and rural emergency hospitals to collect the facility fee as well as the professional fee, as this essential for rural emergency hospital financial viability; and be it further
RESOLVED, That ACEP advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient for their portion to shift the burden of collecting from the patient with a high-deductible insurance plan to the insurance company and allow for more equitable payments to both the rural and referral hospitals for initial stabilization in a rural area and definitive care at a tertiary center.

RESOLUTION 36
RESOLVED, That ACEP work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to implementation of the CURES Act; and be it further
RESOLVED, That ACEP develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

RESOLUTION 37
RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; and be it further
RESOLVED, That ACEP support that when a nominal compensation amount is stated to compensate the emergency physician, the amount must meet or exceed an established Minimum Emergency Physician Pay Ratio; and be it further
RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individual, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

RESOLUTION 38
RESOLVED, That ACEP advocate, at both state and national levels, that ABEM-certified providers serve as the highest level of medical experts on the matter of management of patients with hyperactive delirium with severe agitation in the prehospital and emergency medical settings; and be it further
RESOLVED, That ACEP play an active role, at both state and national levels, in advocating against any non-ABEM-certified specialty’s assertion to having greater expertise in the acute therapeutic (i.e., pharmacologic and non-pharmacologic) management of patients with hyperactive delirium in the prehospital setting; and be it further
RESOLVED, That ACEP oppose any non-ABEM-certified specialty’s medical oversight, in part or in whole, of prehospital medical direction, particularly when pertaining to the management of hyperactive delirium with severe agitation; and be it further
RESOLVED, That ACEP partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators and legislators on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation.

RESOLUTION 39
RESOLVED, That ACEP recommit to the goal of reducing overdose deaths in this country by working with Customs and Border Patrol, the Drug Enforcement Agency, state legislatures on the southern border, federal legislatures, and any other relevant stakeholders; and be it further
RESOLVED, That ACEP continue to advocate for governmental actions to decrease the supply of fentanyl and other illegal drugs entering our country by whatever means necessary and to highlight the continued increase in overdoses and overdose deaths

RESOLUTION 40
RESOLVED, That ACEP advocate for state and federal laws requiring payers to reimburse emergency departments, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

RESOLUTION 41
RESOLVED, That ACEP amend the current policy statement “Naloxone Prescriptions by Emergency Physicians” to include endorsement for Take Home Naloxone programs in emergency departments; and be it further
RESOLVED, That ACEP seek to increase the distribution of naloxone from the emergency department by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; and be it further
RESOLVED, That ACEP promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose and work toward increasing the number of Take Home Naloxone programs in emergency departments, partnering with other like-minded organizations, and promoting take home naloxone as a best practice; and be it further
RESOLVED, That ACEP advocate for regulatory and payment reform that would facilitate reimbursement to hospitals and emergency departments for naloxone dispensed directly to patients as part of Take Home Naloxone programs, thus removing financial disincentives for hospitals to have Take Home Naloxone programs; and be it further
RESOLVED, That ACEP promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their emergency department.

RESOLUTION 42
RESOLVED, That ACEP advocate for the administration of vaccines against COVID-19 to qualified patients that present to the emergency department (ED); and be it further
RESOLVED, That ACEP support the development of best practices for discussing COVID-19 vaccines with patients, clinical decision making around when to administer the vaccine, building capacity to administer vaccines to emergency department patients, and integrating ED vaccination programs into larger community vaccination efforts.

RESOLUTION 43
RESOLVED, That ACEP adopt and promote a practice of “shared governance based due process” that has the following general qualities and that it applies to:

1. Employees of a hospital or health system.
2. Independent contractors or employees of a large group with a MSO
3. Independent contractors or employees of a small group

Definitions
1. Individual Physician (IP) requesting due process.
2. Management Service Organization (MSO) or individual or entity that makes decisions, negotiates contracts, or provides management services. This can also apply to administrative physicians in small group or deans/chairs/administrative faculty.
3. Practicing physicians in Physician Group (PPG) would be the entity deciding that outcome of the IP and be limited to the physicians practicing in the group at that hospital in that department. Their vote would be based on number of clinical hours worked in the past six months. Groups could establish some type of seniority multiplier based on years worked or full votes to each full-time clinical physician based on a minimum hours such as 80/hours a month.

The hospital, health system, medical group, or MSO would still arrange and sign contracts with individual physicians (IP). However, in the event a hospital administration, MSO, or health system requests the immediate removal of an IP, or removes them from the schedule, or fails to schedule them for their usual numbers of shifts, the IP would have the opportunity to have a hearing before the PPG. The PPG would then determine if the IP should be immediately terminated or removed from the schedule. The proceedings/vote would be confidential, but results would be reported to the MSO. If the MSO or IP disagrees with the decision, the MSO or IP could still initiate a hospital medical staff due process complaint (if available to them), arbitration process, or legal remedy.

**RESOLUTION 44**
RESOLVED, That ACEP promote the equitable, culturally competent, and knowledgeable treatment of transgender and gender diverse patients receiving care in the emergency department; and be it further
RESOLVED, That ACEP compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the emergency department; and be it further
RESOLVED, That ACEP encourage hospitals to provide adequate and appropriate education, training, and resources to all emergency department physicians on the needs and best practices related to care of transgender and gender diverse patients; and be it further
RESOLVED, That ACEP encourage emergency departments to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

**RESOLUTION 45**
RESOLVED, That ACEP define the essential operational and quality metrics appropriate for managing a small, rural, or critical access ED; and be it further
RESOLVED, That ACEP provide regional performance measure data on operational and quality metrics to small, rural, and critical access hospital emergency departments in the form of a free, basic, annual report.

**RESOLUTION 46**
RESOLVED, That ACEP study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

**RESOLUTION 47**
RESOLVED, That ACEP advocate for paid family leave, including but not limited to supporting the American Medical Association’s effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); and be it further
RESOLVED, That ACEP conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and be it further
RESOLVED, That ACEP develop a policy statement in support of paid family leave outside of the language in ACEP’s “Family and Medical Leave” policy statement revised in 2019.

**RESOLUTION 48**
RESOLVED, That ACEP study financial and other incentives that might be used to reduce emergency department crowding.

**RESOLUTION 49**
RESOLVED, That ACEP work with other stakeholders to discourage states and hospitals from using forced EMS diversion to substitute for system-wide hospital admission load balancing; and be it further
RESOLVED, That ACEP collect data on the clinical impact of EMS diversion policies.

**RESOLUTION 50**
RESOLVED, That ACEP develop a policy statement on the harms of marijuana as seen in emergency department presentations; and be it further
RESOLVED, That ACEP provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses.

RESOLUTION 51
RESOLVED, That ACEP adopt the following Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation:

Detained, arrested, and incarcerated persons have the right to:
1. Medical neutrality – equal evaluation and treatment for emergency medical conditions regardless of their status as a detained or incarcerated person.
2. Speak with their provider privately.
3. Removal of physical restraints for the purpose of a physical exam at the request of the treating physician.
4. Medical care at a facility that has a protocol for and supports quality analysis of medical care.
5. Privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless expressly pertinent to delivery of care.
6. Informed consent – to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans.
7. Refuse care and diagnostic testing, including nutrition, laboratory studies, medications, and procedures, with the exception of psychoactive medications if the patient is deemed a potential harm to self or others if psychoactive medications are withheld OR with the exception of previously set forth state policies or contracts determining otherwise.
8. Administration of interventions and requests for consultations in a timely manner consistent with local standards of care.
9. Make their healthcare decisions independently, if deemed competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers.
10. Visitation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions.; and be it further

RESOLVED, That ACEP work with interested parties and key stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

RESOLUTION 52
RESOLVED, That ACEP work with interested state chapters, law enforcement personnel, and other stakeholders to develop protocols and standards for the medical screening examination of individuals who are in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center; and be it further

RESOLVED, That ACEP develop best practice guidelines for the conveying of an arrested person’s pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

RESOLUTION 53
RESOLVED, That ACEP issue a statement regarding support for a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions, as doing so will allow emergency physicians to avoid conflicts of interest, improve reporting, data gathering and epidemiologic monitoring, which will better enable us to research how we can best provide the most safe and appropriate care to our patients; and be it further

RESOLVED, That ACEP create an educational toolkit regarding identifying and reporting injuries suspected or reported to be resulting from law enforcement actions similar to that which exists regarding child and elder or dependent abuse or neglect, thereby enhancing physician understanding of these injuries and improving reporting.

RESOLUTION 54
RESOLVED, That ACEP support the research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the ED to create transparency and protect the rights of its vulnerable patient populations; and be it further

RESOLVED, That ACEP advocate for state chapters to create easily accessible transparent toolkits that outline state-specific policies and laws regarding law enforcement presence in the ED, thereby enhancing physician understanding of patient and physician rights in their interactions with law enforcement within the ED as well as their own rights as physicians.
RESOLUTION 55
RESOLVED, That ACEP acknowledge and affirm that current iterations of patient satisfaction instruments are in clear violation of existing ACEP policy; and be it further
RESOLVED, That ACEP define standardized inclusion and exclusion criteria for patient experience survey populations; and be it further
RESOLVED, That ACEP define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and be it further
RESOLVED, That ACEP aggressively advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

RESOLUTION 56
RESOLVED, That ACEP issue a statement to the membership regarding the lack of validity in race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color patients and communities; and be it further
RESOLVED, That ACEP commit to the education of its membership by denouncing the use of race-based calculators in its clinical policies.

RESOLUTION 57
RESOLVED, That ACEP seek to improve the recognition of, and attention to, social determinants of health (SDH) by supporting research of evidence-based SDH screening and interventions in the ED with a focus on the unique strengths and challenges the ED setting poses for identifying and influencing SDH in order to develop interventions feasible for implementation in the ED; and be it further
RESOLVED, That ACEP advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and be it further
RESOLVED, That ACEP push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

RESOLUTION 58
RESOLVED, That ACEP support the development of training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting to replace the 8-hour training that had previously been required for X-waiver applications; and be it further
RESOLVED, That ACEP develop an online peer mentoring platform, similar to Providers Clinical Support System, but limited to emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices while responding to specific practice-based challenges that arise in an asynchronous messaging forum available to all ACEP members.

RESOLUTION 59
RESOLVED, That ACEP promote the use of qualified medical interpreters for all emergency department patient interactions with patients with limited English proficiency unless the communicating provider has proven qualifications to self-interpret in a medical setting; and be it further
RESOLVED, That ACEP provide resources for emergency departments on available interpreter services and how providers can prove qualification for interpreting in a medical setting.

RESOLUTION 60
RESOLVED, That ACEP establish a task force with the following goals:
1. Determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests.
2. Determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees.
3. Determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees’ current and future employability.
4. In the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.
RESOLUTION 61
RESOLVED, That ACEP advocate that all U.S. medical schools, allopathic and osteopathic, require at least one emergency medicine rotation.

RESOLUTION 62
RESOLVED, That ACEP promote and endorse telehealth training opportunities for emergency medicine residents; and be it further
RESOLVED, That ACEP advocate for inclusion of telehealth in The Model of the Clinical Practice of Emergency Medicine; and be it further
RESOLVED, That ACEP support the development of additional telehealth fellowship programs in emergency medicine.

RESOLUTION 63
RESOLVED, That ACEP engage with the Accreditation Council for Graduate Medical Education, the Council of Residency Directors in Emergency Medicine, the Society of Emergency Medicine Physician Assistants, the American Academy of Emergency Nurse Practitioners, and the American Association of Physician Leaders, and other interested parties to develop a standardized curriculum for teaching physicians to function as team leaders in support of physician-led teams; and be it further
RESOLVED, That ACEP develop continuing medical education to instruct physician-led teams based on the curriculum identified by the stakeholders for physicians who are post residency; and be it further
RESOLVED, That ACEP advocate to the Accreditation Council for Graduate Medical Education that specific competencies in team leadership be incorporated in the next revision of The Model of the Practice of Clinical Emergency Medicine.

RESOLUTION 64
RESOLVED, That ACEP support the creation of links between rural hospitals and larger health networks and academic institutions, including medical schools and colleges, to facilitate the creation of rural medicine internships and electives for interested learners at the undergraduate and medical school level; and be it further
RESOLVED, That ACEP support the use of government funding for rural elective rotations for emergency medicine residents at rural critical access hospitals to better train residents for this work and recruit residents to rural practice, where they are most needed; and be it further
RESOLVED, That ACEP support student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

RESOLUTION 65
RESOLVED, That ACEP recognize that patients presenting to rural emergency departments are arguably our most vulnerable ED patient population in the U.S. and deserve increased support; and be it further
RESOLVED, That ACEP support/develop a comprehensive survey of rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and this survey should be volume based and stratified as follows:

<table>
<thead>
<tr>
<th>Rural Type</th>
<th>Description</th>
<th>Annual Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Frontier</td>
<td>&lt; 0.25 pts/hr (annual volume &lt; 2,190)</td>
<td></td>
</tr>
<tr>
<td>Frontier</td>
<td>0.25 pts/hr - 0.5 pts/hr (annual volume 2,191 to 4,380)</td>
<td></td>
</tr>
<tr>
<td>Small Rural</td>
<td>0.5 pts/hr – 2 pts/hr (annual volume 4,381 to 17,520)</td>
<td></td>
</tr>
<tr>
<td>Medium Rural</td>
<td>2 pts/hr – 4 pts/hr (annual volume 17,521 to 35,040)</td>
<td></td>
</tr>
<tr>
<td>Large Rural</td>
<td>&gt; 4 pts/hr (annual volume &gt; 35,041); and be it further</td>
<td></td>
</tr>
</tbody>
</table>

RESOLVED, That ACEP recognize that ABEM/AOBEM-certified physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; and be it further
RESOLVED, That ACEP support rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and be it further
RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 0.5 patients per hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and ACEP will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; and be it further
RESOLVED, That ACEP work with the American Academy of Family Physicians, the American Board of Physician Specialties, the American Academy of Emergency Nurse Practitioners, the Society of Emergency Physician Assistants, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, nurse practitioners, and physician assistants practicing in rural emergency departments; and be it further

RESOLVED, That ACEP closely evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, physician assistants, and nurse practitioners working solo in extreme low volume facilities; and be it further

RESOLVED, That ACEP support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

**RESOLUTION 66**

RESOLVED, That ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an emergency physician and have an emergency physician directly oversee their care on an in-person basis; and be it further

RESOLVED, That ACEP reaffirm its role as a professional medical association dedicated to promoting the role of emergency physicians, instructing the ACEP staff and officers to promote the role of emergency physicians over all other models of emergency care.

**RESOLUTION 67**

RESOLVED, That ACEP support patients’ rights to choose who provides their medical care; and be it further

RESOLVED, That ACEP support the gold standard for board-certified emergency physicians to be involved in every patient who presents to an emergency department; and be it further

RESOLVED, That ACEP support an informed consent form to be documented in emergency department patients’ charts regarding their choice to: 1) agree to care by non-physician practitioner not supervised by physician; 2) agree to care by a non-physician practitioner only supervised by a physician; or 3) agree to care only by a physician.

**RESOLUTION 68**

RESOLVED, That ACEP support legislation to require all facilities that wish to have an emergency department or designate an area as an emergency department or emergency room, to have a board eligible or board certified emergency physician present onsite preferentially, or via telehealth with an onsite non-emergency physician if on-site availability is not possible, 24 hours a day, 7 days a week to qualify to market to the public and bill for emergency services, with the only exception if broadband does not exist or is impossible to access with legitimate and reasonable efforts to do so, to have such a designation; and be it further

RESOLVED, That ACEP support legislation that if a facility does not currently have an onsite board eligible or board certified emergency physician available to see and treat emergency patients 24 hours a day, 7 days a week, that facility must submit a plan to the licensing body that regulates them with specific actions the facility is making and will be making to become compliant with having 24/7 coverage by a board eligible or board certified emergency physician within 24 months; and be it further

RESOLVED, That ACEP support legislation to state: if a facility fails to achieve and maintain 24/7 coverage of any emergency facility by board eligible or board certified emergency physicians within 24 months, they must remove all signage and cease all marketing naming them as an ER or emergency department, emergency center, or expressly post in a conspicuous area on the sign in letters in the same font size as large or larger than the largest letters on signage that “THIS FACILITY DOES NOT ALWAYS STAFF OUR FACILITY WITH BOARD CERTIFIED EMERGENCY PHYSICIANS”; and be it further

RESOLVED, That ACEP encourage that facilities that do not have 24/7 coverage with board eligible or board certified emergency physicians cannot bill at the same rates as facilities (emergency departments, emergency centers, emergency rooms, etc.) that do have board eligible or board certified emergency physicians staffing their facilities 24/7.

**RESOLUTION 69**

RESOLVED, That all physicians, physician assistants, nurse practitioners or any person who might be reasonably be referred to as a provider, clinician, or practitioner, or any person who practices, or could reasonably be interpreted as practicing medicine including the authority to write orders or prescriptions that interacts with a patient, must state their name and then clearly state “I am a medical doctor (MD),” (to include doctors of osteopathic medicine, or the doctor of osteopathic medicine could say “I am a doctor of osteopathic medicine (DO)” or “I am not
a medical doctor” depending on the education and training of that individual.

**RESOLUTION 70**
RESOLVED, That ACEP create a toolkit for members to use at the state level to address practice scope expansion efforts that emphasizes the importance of a physician led team for optimal patient safety; and be it further
RESOLVED, That ACEP’s advocacy team create a tracking system for unsupervised practice efforts in each state to ensure that the voice of emergency physicians can be heard for this important patient safety topic; and be it further
RESOLVED, That ACEP’s advocacy team create a “strike team” of advocacy experts in emergency medicine scope expansion issues that can be tasked to help engage states who are actively involved in scope expansion legislation and support the state chapters and physicians at the local level; and be it further
RESOLVED, That ACEP partner with the American Medical Association Scope of Practice Partnership, Physicians for Patient Protection, and other like-minded groups to address scope expansion efforts on a national basis.

**RESOLUTION 71**
RESOLVED, That ACEP support a reduction in non-physician practitioner emergency department staffing over the next three years to eliminate the use of non-physician practitioners in the ED, unless the supply of emergency physicians for the location is not adequate for the staffing needs.

**RESOLUTION 72**
RESOLVED, That emergency physicians have the choice as to whether to supervise or collaborate with non-physicians; and be it further RESOLVED, That emergency physicians be fairly compensated to supervise physician assistants and/or collaborate with nurse practitioners; and be it further RESOLVED, That the fair compensation for supervision and collaborating with non-physicians is in addition to the compensation that the emergency physician receives for practicing emergency medicine without supervision and collaborating.

**RESOLUTION 73**
RESOLVED, That the ACEP policy statement, “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department,” be revised to remove “offsite” supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants and nurse practitioners in the emergency department; and be it further RESOLVED, That ACEP oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

**RESOLUTION 74**
RESOLVED, That ACEP support a federal definition of the practice of medicine to include the ordering of tests, diagnosing, prescribing of medications, and/or ordering of treatments on human beings; and be it further RESOLVED, That anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical boards that regulate the practice of medicine.

**RESOLUTION 75**
RESOLVED, That ACEP contact the Emergency Nurses Association to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force’s identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse; and be it further RESOLVED, That ACEP collaborate with the Emergency Nurses Association to advocate for a minimum level of nursing experience prior to working in the emergency department given the variety of acuity and pathology seen in undifferentiated patients presenting to the ED; and be it further RESOLVED, That ACEP and the Emergency Nurses Association collaborate in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in emergency departments across the country.

**RESOLUTION 76**
RESOLVED, That ACEP object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an emergency department; and be it
RESOLVED, That ACEP object to the use of unsupervised assistant physicians as medical practitioners at any level in an emergency department; and be it further
RESOLVED, That ACEP create a working group to recommend the minimum qualifications and clinical experience necessary to work in an emergency department as a supervised advanced practice provider; and be it further
RESOLVED, That ACEP establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and be it further
RESOLVED, That ACEP establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers.

RESOLUTION 77
RESOLVED, That ACEP support contract management groups, other employers, persons or entities who have employment or independent contract work agreements with emergency physicians be held accountable to any emergency physician who practices at any facility that utilizes non-physicians and is expected to supervise or have a collaborative agreement with any non-physician that raises a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician’s ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control; and be it further
RESOLVED, That ACEP support emergency physicians not being forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians’ sole determination, do not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc.; and be it further
RESOLVED, That ACEP support that no emergency physician who raises concerns regarding a non-physician’s care, professional behavior, knowledge, or procedural skills receive any negative consequences or retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc., as a result of raising concerns.

RESOLUTION 78 (This late resolution was accepted by the Council.)
RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE, and extends condolences and gratitude to his parents Leon and Elizabeth Ann, his children Grant, Wesley, and Nichelle, his sister Lisa, family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served so well.

RESOLUTION 79 (This late resolution was accepted by the Council.)
RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Juan Francisco Fitz, MD, FACEP, on the State of Texas and the Texas College of Emergency Physicians; and be it further
RESOLVED That the American College of Emergency Physicians and the Texas College of Emergency Physicians acknowledges the substantial loss to the medical community and bereavement of his many colleagues and friends, but above all extend condolences to his family.

RESOLUTION 80 (This late resolution was accepted by the Council.)
RESOLVED, That the American College of Emergency Physicians remember with honor and gratitude this trailblazing pioneer, Jay Edelberg, MD, FACEP, and his selfless contributions to emergency medicine; and be it further
RESOLVED, That the American College of Emergency Physicians extends the same gratitude and condolences to his wife, Caral, his family members, colleagues, and friends who are deeply saddened by this loss.

RESOLUTION 81 (This late resolution was accepted by the Council.)
RESOLVED, That the American College of Emergency Physicians create a national award to honor champions of diversity, inclusion, and health equity and it be named the “Leon L Haley Jr Award” in honor of one of the emergency medicine leaders who promoted diversity, inclusion, health equity and eliminating health disparities throughout his career; and be it further
RESOLVED, That each year at the ACEP Scientific Assembly that there should be a “Leon L Haley Jr Lecture” that will focus on diversity, equity, and inclusion and on the outstanding qualities exemplified by Leon
Haley, including professionalism, humanitarianism, and advocacy for the elimination of healthcare disparities.

RESOLUTION 82  (This late resolution was accepted by the Council.)

RESOLVED, That, the American College of Emergency Physicians (ACEP) work with appropriate stakeholders and the insurance industry to develop ACEP policy defining an accurate job description that can apply to all emergency physicians; one which reflects the true physical and cognitive demands of the specialty, and can be used in the Occupational Information System under development by the Social Security Administration; and be it further

RESOLVED, That the ACEP Board of Directors draft a letter containing an accurate job description which members can use to support appeals to their long term disability claim denials, until an acceptable definition is created for the use of adjudication of disability claims; and be it further

RESOLVED, That ACEP support state chapters in their efforts to work with state insurance regulators to create model regulatory language demanding that specialty-specific job descriptions are clearly stated on disability insurance products when these are being marketed and sold in order to ensure transparency to current and future policy holders.

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Commendation and memorial resolutions were not assigned to a Reference Committee.

Resolutions 10-24 and 81, were referred to Reference Committee A. Michael McCrea, MD, FACEP, chaired Reference Committee A and other members were: Kathleen Clem, MD, FACEP; Debra Fletcher, MD, FACEP; John M. Gallagher, MD, FACEP; Ken Holbert, MD, FACEP; Thom Mitchell, MD, FACEP; Laura Lang, JD; Maude Surprenant Hancock; and Shari Purpura.

Resolutions 25-41 and 82, were referred to Reference Committee B. Ashley Booth-Norse, MD, FACEP, chaired Reference Committee B and other members were: Erik Bluttinger, MD, MSc; Paul Kozak, MD, FACEP; Catherine Marco, MD, FACEP; Howard K. Mell, MD, CPE, FACEP; Thomas J. Sugarman, MD, FACEP; Ryan McBride, MPP; and Jeff Davis.

Resolutions 42-59 were referred to Reference Committee C. L. Carlos Zapata, MD, FACEP, chaired Reference Committee C and other members were: Purva Grover, MD, FACEP; Jonathan Hansen, MD, FACEP; Jeffrey Linzer, MD, FACEP; Eric Maur, MD, FACEP; Sandra Williams, DO, FACEP; Travis Schulz, MLS, AHIP; Kaeli Vandertulip, MBA, MSLS, AHIP.

Resolutions 60-77 were referred to Reference Committee D. Abhi Mehrotra, MD, FACEP, chaired Reference Committee D and other members were: William Falco, MD, FACEP; Daniel Freess, MD, FACEP; Odetolu Odufuye, MD, FACEP; Scott Pasichow, MD, MPH; Stephen Viel, MD, MPH, FACEP; Adam Krushinskie, MPA and Harry Monroe.

Each of the Reference Committees held virtual hearings. Following the Reference Committee hearings, a Candidate Forum for the president-elect candidates was held. The Candidate Forum for the Board of Directors was recorded prior to the Council meeting and the recorded sessions were made available to councillors for viewing on demand.

At 12:45 pm a Town Hall Meeting was convened. The topic was “ACEP’s Strategic Plan. Daniel Stone, ACEP’s consultant for the Strategic Plan, served as the moderator and the discussants were Mark S. Rosenberg, DO, FACEP; Gillian R. Schmitz, MD, FACEP, and Susan E. Sedory, MA, CAE.

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 Dr. Katz addressed the Council and then reviewed the procedure for the adoption of the 2021 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Katz then read the resolveds of the memorial resolutions for Catherine Agustaidy-Becker, MD; Paul Auerbach, MD, FACEP; Jay Edelberg, MD, FACEP; Juan Francisco Fitz, MD, FACEP; Leon H. Haley, Jr., MD, FACEP; Heidi Lako-Adams, MD; Joseph Litner, MD, FACEP; and Samuel Slimmer, Jr. MD, FACEP. The Council
honored the memory of those who passed away since the last Council meeting and adopted the memorial resolutions by observing a moment of silence.

Marianne Gausche-Hill, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Aisha T. Terry, MD, MPH, FACEP, presented the secretary-treasurer’s report.

George RJ Sontag, MD, president of the Emergency Medicine Residents’ Association, addressed the Council.

Dr. Wilcox addressed the Council regarding the activities of the Emergency Medicine Foundation.

Dr. Jacoby addressed the Council regarding the activities of NEMPAC and the 911 Network.

Mark S. Rosenberg, DO, MBA, 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 610 pm for the candidate reception and reconvened at 8:01 am on Sunday, October 24, 2022.

Electronic councillor credentialing was conducted to determine the number of councillors currently participating remotely. Dr. Kraus reported that 387 councillors of the 446 eligible for seating had been credentialled, including 353 participating in person and 34 participating remotely.

Ms. Sedory, executive director and Council secretary, addressed the Council.

Dr. Katz announced that the Reference Committee reports would be discussed in the following order: Reference Committee A, Reference Committee D, Reference Committee C, and Reference Committee B.

REFERENCE COMMITTEE A

Dr. McCrea 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 12, Resolution 14, Resolution 21, Resolution 22, and Resolution 81.

**For adoption as amended or substituted:** Amended Resolution 18, Substitute Resolution 19, and Amended Resolution 23.

**Not for adoption:** Resolution 13, Resolution 15, Resolution 17, Resolution 20, and Resolution 24.

**For referral to the Board of Directors:** Resolution 16

Resolution 12, Resolution 15, Resolution 22, and Amended Resolution 23 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

**AMENDED RESOLUTION 18**

RESOLVED, THAT THE ACEP CONFLICT OF INTEREST FORM INCLUDE ALL IMMEDIATE FAMILY MEMBERS OR INTIMATE PARTNERS IN SITUATIONS OF SAME-SEX COUPLES NOT RECOGNIZED BY LOCAL LAW AS WELL AS NON-ADOPTED CHILDREN OF A CURRENT SPOUSE; AND BE IT FURTHER

RESOLVED, THAT THE ACEP CONFLICT OF INTEREST FORMS BE PROVIDED TO ALL MEMBERS AND RELEVANT STAFF AND BE INCLUDED IN THE INTRODUCTORY MATERIALS FOR THE PROJECT, COMMITTEE, OR TASK FORCE; AND BE IT FURTHER

RESOLVED, THAT A QUESTION BE ADDED TO THE COLLEGE’S CONFLICT OF INTEREST FORM TO INDICATE IF THE PERSON COMPLETING THE FORM IS RELATED TO A
NON-PHYSICIAN PROVIDER AND IF THAT NON-PHYSICIAN PROVIDER FORMERLY OR CURRENTLY WORKS IN AN EMERGENCY DEPARTMENT OR URGENT CARE; AND BE IT FURTHER

RESOLVED, THAT EVERY CANDIDATE FOR THE COLLEGE PRESIDENT, BOARD OF DIRECTORS, OR COUNCIL OFFICER POSITIONS, INCLUDING THOSE RUNNING FROM THE FLOOR, COMPLETE THE ACEP CONFLICT OF INTEREST (COI) FORM AND COPIES OF THOSE COI STATEMENTS BE INCLUDED IN ELECTION MATERIALS AND AVAILABLE TO ALL COUNCILLORS.

**SUBSTITUTE RESOLUTION 19**

RESOLVED, THAT THE COUNCIL STEERING COMMITTEE DEVELOP A CONFLICT OF INTEREST FORM TO BE UTILIZED BY COUNCILLORS, ALTERNATE COUNCILLORS, OR ANY PERSON PROVIDING TESTIMONY AT THE COUNCIL MEETING AND DEVELOP MEANS FOR COUNCILLORS TO ACCESS SUCH FORMS DURING OR PRIOR TO THE COUNCIL MEETING.

RESOLVED, THAT ALL COUNCILLORS, ALTERNATE COUNCILLORS, AND ANYONE ELSE WHO MAY SPEAK DURING COUNCIL ON THE COUNCIL FLOOR OR OTHERWISE COMPLETE A DISCLOSURE FORM PRIOR TO THE COUNCIL MEETING WITH SPECIFIC QUESTIONS REGARDING POTENTIAL CONFLICTS THAT MAY BE OF IMPORTANCE TO THE COUNCIL AT LARGE TO BE AWARE, AND BE IT FURTHER

RESOLVED, THAT THE COLLEGE IMPLEMENT A SYSTEM I.E., ELECTRONIC WRISTBAND THAT CAN BE SCANNED WHEN PERSON APPROACHES ANY MICROPHONE, THAT WILL DISPLAY ON THE LARGE SCREENS IN THE ROOM WHERE COUNCIL IS TAKING PLACE THAT WILL REVEAL PERTINENT ELEMENTS OF THE DISCLOSURE FORM THAT THE SPEAKER COMPLETED PRIOR TO COUNCIL, I.E., EMPLOYER, POSITION WITH EMPLOYER, PERCENTAGE OF CLINICAL TIME VS. NON-CLINICAL TIME, OTHER SOURCES OF REVENUE, ETC., WITHOUT DISCLOSING SPECIFIC AMOUNTS OR DATA THAT THE COUNCIL WOULD FIND TOO INVASIVE.

The committee recommended that Resolution 12 be adopted.

It was moved THAT RESOLUTION 12 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 22 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 OF RESOLUTION 22 BE ADOPTED. The motion was adopted.

It was moved that the SECOND RESOLVED OF RESOLUTION 22 BE ADOPTED. The motion was adopted.

It was moved THAT AMENDED RESOLUTION 23 BE ADOPTED:

RESOLVED, THAT ACEP FOCUS MORE ON MARKETING TO AND EDUCATING THE PUBLIC ON THE VALUE OF BOARD CERTIFICATION IN EMERGENCY PHYSICIANS MEDICINE, FOCUSING ON THE DIFFERENCES IN EDUCATION AND TRAINING THAT BOARD CERTIFIED EMERGENCY PHYSICIANS GO THROUGH COMPARED TO NON-BOARD CERTIFIED EMERGENCY PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS; AND BE IT FURTHER

RESOLVED, THAT ACEP FOCUS MORE RESOURCES ON A LOCAL, STATE, AND NATIONAL LEVEL CAMPAIGN OF MARKETING TO THE PUBLIC THROUGH TV, RADIO, NEWSPAPER, SOCIAL MEDIA, AND PUBLIC SERVICE ANNOUNCEMENTS.
It was moved THAT THE WORDS “NON BOARD CERTIFIED EMERGENCY PHYSICIANS AND” BE DELETED IN THE FIRST RESOLVED. The motion was not adopted.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY INSERTING THE WORDS “ABEM/AOBEM” BEFORE THE WORDS “BOARD CERTIFICATION” AND “BOARD CERTIFIED.” The motion was adopted.

It was moved THAT AMENDED RESOLUTION 23 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved that “ABP” BE ADDED AFTER “ABEM/AOBEM” IN THE FIRST RESOLVED. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 15 not be adopted.

It was moved THAT RESOLUTION 15 BE ADOPTED.

It was moved THAT RESOLUTION 15 BE REFERRED TO THE COUNCIL STEERING COMMITTEE. The motion was adopted.

The committee recommended THAT AMENDED RESOLUTION 10 BE ADOPTED.

It was moved THAT AMENDED RESOLUTION 10 BE ADOPTED.

RESOLVED, THAT THE ACEP BYLAWS ARTICLE VIII – COUNCIL, SECTION 8 – BOARD OF DIRECTORS ACTION ON RESOLUTIONS, BE AMENDED TO READ:

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.

THE ACEP COUNCIL SPEAKER AND VICE SPEAKER OR THEIR DESIGNEE SHALL PROVIDE TO THE COLLEGE A WRITTEN SUMMARY OF THE COUNCIL MEETING WITHIN 45 CALENDAR DAYS OF THE ADJOURNMENT OF THE COUNCIL MEETING. THIS SUMMARY SHALL INCLUDE:

1. AN EXECUTIVE SUMMARY OF THE COUNCIL MEETING.
2. A SUMMARY AND FINAL TEXT OF EACH PASSED AND REFERRED RESOLUTION.

THEREAFTER, THE BOARD OF DIRECTORS SHALL PROVIDE TO THE COLLEGE WRITTEN AND COMPREHENSIVE COMMUNICATION REGARDING THE ACTIONS TAKEN AND STATUS OF EACH ADOPTED AND REFERRED RESOLUTION, A SUMMARY OF THE BOARD OF DIRECTORS’ INTENT, DISCUSSION, AND DECISION FOR EACH REFERRED RESOLUTION SHALL BE INCLUDED. THESE COMMUNICATIONS SHALL BE PROVIDED AT
30 CALENDAR DAY QUARTERLY INTERVALS UNTIL THESE COMMUNICATIONS DEMONSTRATE THAT NO FURTHER BOARD ACTION IS REQUIRED ACCORDING TO THE BYLAWS LISTED PREVIOUSLY IN THIS SECTION.

BYLAW AMENDMENT RESOLUTIONS ARE GOVERNED BY ARTICLE XIII OF THESE BYLAWS.

The motion was adopted.

The committee recommended that Resolution 11 not be adopted.

It was moved THAT RESOLUTION 11 BE ADOPTED. The motion was not adopted.

REFERENCE COMMITTEE D

Dr. Mehrotra presented the report of Reference Committee D. *(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 60, Substitute Resolution 61, Amended Resolution 62, Amended Resolution 63, Amended Resolution 64, Amended Resolution 65, Substitute Resolution 66 (in lieu of Resolutions 66, 67, and 76), Amended Resolution 70, Amended Resolution 72, and Amended Resolution 74.

**Not for adoption:** Resolution 68, Resolution 69, Resolution 71, Resolution 73, Resolution 75, and Resolution 77.

Substitute Resolution 66, Resolution 69, and Resolution 73 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

**AMENDED RESOLUTION 60**

RESOLVED, THAT ACEP ESTABLISH A TASK FORCE WITH THE FOLLOWING GOALS:

1. DETERMINE WHICH ORGANIZATIONS OR GOVERNMENTAL ENTITIES ARE CAPABLE OF BEST SUITED FOR BEING PERMANENTLY RESPONSIBLE FOR RESIDENT AND FELLOW INTERESTS WITHOUT CONFLICTS OF INTERESTS.
2. DETERMINE HOW THESE ORGANIZATIONS CAN BE HELD ACCOUNTABLE FOR FULFILLING THEIR DUTIES TO PROTECT THE RIGHTS AND WELL-BEING OF RESIDENT AND FELLOW TRAINEES.
3. DETERMINE METHODS OF ADVOCATING FOR RESIDENTS AND FELLOWS THAT ARE TIMELY AND EFFECTIVE, WITHOUT JEOPARDIZING TRAINEES’ CURRENT AND FUTURE EMPLOYABILITY.
4. STUDY AND REPORT BACK ON HOW SUCH AN ORGANIZATION MAY BE CREATED, IN THE EVENT THAT NO ORGANIZATIONS OR ENTITIES ARE IDENTIFIED THAT MEET THE ABOVE CRITERIA; AND
5. DETERMINE TRANSPARENT METHODS TO COMMUNICATE AVAILABLE RESIDENCY POSITIONS TO DISPLACED RESIDENTS.

IN THE EVENT THAT NO ORGANIZATIONS OR ENTITIES ARE IDENTIFIED THAT MEET THE ABOVE CRITERIA, DETERMINE HOW SUCH AN ORGANIZATION MAY BE CREATED.

**SUBSTITUTE RESOLUTION 61**

RESOLVED, THAT ACEP ADVOCATE THAT ALL U.S. MEDICAL SCHOOLS, ALLOPATHIC AND OSTEOPATHIC, REQUIRE AT LEAST ONE EMERGENCY MEDICINE ROTATION.

RESOLVED, THAT ACEP ADVOCATE THAT ALL U.S. MEDICAL SCHOOLS, ALLOPATHIC AND OSTEOPATHIC, REQUIRE FORMAL EXPOSURE TO THE SPECIALTY OF EMERGENCY MEDICINE, INCLUDING BUT NOT LIMITED TO A FORMAL CLERKSHIP OR OTHER ACTIVITIES TO ENSURE THAT GRADUATING MEDICAL STUDENTS UNDERSTAND THE ROLE OF EMERGENCY DEPARTMENTS AND THE PRACTICE OF EMERGENCY MEDICINE.
AMENDED RESOLUTION 62
RESOLVED, THAT ACEP PROMOTE AND ENDORSE TELEHEALTH TRAINING OPPORTUNITIES FOR EMERGENCY MEDICINE RESIDENTS; AND BE IT FURTHER RESOLVED, THAT ACEP ADVOCATE FOR INCLUSION OF TELEHEALTH IN THE MODEL OF THE CLINICAL PRACTICE OF EMERGENCY MEDICINE; AND BE IT FURTHER RESOLVED, THAT ACEP SUPPORT THE DEVELOPMENT OF ADDITIONAL TELEHEALTH FELLOWSHIP PROGRAMS IN EMERGENCY MEDICINE.

AMENDED RESOLUTION 63
RESOLVED, THAT ACEP ENGAGE WITH THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, THE COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, THE SOCIETY OF EMERGENCY MEDICINE PHYSICIAN ASSISTANTS, THE AMERICAN ACADEMY OF EMERGENCY NURSE PRACTITIONERS, AND THE AMERICAN ASSOCIATION OF PHYSICIAN LEADERS, AND OTHER INTERESTED PARTIES TO DEVELOP A STANDARDIZED CURRICULUM FOR TEACHING PHYSICIANS TO FUNCTION AS TEAM LEADERS IN SUPPORT OF PHYSICIAN-LED TEAMS; AND BE IT FURTHER RESOLVED, THAT ACEP DEVELOP CONTINUING MEDICAL EDUCATION TO INSTRUCT PHYSICIAN-LED TEAMS BASED ON THE CURRICULUM IDENTIFIED BY THE STAKEHOLDERS FOR PHYSICIANS WHO ARE POST RESIDENCY; AND BE IT FURTHER RESOLVED, THAT ACEP ADVOCATE TO THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION THAT SPECIFIC COMPETENCIES IN TEAM LEADERSHIP BE INCORPORATED IN THE NEXT REVISION OF THE MODEL OF THE PRACTICE OF CLINICAL EMERGENCY MEDICINE. RESOLVED, THAT ACEP ADVOCATE TO THE AMERICAN BOARD OF EMERGENCY MEDICINE AND THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE THAT SPECIFIC COMPETENCIES IN TEAM LEADERSHIP BE INCORPORATED IN THE NEXT REVISION OF THE MODEL OF THE PRACTICE OF CLINICAL EMERGENCY MEDICINE.

AMENDED RESOLUTION 64
RESOLVED, THAT ACEP SUPPORT STAFFING RURAL HOSPITALS WITH ED VOLUMES GREATER THAN 5,000 PATIENTS PER YEAR WITH ABEM/AOBEM BOARD-CERTIFIED/ELIGIBLE EMERGENCY PHYSICIANS INCLUDING COST-BASED REIMBURSEMENT THAT COVERS THE COST OF 24/7 ABEM/AOBEM BOARD-CERTIFIED/ELIGIBLE PHYSICIAN COVERAGE AND SUPPORT EXPANDED ACEP-LED RURAL PROVIDER EDUCATION, BOARD-CERTIFIED EMERGENCY PHYSICIAN MEDICAL DIRECTION, AND TELEMEDICINE ACCESS FOR ALL RURAL EMERGENCY DEPARTMENTS INCLUDING THOSE WHO DO NOT YET HAVE FULL ABEM/AOBEM-CERTIFIED/ELIGIBLE PHYSICIAN COVERAGE OR THOSE WITH EXTREMELY LOW VOLUMES; AND BE IT FURTHER RESOLVED, THAT ACEP SUPPORT THE CREATION OF LINKS BETWEEN RURAL HOSPITALS AND LARGER HEALTH NETWORKS AND ACADEMIC INSTITUTIONS, INCLUDING MEDICAL SCHOOLS AND COLLEGES, TO FACILITATE THE CREATION OF RURAL MEDICINE INTERNSHIPS AND ELECTIVES FOR INTERESTED LEARNERS AT THE UNDERGRADUATE AND MEDICAL SCHOOL LEVEL; AND BE IT FURTHER RESOLVED, THAT ACEP SUPPORT THE USE OF GOVERNMENT FUNDING FOR RURAL ELECTIVE ROTATIONS FOR EMERGENCY MEDICINE RESIDENTS AT RURAL CRITICAL ACCESS HOSPITALS TO BETTER TRAIN RESIDENTS FOR THIS WORK AND RECRUIT RESIDENTS TO RURAL PRACTICE, WHERE THEY ARE MOST NEEDED; AND BE IT FURTHER RESOLVED, THAT ACEP SUPPORT STUDENT LOAN FORGIVENESS FOR PHYSICIANS CHOOSING TO PRACTICE EMERGENCY MEDICINE IN RURAL AREAS.

AMENDED RESOLUTION 65
RESOLVED, THAT ACEP RECOGNIZE THAT PATIENTS PRESENTING TO RURAL EMERGENCY DEPARTMENTS ARE ARGUABLY OUR MOST VULNERABLE ED PATIENT POPULATION IN THE U.S. AND DESERVE INCREASED SUPPORT; AND BE IT FURTHER RESOLVED, THAT ACEP SUPPORT/DEVELOP A COMPREHENSIVE SURVEY OF RURAL EMERGENCY DEPARTMENTS TO INVESTIGATE VOLUMES, CLINICIAN STAFFING PATTERNS,
AND COMMON BARRIERS OF CARE AND STAFFING AND THIS SURVEY SHOULD BE VOLUME BASED AND STRATIFIED AS FOLLOWS:

RESOLVED, THAT ACEP SUPPORT THE RURAL SECTION IN COLLECTING SURVEY DATA FROM RURAL EMERGENCY DEPARTMENTS TO INVESTIGATE VOLUMES, CLINICIAN STAFFING PATTERNS, AND COMMON BARRIERS OF CARE AND STAFFING BASED AND STRATIFIED AS FOLLOWS:

EXTREME FRONTIER < 0.25 PTS/HR (ANNUAL VOLUME < 2,190)
FRONTIER 0.25 PTS/HR - 0.5 PTS/HR (ANNUAL VOLUME 2,191 TO 4,380)
SMALL RURAL 0.5 PTS/HR – 2 PTS/HR (ANNUAL VOLUME 4,381 TO 17,520)
MEDIUM RURAL 2 PTS/HR – 4 PTS/HR (ANNUAL VOLUME 17,521 TO 35,040)
LARGE RURAL > 4 PTS/HR (ANNUAL VOLUME > 35,041); AND BE IT FURTHER

RESOLVED, THAT ACEP RECOGNIZE THAT ABEM/AOBEM-CERTIFIED OR ELIGIBLE PHYSICIANS ARE UNDERREPRESENTED IN RURAL EMERGENCY DEPARTMENTS AND THAT VERY LOW VOLUME EDS GENERALLY CANNOT SUPPORT FULL-TIME ABEM/AOBEM-CERTIFIED PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGE SUPPORT RURAL EMERGENCY DEPARTMENTS TO RETAIN ABEM/AOBEM-CERTIFIED PHYSICIANS TO SERVE AS EMERGENCY DEPARTMENT MEDICAL DIRECTORS SO THERE WILL BE PHYSICIAN-LED TEAMS IN ALL U.S. EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT STAFFING RURAL HOSPITALS WITH ED VOLUMES GREATER THAN 0.5 PATIENTS PER HOUR WITH DEDICATED PHYSICIAN COVERAGE; ABEM/AOBEM CERTIFIED PHYSICIANS ARE PREFERRED IF AVAILABLE; AT VOLUMES GREATER THAN 1.0 PATIENTS PER HOUR, ABEM/AOBEM CERTIFIED PHYSICIAN COVERAGE IS STRONGLY ENCOURAGED; AND ACEP WILL SUPPORT COST-BASED REIMBURSEMENT THAT COVERS THE COST OF 24/7 ABEM/AOBEM CERTIFIED PHYSICIAN COVERAGE; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN BOARD OF PHYSICIAN SPECIALTIES, THE AMERICAN ACADEMY OF EMERGENCY NURSE PRACTITIONERS, THE SOCIETY OF EMERGENCY PHYSICIAN ASSISTANTS, MEDICAL LIABILITY INSURANCE CARRIERS, HEALTH SYSTEMS, PHYSICIAN GROUPS, AND OTHER STAKEHOLDER ORGANIZATIONS TO DEVELOP AND SUPPORT A UNIVERSAL MINIMUM STANDARD FOR ALL NON-EMERGENCY MEDICINE TRAINED PHYSICIANS, NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS PRACTICING IN RURAL EMERGENCY DEPARTMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP CLOSELY EVALUATE AND APPROVE SPECIFIC TRAINING PATHWAYS AND ONBOARDING PROTOCOLS AND CLINICAL SUPPORT SYSTEMS (E.G., TELEEM) FOR NON-EMERGENCY MEDICINE TRAINED PHYSICIANS, PHYSICIAN ASSISTANTS, AND NURSE PRACTITIONERS WORKING SOLO IN EXTREME LOW VOLUME FACILITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT AND ENDORSE RURAL-SPECIFIC TOOLS INCLUDING TELEMEDICINE INITIATIVES, THE DEVELOPMENT OF REGIONAL EXPEDITED TRANSFER AGREEMENTS, REGIONAL HUB AND SPOKE MODEL INTEGRATION, AND RURAL SPECIFIC EDUCATIONAL TOOLS.

**AMENDED RESOLUTION 70**

RESOLVED, THAT ACEP CREATE A TOOLKIT FOR MEMBERS TO USE AT THE STATE LEVEL TO ADDRESS PRACTICE SCOPE EXPANSION EFFORTS THAT EMPHASIZES THE IMPORTANCE OF A PHYSICIAN LED TEAM FOR OPTIMAL PATIENT SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP’S ADVOCACY TEAM CREATE A TRACKING SYSTEM FOR UNSUPERVISED PRACTICE EFFORTS IN EACH STATE TO ENSURE THAT THE VOICE OF EMERGENCY PHYSICIANS CAN BE HEARD FOR THIS IMPORTANT PATIENT SAFETY TOPIC; AND BE IT FURTHER

RESOLVED, THAT ACEP’S ADVOCACY TEAM CREATE A “STRIKE TEAM” OF ADVOCACY EXPERTS IN EMERGENCY MEDICINE SCOPE EXPANSION ISSUES THAT CAN BE TASKED TO HELP ENGAGE STATES WHO ARE ACTIVELY INVOLVED IN SCOPE EXPANSION...
LEGISLATION AND SUPPORT THE STATE CHAPTERS AND PHYSICIANS AT THE LOCAL LEVEL; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH THE AMERICAN MEDICAL ASSOCIATION SCOPE OF PRACTICE PARTNERSHIP, PHYSICIANS FOR PATIENT PROTECTION, AND OTHER LIKE-MINDED GROUPS TO ADDRESS SCOPE EXPANSION EFFORTS ON A NATIONAL BASIS.

RESOLVED, THAT ACEP REPORT ON EFFORTS TO MAINTAIN AND CHALLENGE SCOPE OF PRACTICE FOR OUR COUNCIL'S CONSIDERATION HIGHLIGHTING, AT A MINIMUM, ACTIVITIES BY ACEP AND STATE CHAPTERS IN STATES WHERE SCOPE OF PRACTICE IS BEING CHALLENGED AND OUTCOMES OF THOSE EFFORTS.

AMENDED RESOLUTION 72

RESOLVED, THAT EMERGENCY PHYSICIANS HAVE THE CHOICE AS TO WHETHER TO SUPERVISE OR COLLABORATE WITH NON-PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT EMERGENCY PHYSICIANS BE FAIRLY COMPENSATED TO SUPERVISE ABEM/AOBEM BOARD CERTIFIED/ELIGIBLE PHYSICIAN LED TEAMS, ASSISTANTS AND/OR COLLABORATE WITH NURSE PRACTITIONERS; AND BE IT FURTHER

RESOLVED, THAT THE FAIR COMPENSATION FOR SUPERVISION AND COLLABORATING WITH NON-PHYSICIANS IS IN ADDITION TO THE COMPENSATION THAT THE EMERGENCY PHYSICIAN RECEIVES FOR PRACTICING EMERGENCY MEDICINE WITHOUT SUPERVISION AND COLLABORATING.

AMENDED RESOLUTION 74

RESOLVED, THAT ACEP SUPPORT A FEDERAL UNIVERSAL DEFINITION OF THE PRACTICE OF MEDICINE TO INCLUDE THE ORDERING OF DIAGNOSTIC TESTS, DIAGNOSING CLINICAL CONDITION/DISEASE, PRESCRIBING OF MEDICATIONS, AND/OR ORDERING OF TREATMENTS ON HUMAN BEINGS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT THAT ANYONE, PHYSICIANS OR NON-PHYSICIAN PRACTITIONERS, WHO ENGAGE IN THE PRACTICE OF MEDICINE BE REGULATED BY THE RESPECTIVE STATE MEDICAL BOARD OF THEIR RESPECTIVE STATES; RESPECTIVE STATE MEDICAL BOARDS THAT REGULATE THE PRACTICE OF MEDICINE; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AMA AND SUBMIT A RESOLUTION TO THEIR HOUSE OF DELEGATES TO CREATE A UNIVERSAL DEFINITION OF THE PRACTICE OF MEDICINE TO INCLUDE THE ORDERING OF DIAGNOSTIC TESTS, DIAGNOSING CLINICAL CONDITION/DISEASE, PRESCRIBING OF MEDICATIONS, AND/OR ORDERING OF TREATMENTS ON HUMAN BEINGS.

The committee recommended that Substitute Resolution 66 be adopted with the revised title “ACEP Promotion of the Role of Emergency Physicians Led Teams” in lieu of Resolutions 66, 67, and 76.

It was moved THAT SUBSTITUTE RESOLUTION 66 BE ADOPTED IN LIEU OF RESOLUTIONS 66, 67, AND 76:

RESOLVED, THAT ACEP PUBLISH AND PROMOTE A POLICY EXPLICITLY STATING THAT ALL PATIENTS PRESENTING TO AN EMERGENCY DEPARTMENT DESERVE TO BE ASSESSED BY AN ABEM/AOABEM BOARD CERTIFIED EMERGENCY PHYSICIAN AND HAVE AN EMERGENCY PHYSICIAN DIRECTLY OVERSEE THEIR CARE ON AN IN-PERSON BASIS; AND BE IT FURTHER

RESOLVED, THAT ACEP REAFFIRM ITS ROLE AS A PROFESSIONAL MEDICAL ASSOCIATION DEDICATED TO PROMOTING THE ROLE OF EMERGENCY PHYSICIANS, INSTRUCTING THE ACEP STAFF AND OFFICERS TO PROMOTE THE ROLE OF EMERGENCY PHYSICIANS OVER ALL OTHER MODELS OF EMERGENCY CARE.

RESOLVED, THAT ACEP SUPPORT THE STANDARD THAT BOARD-CERTIFIED/ELIGIBLE EMERGENCY PHYSICIANS ARE TO BE INVOLVED IN EVERY PATIENT ENCOUNTER PRESENTING TO AN EMERGENCY DEPARTMENT.
It was moved THAT “/ELIGIBLE” BE INSERTED AFTER THE WORD “CERTIFIED” IN THE FIRST RESOLVED.

It was moved THAT THE SUBSTITUTE RESOLUTION 66 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 69 not be adopted.

It was moved THAT RESOLUTION 69 BE ADOPTED.

It was moved THAT RESOLUTION 69 BE AMENDED TO READ:

RESOLVED, THAT ALL PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS OR ANY PERSON WHO MIGHT BE REASONABLY BE REFERRED TO AS A PROVIDER, CLINICIAN, OR PRACTITIONER, OR ANY PERSON WHO PRACTICES, OR COULD REASONABLY BE INTERPRETED AS PRACTICING MEDICINE INCLUDING THE AUTHORITY TO WRITE ORDERS OR PRESCRIPTIONS THAT INTERACTS WITH A PATIENT, MUST STATE THEIR NAME AND THEN CLEARLY STATE “I AM A MEDICAL DOCTOR (MD),” (TO INCLUDE DOCTORS OF OSTEOPATHIC MEDICINE, OR THE DOCTOR OF OSTEOPATHIC MEDICINE COULD SAY “I AM A DOCTOR OF OSTEOPATHIC MEDICINE (DO)” OR “I AM NOT A MEDICAL DOCTOR” DEPENDING ON THE EDUCATION AND TRAINING OF THAT INDIVIDUAL THEIR ROLE IN THE PATIENT’S CARE THAT DELINEATES BETWEEN PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS. IT IS A PROFESSIONAL EXPECTATION THAT A PHYSICIAN OR NON-PHYSICIAN PRACTITIONER CORRECT ANY MISINTERPRETATION BY THE EMERGENCY DEPARTMENT PATIENT. The motion was not adopted.

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

The committee recommended that Resolution 73 not be adopted.

It was moved THAT RESOLUTION 73 BE ADOPTED.

It was moved THAT RESOLUTION 73 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Resolution 42, Resolution 44, Resolution 46, Resolution 47 (first resolved), Amended Resolution 48, Amended Resolution 50, Amended Resolution 52, Amended Resolution 53, Amended Resolution 54, Amended Resolution 55, Amended Resolution 56, Amended Resolution 57, Resolution 58, and Amended Resolution 59.

**Not for adoption:** Resolution 45, Resolution 47 (second resolved), and Resolution 49.

**For referral to the Board of Directors:** Resolution 43, Resolution 47 (third resolved), and Resolution 51.

Resolution 47, Resolution 49, Amended Resolution 50, Amended Resolution 53, and Amended Resolution 55 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.
AMENDED RESOLUTION 48
RESOLVED, THAT ACEP STUDY FINANCIAL AND OTHER INCENTIVES THAT MIGHT BE USED TO REDUCE BOARDING OF ADMITTED PATIENTS IN THE EMERGENCY DEPARTMENT CROWDING.

AMENDED RESOLUTION 52
RESOLVED, THAT ACEP WORK WITH INTERESTED STATE CHAPTERS, LAW ENFORCEMENT PERSONNEL, AND OTHER STAKEHOLDERS TO DEVELOP PROTOCOLS AND STANDARDS GUIDELINES FOR THE MEDICAL SCREENING EXAMINATION OF INDIVIDUALS WHO ARE IN LAW ENFORCEMENT CUSTODY WHEN THE ARRESTING AGENCY REQUESTS A MEDICAL EVALUATION OF THAT INDIVIDUAL PRIOR TO PROCESSING INTO A DETENTION CENTER; AND BE IT FURTHER
RESOLVED, THAT ACEP DEVELOP BEST PRACTICE GUIDELINES FOR THE CONVEYING OF AN ARRESTED PERSON’S PERTINENT MEDICAL INFORMATION TO MEDICAL PERSONNEL AT THE RECEIVING CORRECTIONAL FACILITY, CONSISTENT WITH MEDICAL ETHICS AND MEDICAL PRIVACY LAWS.

AMENDED RESOLUTION 54
RESOLVED, THAT ACEP SUPPORT THE RESEARCH, DEVELOPMENT, AND ADOPTION OF BEST PRACTICES FOR EMERGENCY PHYSICIANS REGARDING LAW ENFORCEMENT AND SECURITY PERSONNEL PRESENCE IN THE HOSPITAL ENVIRONMENT, INCLUDING BUT NOT LIMITED TO THE ED, TO CREATE TRANSPARENCY AND PROTECT THE RIGHTS OF ITS VULNERABLE PATIENT POPULATIONS; AND BE IT FURTHER
RESOLVED, THAT ACEP ADVOCATE FOR STATE CHAPTERS COLLABORATE WITH OTHER INTERESTED ORGANIZATIONS TO CREATE EASILY ACCESSIBLE TRANSPARENT TOOLKITS THAT OUTLINE STATE-SPECIFIC POLICIES AND LAWS REGARDING LAW ENFORCEMENT PRESENCE IN THE HOSPITAL ENVIRONMENT, INCLUDING BUT NOT LIMITED TO THE ED, THEREBY ENHANCING PHYSICIAN UNDERSTANDING OF PATIENT AND PHYSICIAN RIGHTS IN THEIR INTERACTIONS WITH LAW ENFORCEMENT WITHIN THE ED AS WELL AS THEIR OWN RIGHTS AS PHYSICIANS.

AMENDED RESOLUTION 56
RESOLVED, THAT ACEP ISSUE A STATEMENT TO THE MEMBERSHIP REGARDING THE LACK OF VALIDITY IN RACE-BASED SCIENCE AND ITS DETRIMENTAL IMPACT ON THE HEALTH OF BLACK, INDIGENOUS, AND PEOPLE OF COLOR PATIENTS AND COMMUNITIES; AND BE IT FURTHER
RESOLVED, THAT ACEP COMMIT TO THE EDUCATION OF ITS MEMBERSHIP BY DENOUNCING THE USE OF RACE-BASED CALCULATORS IN ITS CLINICAL POLICIES; AND BE IT FURTHER
RESOLVED, THAT ACEP COMMIT TO NOT SUPPORT RESEARCH STUDIES THAT UTILIZE RACE-BASED CALCULATIONS THAT ARE NOT SUPPORTED BY SOUND SCIENTIFIC EVIDENCE.

AMENDED RESOLUTION 57
RESOLVED, THAT ACEP SEEK TO IMPROVE THE RECOGNITION OF, AND ATTENTION TO, SOCIAL DETERMINANTS OF HEALTH (SDH) BY SUPPORTING RESEARCH OF EVIDENCE-BASED SDH SCREENING AND INTERVENTIONS IN THE ED WITH A FOCUS ON THE UNIQUE STRENGTHS AND CHALLENGES THE ED SETTING POSES FOR IDENTIFYING AND INFLUENCING SDH IN ORDER TO DEVELOP INTERVENTIONS FEASIBLE FOR IMPLEMENTATION IN THE ED; AND BE IT FURTHER
RESOLVED, THAT ACEP ADVOCATE FOR THE ALLOCATION OF PRIVATE AND PUBLIC SECTOR RESOURCES FOR IDENTIFYING AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN THE EMERGENCY DEPARTMENT; AND BE IT FURTHER
RESOLVED, THAT ACEP PUSH FOR LEGISLATIVE AND POLITICAL ACTION TO ACHIEVE BROAD, SYSTEMIC SOLUTIONS TO THOSE SOCIAL DETERMINANTS OF HEALTH THAT CREATE INEQUITY IN HEALTH STATUS AND OUTCOMES SO THAT TO THE GREATEST EXTENT POSSIBLE, ADDRESSING SOCIAL DETERMINANTS OF HEALTH IS CONSIDERED INTEGRAL TO IMPROVING THE HEALTH OF THE COUNTRY.
AMENDED RESOLUTION 59

RESOLVED, THAT ACEP PROMOTE THE USE OF QUALIFIED MEDICAL INTERPRETERS FOR ALL EMERGENCY DEPARTMENT PATIENT INTERACTIONS WITH PATIENTS WITH LIMITED ENGLISH PROFICIENCY UNLESS THE COMMUNICATING PROVIDER HAS PROVEN QUALIFICATIONS TO SELF-INTERPRET IN A MEDICAL SETTING; AND BE IT FURTHER RESOLVED, THAT ACEP PROVIDE RESOURCES FOR EMERGENCY DEPARTMENTS ON AVAILABLE INTERPRETER SERVICES AND HOW PROVIDERS CAN PROVE QUALIFICATION FOR INTERPRETING IN A MEDICAL SETTING.

The committee recommended that Amended Resolution 50 be adopted.

It was moved THAT AMENDED RESOLUTION 50 BE ADOPTED.

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT PRACTICE GUIDELINES ON THE TREATMENT OF HARM COMPLICATIONS OF MARIJUANA USE AS SEEN IN EMERGENCY DEPARTMENT PRESENTATIONS; AND BE IT FURTHER RESOLVED, THAT ACEP PROVIDE EDUCATION AND GUIDANCE TO EMERGENCY PHYSICIANS IN RELATIONSHIP TO DOCUMENTATION AND OVERALL AWARENESS OF CANNABIS RELATED ED DIAGNOSES.

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

RESOLVED, THAT ACEP DEVELOP AND DISSEMINATE PUBLIC FACING INFORMATION ON THE COMPLICATIONS OF MARIJUANA USE AS SEEN IN THE EMERGENCY DEPARTMENT.

The motion was adopted.

The amended main motion was then voted on and adopted.

The Council recessed at 11:30 am for the awards luncheon and reconvened at 1:45 pm on Sunday, October 24, 2021.

Electronic councillor credentialing was conducted to determine the number of councillors currently participating remotely. Dr. Kraus reported that 392 councillors of the 446 eligible for seating had been credentialed, including 353 participating in person and 39 participating remotely.

The committee recommended that Amended Resolution 53 be adopted.

It was moved THAT AMENDED RESOLUTION 53 BE ADOPTED:

RESOLVED, THAT ACEP ISSUE A STATEMENT REGARDING SUPPORT FOR A REPORTING PROCESS TO AN INDEPENDENT ENTITY REGARDING INJURIES SUSPECTED OR REPORTED TO BE RESULTING FROM LAW ENFORCEMENT ACTIONS, AS DOING SO WILL ALLOW EMERGENCY PHYSICIANS TO AVOID CONFLICTS OF INTEREST, IMPROVE REPORTING, DATA GATHERING AND EPIDEMIOLOGIC MONITORING, WHICH WILL BETTER ENABLE US TO RESEARCH HOW WE CAN BEST PROVIDE THE MOST SAFE AND APPROPRIATE CARE TO OUR PATIENTS; AND BE IT FURTHER RESOLVED, THAT ACEP WORK WITH STATE CHAPTERS AND OTHER COMPONENT BODIES, TO ESTABLISH BEST PRACTICES AND CREATE AN EDUCATIONAL TOOLKIT SIMILAR TO TOOLKITS FOR OTHER VULNERABLE POPULATIONS, REGARDING IDENTIFYING THE IDENTIFICATION AND REPORTING OF INJURIES SUSPECTED OR REPORTED TO BE THE RESULT OF RESULTING FROM LAW ENFORCEMENT ACTIONS SIMILAR TO THAT WHICH EXISTS REGARDING CHILD AND ELDER OR DEPENDENT ABUSE OR NEGLECT, THEREBY ENHANCING PHYSICIAN UNDERSTANDING OF THESE INJURIES AND IMPROVING REPORTING.

It was moved THAT AMENDED RESOLUTION 53 BE REFERRED TO THE BOARD OF DIRECTORS.

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

The committee recommended that Amended Resolution 55 be adopted.

It was moved THAT AMENDED RESOLUTION 55 BE ADOPTED:

RESOLVED, THAT ACEP ACKNOWLEDGE AND AFFIRM THAT CURRENT ITERATIONS OF SOME PATIENT SATISFACTION INSTRUMENTS ARE IN CLEAR VIOLATION OF EXISTING ACEP POLICY (E.G., THE 2016 “PATIENT EXPERIENCE OF CARE SURVEYS” POLICY STATEMENT); AND BE IT FURTHER RESOLVED, THAT ACEP DEFINE STANDARDIZED INCLUSION AND EXCLUSION CRITERIA FOR PATIENT EXPERIENCE SURVEY POPULATIONS; AND BE IT FURTHER RESOLVED, THAT ACEP DEFINE IMPROVED METHODOLOGIES FOR PATIENT EXPERIENCE SURVEYS, INCLUDING WORDING TO REDUCE OR ELIMINATE BIAS, AND APPROPRIATE POWER CALCULATIONS SUCH THAT SUFFICIENT SURVEYS ARE COLLECTED TO YIELD MORE STATISTICALLY VALID RESULTS; AND BE IT FURTHER RESOLVED, THAT ACEP AGGRESSIVELY ADVOCATE FOR PATIENT EXPERIENCE SURVEY VALIDITY AND WORK WITH CMS AND OTHER STAKEHOLDERS TO IMPLEMENT PROMPT, ACTIONABLE CHANGE TO CURRENT ED SURVEY PRACTICES.

It was moved THAT THE WORDS “THAT CURRENT ITERATIONS OF SOME PATIENT SATISFACTION INSTRUMENTS ARE IN CLEAR VIOLATION OF” BE DELETED FROM THE FIRST RESOLVED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 49 not be adopted.

It was moved THAT RESOLUTION 49 BE ADOPTED.

It was requested that each resolved be voted on separately.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 49 BE ADOPTED.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 49 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 49 BE ADOPTED.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 49 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that the first resolved of Resolution 47 be adopted.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 47 BE ADOPTED. The motion was adopted.

The committee recommended that the second resolved of Resolution 47 not be adopted.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 47 BE ADOPTED. The motion was not adopted.

The committee recommended that the third resolved of Resolution 47 be referred to the Board of Directors.

It was moved THAT THE THIRD RESOLVED OF RESOLUTION 47 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.
It was MOVED THAT THE COUNCIL RECONSIDER AMENDED RESOLUTION 53. The motion was adopted.

It was moved THAT AMENDED RESOLUTION 53 BE ADOPTED. The motion was not adopted.

REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 26, Substitute Resolution 28, Amended Resolution 29, Resolution 30, Amended Resolution 31, Amended Resolution 32, Resolution 33, Resolution 34, Resolution 35 (first two resolveds), Resolution 36, Amended Resolution 38, Substitute Resolution 41 (in lieu of Resolutions 40 and 41), and Amended Resolution 82.

Not for adoption: Resolution 27, Resolution 37, and Resolution 39.

For referral to the Board of Directors: Resolution 25 and Resolution 35 (last three resolveds).

Amended Resolution 32, Resolution 33, Resolution 37, and Amended Resolution 38 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 26

RESOLVED, THAT ACEP SUPPORT FEDERAL FUNDING OF SYRINGE SERVICES PROGRAMS; AND BE IT FURTHER RESOLVED, THAT ACEP DEVELOP ADVOCACY MATERIALS TO ASSIST AND ENCOURAGE CHAPTERS TO ADVOCATE FOR STATE AND LOCAL LAWS PERMITTING SYRINGE SERVICES PROGRAMS INTENDED TO REDUCE THE RISK OF HARM ASSOCIATED WITH INJECTION DRUG USE IN ADDITION TO NALOXONE AND EDUCATIONAL MATERIAL; AND BE IT FURTHER RESOLVED, THAT ACEP UPDATE HARM REDUCTION MATERIALS AND RESOURCES AVAILABLE TO ITS MEMBERS TO INCLUDE INFORMING PATIENTS OF THE RISKS OF FENTANYL ANALOGUES AND OTHER POTENTIALLY HARMFUL ADMIXTURES AND THE UTILIZATION AND LIMITATIONS OF FENTANYL TEST STRIPS TO BETTER INFORM DECISION-MAKING WHEN USING DRUGS AND OTHER METHODS OF TESTING FOR CONTAMINANTS AND ADULTERANTS.

SUBSTITUTE RESOLUTION 28


AMENDED RESOLUTION 29

RESOLVED, THAT ACEP DEVELOP STRATEGIES TO ASSIST CHAPTERS IN IDENTIFYING IF DOWNCODING IS OCCURRING IN THEIR STATE; AND BE IT FURTHER RESOLVED, THAT ACEP DEVELOP SPECIFIC MODEL LEGISLATIVE LANGUAGE TO INCLUDE DOWNCODING IN EXISTING PRUDENT LAYPERSON STATUTES; AND BE IT FURTHER RESOLVED, THAT ACEP WORK WITH THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND PRIVATE INSURERS TO PREVENT THE PRACTICE OF DOWNCODING IN STATE MEDICAID PROGRAMS AND BY PRIVATE INSURERS; AND BE IT FURTHER RESOLVED, THAT ACEP WORK WITH CHAPTERS TO DEVELOP SPECIFIC MODEL LEGISLATIVE LANGUAGE TO REQUIRE TRANSPARENCY WHEN INSURANCE COMPANIES MAKE CHANGES TO OR REQUIRE ADDITIONAL INFORMATION FOR A CLAIM.
AMENDED RESOLUTION 31

RESOLVED, THAT ACEP SUBMIT A RESOLUTION TO THE JUNE 2022 AMA HOUSE OF DELEGATES ANNUAL MEETING PROMOTING THE CONCEPTS OF ARIZONA HOUSE BILL 2622 (2021) AS SIGNED INTO LAW AS MODEL STATE AND NATIONAL LEGISLATION TO PROTECT EMERGENCY PHYSICIANS FROM CORPORATE, WORKPLACE, AND/OR EMPLOYER RETALIATION WHEN REPORTING SAFETY, HARASSMENT, OR FRAUD CONCERNS AT THE PLACES OF WORK (LICENSED HEALTH CARE INSTITUTION) OR GOVERNMENT, WHICH ALSO INCLUDES INDEPENDENT AND THIRD-PARTY CONTRACTORS PROVIDING PATIENT SERVICES AT SAID FACILITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE DEVELOP MODEL LEGISLATION EMULATING ARIZONA HOUSE BILL 2622 (2021) TO SHARE WITH CHAPTERS THROUGH MECHANISMS SUCH AS THE STATE LEGISLATIVE/REGULATORY COMMITTEE AND OTHER MEMBERSHIP OUTREACH.

SUBSTITUTE RESOLUTION 41

RESOLVED, THAT ACEP AMEND THE CURRENT POLICY STATEMENT “NALOXONE PRESCRIPTIONS BY EMERGENCY PHYSICIANS” TO INCLUDE ENDORSEMENT FOR TAKE-HOME NALOXONE PROGRAMS IN EMERGENCY DEPARTMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP SEEK TO INCREASE THE DISTRIBUTION OF NALOXONE FROM THE EMERGENCY DEPARTMENT BY RESEARCHING AND ADVOCATING FOR A STANDARDIZED, LOWER BARRIER, AND COST-EFFECTIVE TAKE-HOME MODEL FOR NALOXONE FOR AT RISK PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH OTHER LIKE-MINDED ORGANIZATIONS TO PROMOTE TAKE-HOME NALOXONE PROGRAMS AS A BEST PRACTICE FOR PATIENTS AT RISK OF OPIOID OVERDOSE, AND WORK TOWARD INCREASING TO INCREASE THE NUMBER OF TAKE-HOME NALOXONE PROGRAMS IN EMERGENCY DEPARTMENTS, PARTNERING WITH OTHER LIKE-MINDED ORGANIZATIONS, AND PROMOTING TAKE HOME NALOXONE AS A BEST PRACTICE; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR REGULATORY AND PAYMENT REFORM THAT WOULD FACILITATE REIMBURSEMENT, FROM PUBLIC AND PRIVATE Payers, TO HOSPITALS AND EMERGENCY DEPARTMENTS FOR NALOXONE DISPENSED DIRECTLY TO PATIENTS AS PART OF TAKE-HOME NALOXONE PROGRAMS, THUS REMOVING FINANCIAL DISINCENTIVES FOR HOSPITALS TO HAVE TAKE-HOME NALOXONE PROGRAMS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE EDUCATING EDUCATE EMERGENCY PHYSICIANS ABOUT STRATEGIES TO IMPLEMENT TAKE HOME NALOXONE PROGRAMS IN THEIR EMERGENCY DEPARTMENT.

AMENDED RESOLUTION 82

RESOLVED, THAT, THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP) WORK WITH APPROPRIATE STAKEHOLDERS AND THE INSURANCE INDUSTRY TO DEVELOP ACEP POLICY DEFINING AN ACCURATE JOB DESCRIPTION THAT CAN APPLY TO ALL EMERGENCY PHYSICIANS; ONE WHICH REFLECTS THE TRUE PHYSICAL AND COGNITIVE DEMANDS OF THE SPECIALTY, AND CAN BE USED IN THE OCCUPATIONAL INFORMATION SYSTEM UNDER DEVELOPMENT BY THE SOCIAL SECURITY ADMINISTRATION; AND BE IT FURTHER

RESOLVED, THAT THE Acep BOARD OF DIRECTORS DRAFT A LETTER CONTAINING CONSIDER DEVELOPING AN ACCURATE JOB DESCRIPTION FOR EMERGENCY PHYSICIANS, WHICH MEMBERS CAN BE USED TO SUPPORT APPEALS TO THEIR OF LONG TERM DISABILITY CLAIM DENIALS, UNTIL AN ACCEPTABLE DEFINITION ACEP POLICY IS CREATED, FOR THE USE OF ADJUDICATION OF DISABILITY CLAIMS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT STATE CHAPTERS IN THEIR EFFORTS TO WORK WITH STATE INSURANCE REGULATORS TO CREATE MODEL REGULATORY LANGUAGE DEMANDING THAT SPECIALTY-SPECIFIC JOB DESCRIPTIONS ARE CLEARLY STATED ON DISABILITY INSURANCE PRODUCTS WHEN THESE ARE BEING MARKETED AND SOLD IN ORDER TO ENSURE TRANSPARENCY TO CURRENT AND FUTURE POLICY HOLDERS.

The committee recommended that Resolution 33 be adopted.
It was moved THAT RESOLUTION 33 BE ADOPTED. The motion was adopted.

The committee recommended that Amended Resolution 32 be adopted.

It was moved THAT AMENDED RESOLUTION 32 BE ADOPTED:

RESOLVED, THAT ACEP PROMOTE AND ENDORSE THAT EMERGENCY DEPARTMENTS BECOME “FIREARM FREE” ZONES, WITH THE EXCEPTION OF ACTIVE DUTY LAW ENFORCEMENT OFFICERS, HOSPITAL SECURITY, MILITARY POLICE, AND FEDERAL AGENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENDORSE AND PROMOTE SCREENING FOR FIREARMS WEAPONS IN THE EMERGENCY DEPARTMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE PUBLIC EDUCATION AND ACADEMIC RESEARCH TO DECREASE WORKPLACE VIOLENCE BY DECREASING FIREARM MORBIDITY AND MORTALITY.

It was moved THAT THE RESOLUTION BE AMENDED BY REINSTATING THE FIRST RESOLVED. The motion was adopted.

It was requested that the first resolved be voted on separately.

It was moved THAT THE FIRST RESOLVED OF AMENDED RESOLUTION 32 BE ADOPTED. The motion was adopted.

It was moved THAT THE SECOND AND THIRD RESOLVEDS OF AMENDED RESOLUTION 32 BE ADOPTED.

It was moved THAT THE WORDS “BY DECREASING FIREARM MORBIDITY AND MORTALITY” BE DELETED FROM THE THIRD RESOLVED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 38 be adopted.

It was moved THAT AMENDED RESOLUTION 38 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE, AT BOTH STATE AND NATIONAL LEVELS, THAT ABEM/AOBEM-CERTIFIED PROVIDERS SERVE AS THE HIGHEST LEVEL OF MEDICAL EXPERTS ON THE MATTER OF MANAGEMENT OF PATIENTS WITH HYPERACTIVE DELIRIUM WITH SEVERE AGITATION IN THE PREHOSPITAL OUT-OF-HOSPITAL AND EMERGENCY MEDICAL DEPARTMENT SETTINGS; AND BE IT FURTHER

RESOLVED, THAT ACEP PLAY AN ACTIVE ROLE, AT BOTH STATE AND NATIONAL LEVELS, IN ADVOCATING AGAINST ANY NON-ABEM/AOBEM-CERTIFIED SPECIALTY’S ASSERTION TO HAVING GREATER EXPERTISE IN THE ACUTE THERAPEUTIC (I.E., PHARMACOLOGIC AND NON-PHARMACOLOGIC) MANAGEMENT OF PATIENTS WITH HYPERACTIVE DELIRIUM IN THE PREHOSPITAL OUT-OF-HOSPITAL SETTING; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE ANY NON-ABEM/AOBEM-CERTIFIED SPECIALTY’S MEDICAL OVERSIGHT, IN PART OR IN WHOLE, OF PREHOSPITAL OUT-OF-HOSPITAL MEDICAL DIRECTION, PARTICULARLY WHEN PERTAINING TO THE MANAGEMENT OF HYPERACTIVE DELIRIUM WITH SEVERE AGITATION; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH THE NATIONAL ASSOCIATION OF EMS PHYSICIANS (NAEMSP) TO WORK WITH STATE AND NATIONAL REGULATORS AND LEGISLATORS ON ALL ISSUES PERTAINING TO THE PREHOSPITAL OUT-OF-HOSPITAL MANAGEMENT OF HYPERACTIVE DELIRIUM WITH SEVERE AGITATION.

It was moved THAT THE WORD PROVIDER” BE REPLACED WITH THE WORD “PHYSICIANS” IN THE FIRST RESOLVED. 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.

It was moved THAT RESOLUTION 37 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

Gillian R. Schmitz, MD, FACEP, president-elect, addressed the Council.

Electronic councillor credentialing was conducted to determine the number of councillors currently participating remotely. Dr. Kraus reported that 391 councillors of the 446 eligible for seating had been credentialed, including 335 participating in person and 56 participating remotely.

The total number of councillors credentialed for the meeting was 437 of the 446 eligible for seating, including 361 participating in person and 76 participating remotely.

The Tellers, Credentials, & Elections Committee conducted the Vice Speaker election. Dr. Costello was elected.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Khoury, and Dr. Knowles were elected to a three-year term. Dr. Cirillo and Dr. Finnell were re-elected to a three-year term.

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

There being no further business, Dr. Katz adjourned the 2021 Council meeting at 5:52 pm on Sunday, October 24, 2021. The next meeting of the ACEP Council is scheduled for September 28-29, 2021, at the Hilton San Francisco Union Square Hotel in San Francisco, CA.

Respectfully submitted,

Susan E. Sedory, MA, CAE
Council Secretary and Executive Director

Approved by,

Gary R. Katz, MD, MBA, FACEP
Council Speaker
Speaker Kelly Gray-Eurom, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:01 am Central time on Monday, January 24, 2022.

Steering Committee members present for all or portions of the meeting were: Eileen Baker, MD, FACEP; Lisa Bundy, MD, FACEP; Melissa Costello, MD, FACEP, vice speaker; Carrie de Moor, MD, FACEP; Hilary Fairbrother, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, speaker; William Falco, MD, FACEP; Carlton Heine, MD, FACEP; Steven Kailes, MD, FACEP; Phillip Luke LeBas, MD, FACEP; Kristin McCabe-Kline, MD, FACEP; Christina Millhouse, MD, FACEP; Bing Pao, MD, FACEP; Michael Ruzek, DO, FACEP; Gary Starr, MD, FACEP; Thomas Sugarman, MD, FACEP; Larisa Traill, MD, FACEP; and Ashley Tarchione, MD.

Other members and guests present for all or portions of the meeting were: J.T. Finnell, MD, FACEP; Jeffrey Goodloe, MD, FACEP, secretary-treasurer; Alison Haddock, MD, FACEP, chair of the Board; Christopher Kang, MD, FACEP, president-elect; Gabor Kelen, MD, FACEP; Rami Khoury, MD, FACEP; Heidi Knowles, MD, FACEP; Kurtis Mayz, MD, FACEP; Mark Rosenberg, DO, FACEP, immediate past president; Gillian Schmitz, MD, FACEP, president; James Shoemaker, MD, FACEP; Ryan Stanton, MD, FACEP; Aisha Terry, MD, FACEP, vice president; and Arvind Venkat, MD, FACEP.

Staff present for all or portions of the meeting were: Mary Ellen Fletcher, CPC, CEDC; Pawan Goyal, MD, MHA, FHIMSS; Maude Suprenant Hancock; Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; Layla Powers, MBA; Sandra Schneider, MD, FACEP; Susan Sedory, MA, CAE; Carole Wollard; and Laura Wooster, MPH.

Officer and Staff Reports

Speaker

Dr. Gray-Eurom welcomed everyone and thanked them for their participation and commitment to the College. She reported that she and Dr. Costello attended the Board of Directors retreat in December and will participate in the virtual Board meeting that will be held January 25-26, 2022, as well as all other Board meetings that will be held throughout the year.

Vice Speaker

Dr. Costello reported on her service on the Finance Committee as the speaker’s designee and provided a brief ACEP financial update. The Finance Committee holds monthly conference calls and will review a budget reforecast in February.

President

Dr. Schmitz reported on her activities since taking office as president. She highlighted the top issues that members are concerned about and discussed: the emergency medicine and workforce trends; a New Practice Models Task Force that will be appointed; ACEP’s efforts and assistance to chapters to combat scope of practice issues; ACEP’s decision to join with the American College of Radiology and the American Society of Anesthesiology and file a lawsuit regarding the Interim Final Rule of the No Surprises Act; and the #BikERdocs on Peloton activity.

President-Elect

Dr. Kang thanked Steering Committee members for their service, encouraged awareness of key issues for the College, and invited everyone to contact him for assistance if needed.
Executive Director

Ms. Sedory reported on: the updated Strategic Plan, which will serve as the foundation for the upcoming budget preparations; the technology audit that is underway to help prepare ACEP for the future and provide recommendations to better manage our membership database, the ability to deliver personalized services to members, and the digital transformation for the delivery of education and other products and services to members; a new Chief Technology Officer and Membership Engagement Senior Vice President were recently hired; and the upcoming ASAE Chief Elected Officer Symposium that she will attend with Dr. Schmitz, Dr. Haddock, Ms. Montgomery, and Ms. Moore.

Steering Committee Expectations

Dr. Gray-Eurom reminded the Steering Committee of their expectation to attend the May 1, 2022, Steering Committee meeting and the Leadership & Advocacy Conference May 1-3, 2022, in Washington, DC. The Steering Committee will also meet at 6:00 pm on Wednesday, September 28, 2022, in San Francisco, the evening prior to the Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Gray-Eurom reviewed the report from the Tellers, Credentials, & Elections Committee from the 2021 Council meeting. There were 446 councillors allocated for the 2021 meeting and 434 were credentialed. There were 361 councillors credentialed in person and 76 were credentialed for remote participation. The South Dakota Chapter and the Tactical Emergency Medicine Section were unrepresented. The following chapters were underrepresented by one councillor: Alaska, Idaho, Oklahoma, Puerto Rico, Vermont, Washington, West Virginia. Multiple attempts were made to identify members to fill these unrepresented and underrepresented councillor positions.

Electronic voting was conducted using online voting software from www.associationvoting.com. The electronic voting software was programmed with the unique membership numbers of councillors prior to the Council meeting.

Councillor Allocation

Dr. Gray-Eurom reported that councillor allocation for 2022 is 437 based on the total membership as of December 31, 2021. This is 13 less councillors than were allocated for the 2021 meeting. None of the chapters gained a councillor this year. The following chapters each lost one councillor: Alaska, Government Services, Illinois, Kansas, Michigan, New York, Texas, and Washington. California lost two and councillors and Florida lost three. Multiple communications were sent to chapters to remind them of the councillor allocation deadline and to follow up with any lapsed members.

The Aerospace Medicine Section has not yet met the minimum membership requirement of 100 members. All other sections met the minimum membership requirement of 100 members and will have a councillor for the 2022 Council meeting.

2021 Hybrid Council Meeting

Dr. Gray-Eurom and Dr. Costello discussed various aspects of the 2021 hybrid Council meeting. Zoom was used for remote participation. The chat feature was not enabled and there was no method for remote participants to be recognized to speak. Remote participants were able to view and hear the live Council meeting, the Reference Committee hearings, and the Candidate Forum. Councillors participating remotely were able to vote on all matters of business. There were 76 councillors credentialed for remote participation (17% of the 446 councillors allocated). The number of alternate councillors and other non-councillor remote participation was not recorded. The Steering Committee affirmed the value of in-person interactions and the additional costs must be considered, particularly if there are only a small number of remote participants. There was consensus to plan for a hybrid 2022 Council meeting subject to funds availability in the budget.

Temporary Council Meeting Standing Rules were developed and adopted by the Council to accommodate the hybrid nature of the meeting. Except as expressly provided in the Temporary Rules, all other Council Standing Rules remained in effect. The Bylaws & Council Standing Rules Subcommittee will be assigned an objective to review the Council Standing Rules and recommend revisions to the Standing Rules that may be needed to address remote participation and eliminate the need for temporary Standing Rules at future meetings.
The demographic survey questions were suspended for the 2021 meeting because of the time needed to generate ballots and vote on each question. The demographic questions will be reinstated for the 2022 meeting.

The asynchronous testimony process was continued for discussion of the resolutions in advance of the Council meeting. The Reference Committees developed preliminary reports based on the asynchronous testimony. The preliminary reports were the foundation for the live Reference Committee testimony and the final Reference Committee reports were developed based on the live testimony. The Steering Committee concurred that asynchronous testimony and development of preliminary Reference Committee reports should continue.

The Town Hall meeting focused on ACEP’s revised Strategic Plan. The Steering Committee did not identify any potential topics at this time for the 2022 Town Hall meeting.

Coffee and other beverages were available during the Council meeting; however, continental breakfast was not available because of budget constraints. Additionally, the Council Awards Luncheon was held in the main Council meeting room with boxed lunches instead of the traditional seated luncheon held in a separate room. The Steering Committee expressed support for reinstating the continental breakfast and a seated awards luncheon if possible based on the budget.

The Annual Meeting Subcommittee will review the Council meeting agenda, discuss suggestions for the Town Hall meeting topic, review the demographic survey questions, discuss potential options for morning food and beverage, and options for the Council Awards Luncheon and provide recommendations for the Steering Committee to consider at the May 1 meeting.

Electronic Voting

Dr. Gray-Eurom led a discussion regarding electronic voting and potential changes that may be needed in the Council Standing Rules if the Council meeting is held virtually or as a hybrid meeting in future years. The Council adopted Temporary Standing Rules to conduct business as a virtual meeting in 2020 and as a hybrid meeting in 2021. The committee also discussed whether to reinstate using the keypad system for electronic voting during the Council meeting or continue to use an online voting system such as the system that was used for the 2021 meeting. The cost for the online voting system is significantly less than the cost for using the keypads. The Steering Committee supported continuing to use an online voting system instead of the keypads so that the same system would be used whether in person, hybrid, or fully virtual. The Bylaws & Council Standing Rules Subcommittee will discuss electronic voting and potential changes to the Council Standing Rules and provide their recommendations for the Steering Committee to consider at the May 1 meeting.

Elections Process

Dr. Gray-Eurom highlighted the campaign and elections process and several changes that are needed to the Candidate Campaign Rules:

- Required candidate materials for floor nominees must be available immediately at the time of floor nomination – completed by the due date for all nominees or at notification of intent to seek nomination, whichever date is later.
- Requiring require responses to the written questions developed by the Candidate Forum Subcommittee.
- Specifying that logos of other organizations are not allowed.
- Clarification regarding faculty speaking at their home residency program(s) and provide a definition of “home” program(s).
- Additional guidance regarding candidates’ use of social media and language prohibiting candidate solicitation of social media groups for their endorsement.
- Additional guidance to address other types of speaking requests.

The Steering Committee agreed that the Candidate Campaign Rules should be revised to address these issues. There was agreement that the list of chapter presidents can also be provided to candidates in addition to the list of chapter executives and the list of councillors and alternate councillors. Additionally, the Steering Committee supported the ability for candidates to speak at non-ACEP meetings with the caveat that their candidacy cannot be discussed. The Candidate
Forum Subcommittee will review the Candidate Campaign Rules and provide their recommendations for the Steering Committee to consider at the May 1 meeting. Additionally, the Bylaws & Council Standing Rules Subcommittee will review potential changes to the “Nominations” section of the Council Standing Rules regarding floor candidates and required candidate materials.

**Council Meritorious Service Award**

The Steering Committee reviewed the history of the Council Meritorious Service Award and discussed whether it should be renamed in honor of a prominent member who has served for many years in the Council or in honor of one of the past Council speakers. There was consensus that the award should not be renamed.

**2021 Resolutions Requiring Steering Committee Action**

Dr. Gray-Eurom reviewed five resolutions adopted by the Council and one resolution referred to the Steering Committee requiring discussion and action by the Steering Committee.

- **Amended Resolution 10(21) Board of Directors Action on Council Resolutions – Bylaws Amendment**
  An executive summary of all resolutions considered by the Council and a summary of all resolutions adopted by the Council requiring Board action, including the final text of each resolution, is currently provided to the Council within 30 days of the Council meeting. A database has been developed on the ACEP website, [Actions on Council Resolutions](https://www.acep.org), that includes the original resolution, background information, Council action, testimony in the Reference Committee, Board action, and implementation action for each resolution. The search function includes a global search across all resolutions and a search capability in a particular year. There was consensus that using the database for reporting implementation actions meets the intent of the resolution.

- **Resolution 14(21) Establishing a Young Physician Position on the ACEP Nominating Committee**
  Dr. Gray-Eurom informed the Steering Committee that operationally, the Nominating Committee has included a young physician member for the past several years. The resolution does not specify that the young physician must be a member of or appointee from the Young Physicians Section. The Bylaws & Council Standing Rules Subcommittee will develop a resolution for the Steering Committee to consider at the May 1 meeting. The resolution will also include a definition of “young physician.”

- **Amended Resolution 18(21) Change to ACEP Conflict of Interest Statement**
  The resolution will be assigned to the Ethics Committee, working with ACEP’s General Counsel, to review and update, as appropriate, the “Conflict of Interest” (COI) policy statement. ACEP’s General Counsel will work with staff to update the COI disclosure form, ACEP’s Executive Director, Chief Operating Officer, and Senior Vice President staff members are required to complete COI statements. The Committee Manual will be updated and staff liaisons instructed on how to facilitate these changes, including information about distributing the COI disclosure statements. All candidates will be required to complete the updated COI disclosure form instead of the “Candidate Disclosure Form” that was used in the past.

  It was noted that the Council Standing Rules contain a provision that “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.” The resolution seeks transparency from all individuals providing testimony and the ability to review COI disclosure statements. There were some concerns expressed about the specific changes to the COI disclosure because of privacy issues.

- **Substitute Resolution 19(21) Clear and Complete Conflict of Interest Disclosure at the Council Meeting**
  The resolution was assigned to ACEP’s General Counsel to review and update the “Conflict of Interest” disclosure form, as directed in Amended Resolution 18(21), and to Governance Operations staff to work with component bodies to collect COI disclosure forms from councillors and alternate councillors and others providing testimony during the Council meeting. Technology Services staff will be assigned to develop a means for councillors to access conflict of interest forms during or prior to the Council meeting.
The Steering Committee discussed potential unintended consequences, challenges that may occur in trying to collect COI statements, and non-compliance. The Steering Committee agreed that this capability needs to be implemented for the 2022 Council meeting, either using the current COI form or an updated COI form based on the revisions requested in Amended Resolution 18(21), and that councillors should not be credentialed until a disclosure form is completed. Completion of forms for alternate councillors, past speakers, past presidents, and past chairs can be verified when checking in for the meeting at Councillor Credentialing. Multiple emails and signage can be used to remind everyone that a disclosure form must be on file prior to providing testimony in Reference Committees and on the Council floor.

- **Amended Resolution 23(21) Media Marketing of Value of Emergency Medicine Board Certification**
  The Steering Committee reviewed the amendment to the first resolved that was adopted by the Board of Directors on October 28, 2021:
  
  RESOLVED, That ACEP focus more on marketing to and educating the public on the value of ABEM/AOBEM emergency physician (as defined in ACEP’s policy statement “Definition of an Emergency Physician”) board certification in emergency medicine, focusing on the differences in education and training that ABEM/AOBEM board certified emergency physicians go through compared to non-ABEM/AOBEM board certified emergency physicians and non-physician practitioners; and be it further

  The Steering Committee affirmed that the amendment did not change the basic intent of the resolution.

- **Referred Resolution 15(21) Member Determined Council Representation**
  The Bylaws & Council Standing Rules Subcommittee will discuss the referred resolution and provide a recommendation for the Steering Committee to consider at the May 1 meeting.

**Action on Resolutions**

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2021, 2020, and 2019 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

**Subcommittee Appointments**

Dr. Gray-Eurom asked Steering Committee members to notify Ms. Montgomery of their interest in serving on the Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, or the Candidate Forum Subcommittee. All subcommittee members should plan to serve on at least two subcommittees. All second year Steering Committee members will be appointed to the Candidate Forum Subcommittee unless planning to seek nomination to the Board of Directors. Ms. Montgomery will email the objectives and deadlines of the subcommittees. The subcommittee reports will be discussed at the May 1, 2022, Steering Committee meeting.

**Next Meeting**

The next meeting of the Council Steering Committee is scheduled for Sunday, May 1, 2022, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 1:16 pm Central time on Tuesday, January 26, 2021.

Respectfully submitted,

Kelly Gray-Eurom, MD, MMM, FACEP  
Council Speaker and Chair

Melissa W. Costello, MD, FACEP  
Council Vice Speaker and Vice Chair
Steering Committee Meeting
May 1, 2022

Minutes

Speaker Kelly Gray-Eurom, MD, FACEP, called to order a conference call meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:08 am Eastern time on Sunday, May 1, 2022.

Steering Committee members present for all or portions of the meeting were: Eileen Baker, MD, FACEP; Lisa Bundy, MD, FACEP; Melissa Costello, MD, FACEP, vice speaker; Carrie de Moor, MD, FACEP; Hilary Fairbrother, MD, FACEP; Kelly Gray-Eurom, MD, FACEP, speaker; William Falco, MD, FACEP; Carlton Heine, MD, FACEP; Steven Kailes, MD, FACEP; Phillip Luke LeBas, MD, FACEP; Kristin McCabe-Kline, MD, FACEP; Christina Millhouse, MD, FACEP; Bing Pao, MD, FACEP; Michael Ruzek, DO, FACEP; Gary Starr, MD, FACEP; Thomas Sugarman, MD, FACEP; Larisa Traill, MD, FACEP; and Ashley Tarchione, MD.

Other members and guests present for all or portions of the meeting were: James B. Aiken, MD, FACEP; Stephen H. Anderson, MD, FACEP; Angela Cai, MD; Nicholas Cozzi, MD, MBA; James M. Cusick, MD, FACEP; Blake Denley, MD; J.T. Finnell, MD, FACEP; Vidor Friedman, MD, FACEP; Jeffrey Goodloe, MD, FACEP; Alison Haddock, MD, FACEP; Sanford Herman, MD, FACEP; Christopher Kang, MD, FACEP; Gary Katz, DO, MBA, FACEP; Gabor Kelen, MD, FACEP; Rami Khoury, MD, FACEP; Heidi Knowles, MD, FACEP; Kurtis Mayz, MD, FACEP; Michael McCrea, MD, FACEP; David Orban, MD, FACEP; Mark Rosenberg, DO, MBA, FACEP; James Shoemaker, Jr., MD, FACEP; Aisha Terry, MD, FACEP; and Arvind Venkat, MD, FACEP.

Staff present for all or portions of the meeting were: Jonathan Fisher, MD, FACEP; Mary Ellen Fletcher, CPC, CEDC, CAE; Sonja Montgomery, CAE; Leslie Moore, JD; Sandra Schneider, MD, FACEP; and Susan Sedory, MA, CAE;

Minutes

Dr. Gray-Eurom announced a correction to the minutes of the January 24, 2022, Steering Committee meeting. There are 433 councillors allocated for the 2022 meeting instead of 437 as recorded in the minutes. The minutes were then approved as corrected.

Officer and Staff Reports

Speaker

Dr. Gray-Eurom welcomed everyone and thanked them for their participation and commitment to the College. She then announced the 2022 Council awards recipients:

Council Meritorious Service Award – James B. Aiken, MD, FACEP
Council Horizon Award – Scott Pasichow, MD, MPH and Michael Ruzek, DO, FACEP
Council Teamwork Award – Louisiana Chapter
Council Champion in Diversity & Inclusion Award – Ramon W. Johnson, MD, FACEP
Council Curmudgeon Award – Marsha D Ford, MD, FACEP

Dr. Gray-Eurom announced the 2022 candidates:

President-Elect: Aisha T. Terry, MD, MPH, FACEP
Board of Directors: William B. Felegi, DO, FACEP
Jeffrey M. Goodloe, MD, FACEP
Gabor D. Kelen, MD, FACEP
Jeffrey F. Linzer, Sr., MD, FACEP
Dr. Gray-Eurom reminded the Steering Committee of the various meetings that will be held on Wednesday, September 28, 2022, in San Francisco.

**Vice Speaker**

Dr. Costello reported on her service on the Finance Committee as the speaker’s designee and provided a brief ACEP financial update.

**President**

Dr. Schmitz was unable to attend the Steering Committee meeting.

**President-Elect**

Dr. Kang reported on several key initiatives on behalf of Dr. Schmitz, including an update on ACEP’s activities regarding workforce issues and an overview of the pillars of the new Strategic Plan. He directed members to the ACEP website for more information.

**Executive Director**

Ms. Sedory provided additional details regarding the Strategic Plan and reported on the work of the New Practice Models Task Force, the Emergency Medicine Data Institute, and ACEP’s accreditation programs.

**Annual Meeting Subcommittee**

Dr. Millhouse 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 2022 Town Hall meeting topic. The subcommittee supports the current format of the Town Hall meeting that includes a pro/con debate of various aspects of an issue by high-level speakers/content experts followed by a period of Q & A. The subcommittee suggested the following topics for consideration: workforce, No Surprises Act implementation, scope of practice, preparing for the next pandemic, future of telehealth in emergency medicine, Medicare payment reform, physician mental health/state physician monitoring programs, and practice of emergency medicine in a post-COVID world. The Steering Committee suggested that emergency medicine as a public utility (financial model) and generational dynamics in emergency medicine be considered as potential topics. The Council officers will make the final determination about the format, topic, and speakers for this year’s Town Hall meeting this summer.

The subcommittee reviewed the implementation actions on 2019-2021 resolutions and concurred that the actions taken are consistent with the Council’s expectations. The implementation action on the resolutions can be accessed on the ACEP website by all members. [https://www.acep.org/what-we-believe/actions-on-council-resolutions/](https://www.acep.org/what-we-believe/actions-on-council-resolutions/)

The subcommittee provided suggestions for questions that should be considered to use as survey questions during the Council meeting. The Council officers will determine the final survey questions this summer.

The subcommittee reviewed the Council meeting agenda and recommended continuing video reports from EMF and NEMPAC. There was agreement that videos for other reports could also be utilized, however, reports from the president, president-elect, and executive director should always be live. Additionally, although there is the option of a video presentation, individuals should be offered the ability to present their report in person.

The subcommittee discussed the challenges with using an online voting system: programming in advance with the names and credentials of the councillors who will be voting during the Council meeting; changes to delegations onsite could not be programmed into the system; alternate councillors substituting for councillors must use the login credentials
of the credentialed councillor; the need to generate a ballot code for each vote; the requirement to enter the ballot code for the vote to register; brief delays for ballot code generation when the Council approves a motion to “vote immediately” and the subsequent vote on the matter pending before the Council. Staff were directed to investigate the possibility of updating the online voting system onsite when there changes in councillor delegations. The Steering Committee concurred with the subcommittee’s recommendation to continue using the online voting system instead of the keypads.

The subcommittee reviewed the costs for providing continental breakfast, in addition to coffee and other beverages during the Council meeting. The Steering Committee supported the subcommittee’s recommendation to include continental breakfast in addition to coffee and other beverages if the costs can be accommodated in ACEP’s FYY 2022-23 budget.

The subcommittee discussed the Council Awards Luncheon and alternative options for recognition of the Council awards recipients during the Council meeting. There was consensus from the Steering Committee to reinstate the traditional awards recognition luncheon.

The subcommittee discussed the pros and cons of holding a hybrid Council meeting and the additional associated costs. There was consensus from the Steering Committee that an in-person meeting is preferred, however, a hybrid meeting should be planned given the uncertainty of another COVID surge and the significant value added for members with the addition of remote participation. The final decision regarding a hybrid meeting will be determined based on ACEP’s budget.

**Bylaws & Council Standing Rules Subcommittee**

Dr. Traill presented the subcommittee’s report on their assigned objectives.

The subcommittee reviewed the Council Standing Rules (CSR) for any necessary revisions. A draft CSR resolution was developed with proposed changes to the “Election Procedures” section and the “Voting on Resolutions and Motions” section addressing electronic voting during the Council meeting. Another draft CSR resolution was developed with proposed changes to the “Nominations” section addressing required candidate campaign materials from floor candidates. The Steering Committee provided additional language to include in both resolutions and supported submitting them to the 2022 Council for consideration.

The subcommittee developed a draft Bylaws resolution as directed in Resolution 14(21) Establishing a Young Physician Position on the ACEP Nominating Committee. The Steering Committee provided additional language to include in the resolution and supported submitting it to the 2022 Council for consideration.

The subcommittee had an extensive discussion about Referred Resolution 15(21) Member Determined Council Representation and noted that Reference Committee testimony was generally opposed to the resolution and reflected that the resolution was viewed as cumbersome to implement and addressed an issue not identified as a need. Testimony in favor of the resolution indicated that the resolution continued the efforts of the task force created in response to Amended Resolution 13(18) Growth of the ACEP Council. The subcommittee also reviewed the report from that task force. It was acknowledged that some sections would prefer proportional representation in the Council instead of the current allocation of one councillor per section. The subcommittee expressed concerns that there are potentially many unintended consequences in implementing the alternative methods of councillor allocation as described in the referred resolution, including but not limited to the potential to shift a portion of a chapter’s councillor allocation to sections. Additionally, there are implementation challenges such as how points would be assigned if some members do not assign their points/credits as described in the referred resolution. The subcommittee believes: 1) their review and discussion of the referred resolution addresses the request for a task force or committee to consider an alternative method of councillor allocation; 2) the current method of councillor allocation meets the needs of member representation in the Council; and 3) no further study of alternative methods of councillor allocation are needed to address Referred Resolution 15(21) Member Determined Council Representation. The Steering Committee supported the subcommittee’s findings.

The subcommittee discussed briefly other changes to the Bylaws that may be needed and agreed to submit their comments to the Bylaws Committee to review during the 2022-23 committee year.
Candidate Forum Subcommittee

Dr. Costello presented the subcommittee’s report on their assigned objectives. The majority of the subcommittee’s objectives will be completed this summer and during the 2022 Council meeting.

The subcommittee provided recommendations for several changes to the Candidate Campaign Rules for the Steering Committee to consider regarding required candidate materials, responses to written questions, logos of other organizations in photos, faculty speaking at home residency programs, and additional guidance regarding the use of social media.

It was moved THAT THE STEERING COMMITTEE APPROVE THE REVISED CANDIDATE CAMPAIGN RULES. The motion was adopted.

The subcommittee will meet immediately following this Steering Committee meeting to finalize the candidate written questions and to review the assignments for moderators, coordinators, and door monitors. The subcommittee will meet in San Francisco on September 28, 2022, 4:30 – 6:00 pm to review the format for the Candidate Forum and to meet with the candidates.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Wednesday, September 28, 2022, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 12:25 pm Eastern time on Sunday, May 1, 2022.

Respectfully submitted,

Kelly Gray-Eurom, MD, MMM, FACEP
Council Speaker and Chair

Melissa W. Costello, MD, 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.

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

REFER
Send resolution to the Board of Directors for consideration, perhaps by a committee, the Council Steering Committee, or the Bylaws Interpretation Committee.
2022 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 10-23
Nicole A. Veitinger, DO, FACEP (OH), Chair
Deborah D. Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (HI)
Kurtis A. Mayz, JD, MD, MBA, FACEP (OK)
Alexandra N. Thran, MD, FACEP (VT)
Brad L. Walters, MD, FACEP (MI)

Maude Surprenant Hancock, CAE
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 24-40
Abhi Mehrotra, MD, MBA, FACEP (NC) Chair
Erik Blutinger, MD, MSc (NY)
Angela P. Cornelius, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
Puneet Gupta, MD, FACEP (CA)
Diana Nordlund, DO, JD, FACEP (MI)

Jeff Davis
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 41-58
Dan Freess, MD, FACEP (CT) Chair
Andrea Austin, MD, FACEP (CA)
Lisa M. Bundy, MD, FACEP (MS)
Antony P. Hsu, MD, FACEP (MI)
James D. Maloy, MD, MPH (DC)
David Nestler, MD, MS, FACEP (MN)

Jonathan Fisher, MD, FACEP
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.

Only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements and background sections are informational or explanatory. Only the resolutions adopted by the Council and ratified by the Board of Directors become official. Council Standing rules become official on adoption by Council.

Asynchronous testimony will open on August 29 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2022 resolutions will be posted on the Council engagED when asynchronous testimony is open. After clicking on the link provided:

- login with your ACEP username and password.
- the list of resolutions will display
- click the resolution of interest
- scroll to the bottom to submit your comment

The asynchronous testimony platform is open to all members. When commenting please include the following:
1. Whether you are commenting on behalf of yourself or your component body
   a. chapter, section, AACE, CORD, EMRA, or SAEM
2. Whether you are commenting in support, opposition or suggesting an amendment to the resolution
3. Any additional information to support your position.

The asynchronous platform is the only method to introduce testimony until the live Reference Committee meetings in San Francisco. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. Like in-person testimony, all comments should be addressed to the Reference Committee Chair or the Speaker. Please do not direct any communications to another member, including those who have posted before you, with whom you may or may not agree. And like the in-person Council meeting, proper decorum is expected within the asynchronous testimony platform.

Comments should be concise so as to not exceed an equivalent of 2 minutes of oral testimony. Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this online testimony for the Council meeting, you hereby acknowledge and agree to abide by ACEP’s Meeting Conduct Policy.

Asynchronous testimony will close at 12:00 noon Central time on Monday, September 19. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Friday, September 23 and will be the starting point for the live Reference Committee debate during the Council meeting in San Francisco on Thursday, September 29.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the “Document Library” tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the President-Elect candidates,
Board of Directors candidates, and the resolutions. Additional documents may be added over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in San Francisco!

Your Council Officers,

Kelly Gray-Eurom, MD, MMM, FACEP  Speaker
Melissa W. Costello, MD, FACEP  Vice Speaker
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<th>Resolution</th>
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<td>1</td>
<td>Commendation for Michael L. Callaham, MD, FACEP</td>
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<td>Richelle J. Cooper, MD, MSHS, FACEP</td>
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<td>Richard C. Dart, MD, PhD, FACEP</td>
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<td>Commendation for Virginia Kennedy Palys, JD</td>
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<td>Illinois College of Emergency Physicians</td>
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<td>Commendation for Paul Pomeroy, MD, FACEP</td>
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<td>Commendation for Loren Rives, MNA</td>
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<td>Chad Kessler, MD, FACEP</td>
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<td>Section of Medical Directors</td>
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<td>Commendation for Mark S. Rosenberg, DO, MBA, FACEP</td>
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<td>In Memory of Carey D. Chisholm, MD</td>
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<td>Indiana Chapter</td>
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<td>In Memory of Loren A. Crown, MD, FACEP</td>
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<td>In Memory of Sherrill Mullenix</td>
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In Memory of Adetolu “Tolu” Odufuye, MD
Diversity, Inclusion, & Health Equity Section
Young Physicians Section
Emergency Medicine Residents’ Association
Arizona Chapter
Florida College of Emergency Physicians
Georgia College of Emergency Physicians
Maine Chapter

Candidate Members in the ACEP Council - Bylaws Amendment
Emergency Medicine Residents’ Association

Establishing a Young Physician Position on the ACEP Nominating Committee - Bylaws Amendment
Council Steering Committee

Council Approval of Board Actions on Referred Resolutions – Bylaws Amendment
Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

Past Leader Participation in Council Meetings – Bylaws Amendment
Maine Chapter

Past Leader Participation in Council Meetings – Council Standing Rules Amendment
Maine Chapter

Electronic Voting During the Council Meeting – Council Standing Rules Amendment
Council Steering Committee

Required Candidate Campaign Materials from Floor Candidates – Council Standing Rules Amendment
Council Steering Committee

Criteria for the Location of Future National ACEP Events
Michael Bresler, MD, FACEP
Valerie Norton, MD, FACEP
California Chapter

Disclosure of Clinical Emergency Data Registry Revenue Sources
Brad Dreifuss, MD, FACEP
Robert McNamara, MD, FACEP

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RESOLUTION:    1(22)

SUBMITTED BY: Richelle J. Cooper, MD, MSHS, FACEP
Richard C. Dart, MD, PhD, FACEP
Steven M. Green, MD, FACEP
David L. Schriger, MD, MPH, FACEP
Donald M. Yealy, MD, FACEP

SUBJECT:  Commendation for Michael L. Callaham, MD, FACEP

WHEREAS, Michael L. Callaham, MD, FACEP, served the College and the specialty with skill and dedication as a member of the editorial board of *Annals of Emergency Medicine* for more than 40 years, including 20 years as Editor in Chief; and

WHEREAS, During his time at *Annals* he ensured an ever-rising level of a valid, scientifically rigorous peer-review that has resulted in the publication of manuscripts impactful to the practice of emergency medicine in the U.S. and across the globe; and

WHEREAS, Under his leadership the journal thrived in all ways including an increase in monthly circulation to more than 40,000 subscribers, providing journal access to low- and middle-income country physicians, and more than 2.2 million article downloads in 2020; and

WHEREAS, Under his leadership yearly manuscript submissions have increased to more than 2,200; the scientific impact factor of the journal has increased to 5.721, the highest of any emergency medicine journal; and the journal and the specialty of emergency medicine has had increasing press coverage, with more than 1,100 media mentions of *Annals* articles in 2021; and

WHEREAS, Dr. Callaham has been a staunch advocate for the investigator-authors, and readers of the journal, with routine surveys and critical review and revision of journal processes to meet the end-user needs; and

WHEREAS, During his tenure with the journal he developed innovations and initiatives to increase the value of the journal to the readership; and

WHEREAS, His development and mentorship of the *Annals of Emergency Medicine* resident editor fellowship provided a platform to launch the careers of many future editors and leaders in emergency medicine; and

WHEREAS, Dr. Callaham elevated the presence of emergency medicine, the journal, and the College as president of World Association of Medical Editors (WAME) and as a member of the National Academy of Medicine; and

WHEREAS, Dr. Callaham became the leading world-wide expert in the study and science of peer-review, and represented the College and journal with distinction with numerous contributions to the International Congress on Peer Review and Scientific Publication Peer Review Congress; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Michael L. Callaham, MD, FACEP, to the advancement of science and success of *Annals of Emergency Medicine*; and be it further

RESOLVED, That the American College of Emergency Physicians commends Michael L. Callaham, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.
RESOLUTION: 2(22)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Commendation for Virginia Kennedy Palys, JD

WHEREAS, Virginia (Ginny) Kennedy Palys, JD, has served as the Executive Director of the Illinois College of Emergency Physicians (ICEP) for 38 years; and

WHEREAS, Ms. Kennedy Palys has been dedicated to the growth and development of emergency medicine across the country leading the chapter through unparalleled growth to 1,400 members in 2022; and

WHEREAS, The unwavering support and leadership of Ms. Kennedy Palys steered ICEP through financial challenges while becoming a role model for large chapter executives; and

WHEREAS, Ms. Kennedy Palys strengthened the stability through a partnership with the International Trauma Life Support (ITLS), serving as their Executive Director; and

WHEREAS, ITLS is a 501(c) (3) educational foundation dedicated to reducing death and disability from trauma through training and ITLS trains annually more than 35,000 emergency and pre-hospital professionals in more than 80 countries and ITLS remains the only prehospital trauma education program endorsed by ACEP; and

WHEREAS, Ms. Kennedy Palys has developed four decades of emergency medicine leadership across the country serving as confidant, counselor, advisor, and friend; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Virginia (Ginny) Kennedy Palys, JD, for her career of dedicated service, outstanding leadership, commitment to the College, the emergency physicians of Illinois, the specialty of emergency medicine, and the patients that we serve.
RESOLUTION: 3(22)

SUBMITTED BY: Michigan College of Emergency Physicians
Sara S Chakel, MD, FACEP
Douglas M Char MD, FACEP
Melanie Heniff, MD, JD, FAAP, FACEP
Kurtis A Mayz, JD, MD, MBA, FACEP
Diana Nordlund, DO, JD, FACEP
Suzie Park, DO
Scott H Pasichow, MD, MPH
David T Overton, MD, MBA, FACEP
Michael D Repplinger, MD, PhD, FACEP
Todd L Slesinger, MD, FACEP, FCCM, FCCP
Annalise Sorrentino, MD, FACEP
James D Thompson, MD, FACEP
Larisa M Traill, MD, FACEP
Bradford L Walters, MD, FACEP

SUBJECT: Commendation for Paul R Pomeroy, Jr., MD, FACEP

WHEREAS, Paul R Pomeroy, Jr., MD, FACEP, has served the specialty of emergency medicine and the College with complete dedication over seven decades, from the 1960s through the 2020s; and

WHEREAS, Dr. Pomeroy assisted Dr. Eugene Nagel in trials of EKG telemetry while serving in the US Coast Guard during the Vietnam War, with this technology later being implemented for use by Miami, Florida, Emergency Medical Services (EMS); and

WHEREAS, Dr. Pomeroy began working in Emergency Medicine in 1970 as a moonlighting resident at Wyandotte Hospital in Michigan, and, over his career, subsequently served as the Director of the Emergency Departments of several Michigan hospitals, including Wyandotte Hospital, Pontiac St. Joseph Mercy Hospital, and Livonia St. Mary Mercy Hospital; and

WHEREAS, Dr. Pomeroy, in his leadership roles at the hospitals he served, was instrumental in beginning the process to staff the emergency departments he directed with full-time emergency physicians; and

WHEREAS, Dr. Pomeroy served as EMS Medical Director for Oakland County and Western Wayne County in Michigan, and introduced many innovations and improvements to the systems he served over his career, including elevating the training of Bloomfield Township Fire Department response personnel to paramedic status, teaching Livonia Fire Department basic EMTs to utilize defibrillators in a first for the state of Michigan, and introducing Combitubes as an intermediate airway device in a successful pilot study with the Livonia Fire Department, which led to his directorship of a state-wide Michigan course to train EMS personnel in the usage of Combitubes; and

WHEREAS, Dr. Pomeroy also served as a cruise ship physician prior to his retirement from the clinical practice of medicine after 39 years; and

WHEREAS, Dr. Pomeroy contributed to the education of emergency physicians through his authorship of the chapter on Hypertension in the first two McGraw-Hill editions of Tintinalli’s “A Study Guide in Emergency Medicine,” first published by ACEP in 1978; and
WHEREAS, Dr. Pomeroy has served the Michigan College of Emergency Physicians with distinction, starting with his election to the Michigan Chapter Board of Directors in 1977, including a term as President of the Chapter from 1982-83, and also leading the Chapter’s first long-term planning meeting, directing the Chapter’s first board preparation course, authoring a history of the Chapter for its 30th anniversary, and remaining actively engaged in the Chapter for over 45 years; and

WHEREAS, Dr. Pomeroy has received recognition of his service from the Michigan Chapter as a recipient of the Ronald L Krome Meritorious Service Award (1985); and

WHEREAS, Dr. Pomeroy holds the distinction of longest continuous service as ACEP Councillor, having served as a Councillor for 45 consecutive years, from 1977 through 2021, including service at the only Special Council meeting in the history of the College in 1978, and has also authored numerous Council resolutions throughout his tenure; and

WHEREAS, Dr. Pomeroy served the College Bylaws Committee from 1994 through 2021, including service as chair of the committee; and

WHEREAS, Dr. Pomeroy has received numerous awards for his involvement with the College, including the Council Meritorious Service Award (1992), the Honorary Membership Award (1998), and the John A Rupke Legacy Award (2013); and

WHEREAS, Dr. Pomeroy’s numerous accomplishments over a long and dedicated career have helped to promulgate and grow the specialty of Emergency Medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Paul R Pomeroy, Jr., MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.
RESOLUTION:  4(22)

SUBMITTED BY:  Chad Kessler, MD, FACEP
               Alexander Limkakeng, Jr., MD, FACEP
               Bruce Lo, MD, FACEP
               Laura Oh, MD, FACEP
               Virginia College of Emergency Physicians
               Medical Directors Section

SUBJECT:  Commendation for Loren Rives, MNA

WHEREAS, Loren Rives, MNA, began her employment with ACEP in 2015 as a grants manager and quickly
transitioned to the Senior Manager for Academic Affairs; and

WHEREAS, Ms. Rives has been an exceptional staff liaison to the Academic Affairs Committee; Research
Committee; and Research, Scholarly Activity, and Innovation Section by supporting their efforts and assuring their
tasks were completed to the highest standards; and

WHEREAS, Ms. Rives provided staff support for the Teaching Fellowship, overseeing its co-branding with
the Council of Residency Directors in Emergency Medicine and creating the Resident Teaching Fellowship; and

WHEREAS, Ms. Rives provided staff support for the Emergency Medicine Basic Research Skills (EMBRS)
Course, transitioning it to virtual during the COVID pandemic and then back to an in-person meeting; and

WHEREAS, Ms. Rives took on additional duties as the staff liaison for the Coalition on Psychiatric
Emergencies, coordinating this group and moving it into a productive group that has improved the care of patients
with mental health disorders; and

WHEREAS, Ms. Rives also acquired additional duties as the staff liaison for the Emergency Department
Sickle Cell Care Coalition providing support for their meetings and creating resources for emergency physicians to
better care for patients with sickle cell; and

WHEREAS, Ms. Rives has overseen the Research Forum, improving the meeting, transitioning it from in-
person, to virtual, to hybrid, and back to in-person during the COVID pandemic and created a special separate
Research Forum for COVID to ensure that research on COVID was released as early as possible, thereby saving the
lives of patients; and

WHEREAS, Ms. Rives was an invaluable asset in the creation of the highly successful Virtual Grand Rounds
program; and

WHEREAS, Ms. Rives was a valued member of the ACEP staff, not only for her work but also for how she
performed it and with her quiet, confident manner and incredible work ethic she accomplished all of this and much
more to support emergency physicians and the patients they treat; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Loren Rives, MNA, for her
outstanding service and commitment to the College and the specialty of emergency medicine.
RESOLUTION: 5(22)

SUBMITTED BY: New Jersey Chapter

SUBJECT: Commendation for Mark S. Rosenberg, DO, MBA, FACEP

WHEREAS, Mark S. Rosenberg, DO, MBA, FACEP, has been an extraordinary and dedicated leader while serving on the Board of Directors 2015-22, and in his roles as President-Elect 2019-20, President 2020-21, and Immediate Past President 2021-22; and

WHEREAS, Dr. Rosenberg led ACEP during the COVID-19 pandemic and championed the creation of innovative approaches to patient outreach and vaccine programs in addition to advocating for the safety and well-being of emergency physicians; and

WHEREAS, Dr. Rosenberg, during his tenure on the ACEP Board of Directors, developed The Alternatives to Opioids (ALTO) program to address the issue of variation and over prescribing, which was used to develop The Alternatives to Opioids (ALTO) in the Emergency Department Act (H.R. 5197/S.2516) that was enacted in June 2018; and

WHEREAS, During his term as President, Dr. Rosenberg was committed to ACEP addressing health care disparities/health equity and COVID/future pandemics; and

WHEREAS, Dr. Rosenberg has been an articulate spokesperson for ACEP’s agenda, advocating for the removal of the X-Waiver, and highlighting the barrier to treating overdose patients; and

WHEREAS, Dr. Rosenberg has been a staunch advocate for preserving reimbursement for emergency physicians and ensuring that the “No Surprises Act” protects both patients and physicians from surprise billing; and

WHEREAS, Dr. Rosenberg has exemplified his commitment to ACEP and its members by meeting virtually with every chapter during his presidency; and

WHEREAS, Dr. Rosenberg has served as a member, chair, and Board liaison to various ACEP committees, task forces, and sections and was a founding member and chair of ACEP’s Geriatric Emergency Medicine Section and the Palliative Medicine Section; and

WHEREAS, Dr. Rosenberg was instrumental in the development of ACEP’s Geriatric Emergency Department Accreditation Program and the Pain & Addiction Care in the ED Accreditation Program; and

WHEREAS, Dr. Rosenberg has championed ACEP’s advocacy agenda and has served on the Board of Trustees of the National Emergency Medicine Political Action Committee; and

WHEREAS, Dr. Rosenberg served on the Board of Trustees of the Emergency Medicine Foundation and continues to support his commitment to emergency medicine research through his contributions; and

WHEREAS, Dr. Rosenberg demonstrated leadership through chapter involvement and served on the New Jersey Chapter Board of Directors 2010-17, and as President 2015-16; and

WHEREAS, Dr. Rosenberg has represented the College with honor and distinction and is a role model of commitment and productivity; and
WHEREAS, Dr. Rosenberg will continue to be involved and committed to the practice of emergency medicine and to ACEP’s mission; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Mark S. Rosenberg, DO, MBA, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.
RESOLUTION: 6(22)

SUBMITTED BY: Indiana Chapter

SUBJECT: In Memory of Carey D. Chisholm, MD

WHEREAS, Emergency medicine lost a beloved leader of our specialty in the passing of Carey D. Chisholm, MD, who died July 7, 2021; and

WHEREAS, Dr. Chisholm earned his medical degree from the Medical College of Virginia in 1980 and completed his residency training in emergency medicine at Madigan Army Medical Center; and

WHEREAS, Dr. Chisholm became the emergency medicine residency program director at Brooke Army Medical Center in 1985 and in 1989 he came to Indiana University, where he ultimately served as emergency medicine residency program director for over 23 years; and

WHEREAS, During his greater than 20-year tenure at the Indiana University Emergency Medicine residency program, with his exceptional dedication to physician education and leadership development, he shaped the careers of hundreds of physicians; and

WHEREAS, Dr. Chisholm was also a recognized leader in the field of emergency medicine on a national level having served as president of the Society for Academic Emergency Medicine and received numerous prestigious awards, including the American College of Emergency Physicians Hero of Emergency Medicine award in 2008, and the American Academy of Emergency Medicine Lifetime Achievement Award in 2014; and

WHEREAS, Dr. Chisholm’s passion for teaching had no limit and he was known as much for his bedside clinical teaching as the rigorous emergency medicine residency curriculum that produced more than 500 highly-trained emergency physicians during his tenure as program director, and beyond resident education, he also taught evidence-based medicine, bioethics, and professionalism to medical students; and

WHEREAS, Dr. Chisholm’s dedication to residents’ professional and personal development extended far beyond the walls of the hospital and he frequently hosted educational and social events at his home, or retreats at resident-chosen locations across Indiana and during these gatherings he prepared superb meals for residents and their families, in addition to teaching about clinical and non-clinical topics pertinent to emergency medicine; and

WHEREAS, Dr. Chisholm created a sense of family for the Indiana University emergency medicine community and the relationships, both professional and personal, that developed out of these activities lasted long past residents’ years of training; and

WHEREAS, Even after his retirement as residency program director, Dr. Chisholm continued to serve as an educator and mentor to residents and faculty members and following the tragic death of his long-time friend and colleague, Kevin Rodgers, MD, he, Robin Chisholm, and Ruth Rodgers also created the Chisholm-Rodgers Legacy Fund to support clinical education and leadership development for years to come; and

WHEREAS, Dr. Chisholm’s legacy will be carried out across the globe by the hundreds of physicians he trained, who themselves have gone on to teach other students and care for countless patients; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College’s condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Taylor.
WHEREAS, With the untimely death of Loren A. Crown, MD, FACEP, on May 29, 2022, ACEP lost a gifted communicator, a tireless emergency medicine advocate, and a founder of the Tennessee ACEP Chapter; and

WHEREAS, Dr. Crown received his medical degree from Washington University School of Medicine in St. Louis and completed his medicine residency at the University of Illinois in Chicago; and

WHEREAS, Dr. Crown was board certified in family and sports medicine and practiced emergency medicine at St. Francis (where he established the first chest pain center in West Tennessee and a Level II Trauma Center) and St. Joseph Hospitals and served as medical director of the emergency department; and

WHEREAS, Dr. Crown joined the faculty of the University of Tennessee (UT) Health Sciences Center and moved to Tipton County in 1991 to establish the UT-Tipton Family Practice Program and an Emergency Medicine Fellowship program in Covington to prepare doctors for family and emergency practice in rural communities; and

WHEREAS, At UT, Dr. Crown achieved tenure and the rank of full clinical professor and during the next quarter century, he trained many dozens of fellows, residents, and medical students in family and emergency medicine; and

WHEREAS, Dr. Crown gave lectures both throughout the country and internationally, published more than 100 journal articles, wrote textbook chapters, served as editor of medical journals, presided over conferences, and moderated a medically oriented television program; and

WHEREAS, Dr. Crown was the Medical Advisor for the Southwest Tennessee and Dyersburg State College Paramedic programs; and

WHEREAS, Dr. Crown received many accolades and was elected by the American Academy of Emergency Medicine peers as Physician of the Year, by the Tennessee Rural Health Association as Practitioner of the Year and by his hospital as Doctor of the Year; and

WHEREAS, Active in professional societies, he was Chair of the Board of Certification of Emergency Medicine, President of the Tennessee College of Emergency Physicians, and President of the Memphis Academy of Family Physicians; and

WHEREAS, In community affairs, he served as President of the Memphis branch of the American Heart Association, as Vice President of the Alumni of Leadership Memphis. He also sat on the boards of United Way, the Memphis chapter of the American Red Cross, Art Today, Dyersburg State College Foundation, The Tipton Arts Council, and the Boys and Girls Clubs of Hatchie River; and

WHEREAS, Dr. Crown had a long and distinguished service as a member of ACEP and the Tennessee ACEP Chapter for more than 30 years; and

WHEREAS, Dr. Crown served the Tennessee Chapter as councillor, alternate councillor, and as a member of
WHEREAS, Dr. Crown was a passionate witness on behalf of emergency physicians in the state legislature; and
WHEREAS, Dr. Crown served his community for 30 years as an emergency physician and tirelessly worked to support and advocate for emergency medicine; and
WHEREAS, Dr. Crown additionally practiced Emergency Medicine at the University of Tennessee Health Sciences Center where he touched many lives with his kindness, compassion, and desire to truly help mankind; and
WHEREAS, Dr. Crown was recognized for his deep empathy and compassion for medicine which earned him the exuberant gratitude and admiration of his patients; and
WHEREAS, Dr. Crown will be missed by his friends and colleagues who were privileged to know him for his strength of character, but most importantly that he knew 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, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.
WHEREAS, Sherrill Mullenix contributed immensely to the Emergency Medicine Community in Delaware in her role as the Delaware Chapter Executive for 18 years; and

WHEREAS, Ms. Mullenix shepherded hundreds of residents training in Emergency Medicine and dual-training in Emergency Medicine & Internal Medicine through that training and into practice over 25 years as the EM/IM residency coordinator at ChristianaCare, impacting not only these physicians but by extension the entirety of the Emergency Medicine community and countless patients; and

WHEREAS, Ms. Mullenix further contributed to the education of future Emergency Medicine physicians through her long-standing roles with EMRA; and

WHEREAS, Emergency Medicine in Delaware lost a friend, a colleague, and her constant immeasurable support this year when Ms Mullenix passed away; therefore be it

RESOLVED, That the American College of Emergency Physicians, the Delaware Chapter, and the friends and colleagues of Sherrill Mullenix recognizes her longstanding dedication and incredible contributions to the current state and the future of emergency medicine and acknowledges that she is irreplaceable and is missed.
RESOLUTION:    9(22)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Young Physicians Section
Emergency Medicine Residents’ Association
Arizona Chapter
Florida College of Emergency Physicians
Georgia College of Emergency Physicians
Maine Chapter

SUBJECT: In Memory of Adetolu “Tolu” Odufuye, MD

WHEREAS, Emergency medicine lost a staunch advocate for the specialty in Adetolu “Tolu”
Odufuye, MD, a dedicated mentor, organizational leader, and dear friend, who passed away on June 7,
2022, and left behind family, friends, residents, medical students, and colleagues; and

WHEREAS, Dr. Odufuye graduated from the University of Minnesota-Twin Cities and the Mayo
Clinic College of Medicine, completing her emergency medicine residency at the Department of Emergency
Medicine, Regions Hospital/HealthPartners and served in emergency departments in Atlantic Beach,
Florida, Emory University, Georgia, the Mayo Clinic in Jacksonville, Florida, and ThedaCare Medical
Center in Waupaca, WI; and

WHEREAS, Dr. Odufuye served on national committees and Taskforces for the American College
of Emergency Physicians including the State Legislative and Regulatory Committee, Strategic Planning
Action Team for career fulfillment, and the Diversity, Inclusion and Health Equity (DIHE) Section
Executive Leadership Committee; and

WHEREAS, Dr. Odufuye served as an alternate councilor for the DIHE Section, newsletter editor
and its founding secretary; and

WHEREAS, Dr. Odufuye was elected Chair of the Diversity, Inclusion & Health Equity Section of
which she was an inaugural member; and

WHEREAS, Dr. Odufuye was a passionate voice for equity and for change; and

WHEREAS, Dr. Odufuye touched the lives of countless individuals as a role model, colleague,
consultant, friend; therefore be it

RESOLVED, That ACEP and the Diversity, Inclusion and Health Equity Section hereby
acknowledges the many contributions made by Adetolu “Tolu” Odufuye, 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 Adetolu
“Tolu” Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her
tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and
the United States.
2022 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 10-23

Nicole A. Veitinger, DO, FACEP (OH), Chair
Deborah D. Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (HI)
Kurtis A. Mayz, JD, MD, MBA, FACEP (OK)
Alexandra N. Thran, MD, FACEP (VT)
Brad L. Walters, MD, FACEP (MI)

Maude Surprenant Hancock, CAE
Laura Lang, JD
RESOLUTION: 10(22)

SUBMITTED BY: Emergency Medicine Residents’ Association

SUBJECT: Candidate Members in the ACEP Council

PURPOSE: Bylaws amendment to allow medical students to serve as councillors.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws and implement the amendment.

WHEREAS, Medical student members make up approximately 23% of EMRA membership and 11% of total ACEP membership, and as all EMRA members are ACEP candidate members and there are currently 4,332 medical student members of both EMRA and ACEP as of May 2022; and

WHEREAS, Article VIII – Council, Section 1 – Composition of the Council, paragraph three of the ACEP Bylaws state: “EMRA shall be entitled to eight councilors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA;” and

WHEREAS, Currently there are no medical students serving as ACEP councillors within the College to represent their voice and membership in EMRA, thus not representative of “all of the members of EMRA;” and

WHEREAS, ACEP candidate members comprising medical students decreased roughly 20% from 2021-2022 with further anticipated reductions in 2022-2023; and

WHEREAS, The 2022 Electronic Residency Application Service Match had the highest number of unfilled positions in emergency medicine programs in the last decade with 7.5% of all emergency medicine programs unfilled following the match; and

WHEREAS, Medical student members represent the future of the emergency medicine profession and may offer a perspective not already represented in the ACEP Council as it currently presides; and

WHEREAS, Medical students already serve in vital roles within EMRA by introducing meaningful resolutions, debating the utility of proposed resolutions as amendments to EMRA policy, and furthering the mission and vision of the organization; and

WHEREAS, In the interest of attracting and retaining medical students into the field of emergency medicine, workplace studies have connected employees’ experience of having their voices heard and represented led to more positive work experiences and higher retention; and

WHEREAS, The American Medical Association (AMA) has an important engagement with medical students at all levels of their organization, notably the Medical Student Section (MSS), that often guides broad organizational policy matters and instituting important changes in the field of medicine; therefore be it

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.3 – Candidate Members, paragraph two be amended to read:

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

“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.”

References:

Background

This Bylaws amendment seeks to allow medical students to serve as councillors. ACEP has a long history of medical student participation, beginning in 1975 when the Bylaws were amended to allow medical students to become candidate members of ACEP. Candidate members cannot vote or hold office, except candidate physician members (residents and fellows) can serve as councillors/alternate councillors. Medical students appointed to national ACEP committees are entitled to vote as committee members.

The medical student voice in the Council is intended, under existing policy, is through EMRA as well as their state chapter and section councillors. Although interested in emergency medicine while in medical school, a medical student may not have determined their future medical specialty and there is no guarantee that a medical student will pursue emergency medicine as a career.

The Council has previously debated the ability for medical students to serve as voting members of the Council. Resolution 13(14) Medical Student Voice in the ACEP Council requested the Council Steering Committee to evaluate the Council’s ability to address candidate students’ membership needs, explore ways in which candidate student members can contribute to the Council, explore the possibility of candidate student members serving as alternate councillors, or an appropriate alternative and report the finding and recommendations to the Board of Directors. The Council adopted an amended resolution that removed exploring the ability for medical students to serve as alternate councillors since alternate councillors have the same rights and responsibilities as councillors and many disagreed with medical students serving as councillors with full voting privileges.

The Steering Committee discussed the amended resolution at their meeting on January 20, 2015, and the vice chair of EMRA’s Medical Student Council participated in the discussion. The Steering Committee expressed strong support for welcoming medical student attendance at the Council meeting and addressing their needs to the extent possible within ACEP’s existing structure. The Steering Committee supported continuing to look for ways to involve medical students in the Council meeting, but did not support developing or cosponsoring a resolution to allow medical students to serve as councillors or alternate councillors. The Council meeting is open to all members of ACEP, including medical students. Medical students can attend and participate in the Reference Committee hearings. Suggestions from the Steering Committee for additional medical student participation included:
1. “Shadowing” a councillor or alternate councillor.
2. Attending the Reference Committee hearings and reporting on the discussions to their delegation members who may not be able to attend that Reference Committee hearing or during the discussion on a particular resolution.
3. Active participation in social media communications during the Council meeting.

A report from the Steering Committee’s discussions and the response to EMRA was provided to the Board in June 2015.

**ACEP Strategic Plan Reference**

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

**Fiscal Impact**

Budgeted staff resources to update the Bylaws and implement the amendment.

**Prior Council Action**

June 2015, reviewed the report from the Steering Committee regarding Amended Resolution 13(14) Medical Student Voice in the ACEP Council.

Amended Resolution 13(14) Medical Student Voice in the ACEP Council adopted. The resolution directed the Council Steering Committee to evaluate the Council’s ability to address candidate students’ membership needs, explore ways in which candidate student members can contribute to the Council, and report the finding and recommendations to the Board of Directors.

Resolution 10(13) Medical Student Members not adopted. The resolution was a Bylaws amendment specifying that councillor allocation be based on physician members of the College and would not include medical students.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships for candidate members are to be included when determining section eligibility for a councillor.

Substitute Resolution 5(75) Medical Student Participation in ACEP adopted. Amended the Bylaws to allow medical students to become candidate members of ACEP, but not entitled to vote or hold office.

**Prior Board Action**

Amended Resolution 13(14) Medical Student Voice in the ACEP Council adopted.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted.

*Note: The Board did not adopt Bylaws amendments prior to 1993.*

**Background Information Prepared by:** Sonja Montgomery, CAE
Governance Operations Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 11(22)

SUBMITTED BY: Council Steering Committee

SUBJECT: Establishing a Young Physician Position on the ACEP Nominating Committee

PURPOSE: Bylaws amendment establishing a young physician to the Nominating Committee.

FISCAL IMPACT: Budgeted resources expenses for the Nominating Committee.

WHEREAS, Resolution 14(21) Establishing a Young Physician Position on the Nominating Committee was adopted by the Council and directed the Council Steering Committee to submit a Bylaws amendment to the Council in 2022 to support the establishment of a young physician position on the Nominating Committee; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee be amended to read:

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members, at least one of which will be a young physician, defined as a member under the age of 40 or within the first ten years of practice, 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.

Background

This Bylaws amendment establishes a young physician position on the Nominating Committee.

The current Bylaws language do not exclude a young physician from being appointed by the Council Speaker to serve on the Nominating Committee and for the past several years a young physician member has been appointed to serve on the committee.

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee was adopted by the Council. It directed the Council Steering Committee to submit a Bylaws resolution to the Council in 2022 to establish a young physician position on the Nominating Committee. Although a young physician member had been appointed to the Nominating Committee as standard practice, members requested it be codified in the Bylaws.

The Council Steering Committee discussed the resolution at their January 24, 2022, meeting and assigned it to a subcommittee to develop a Bylaws amendment. The subcommittee believed it was important to include ACEP’s definition of a young physician in the resolution. The draft resolution was reviewed by the Council Steering Committee at their May 1, 2022, meeting and it was approved for submission to the 2022 Council.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.
Fiscal Impact

Budgeted resources for the Nominating Committee.

Prior Council Action

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee adopted. The resolution directed the Council Steering Committee to submit a Bylaws resolution to the Council in 2022 to establish a young physician position on the Nominating Committee.

Prior Board Action

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
Bylaws Amendment

RESOLUTION: 12(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
              Robert McNamara, MD
              Charles Pattavina, MD, FACEP

SUBJECT: Council Approval of Board Actions on Referred Resolutions

PURPOSE: Seeks to amend the Bylaws to: 1) require a report on each resolution referred to the Board will become a matter of business at the subsequent Council meeting; 2) the report will include a summary of the Board’s discussion and their recommendations regarding the referred resolution; and 3) the Board’s recommendations on referred resolutions will be subject to approval by the Council.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws. Budgeted Council Steering Committee and staff resources to develop processes to address the amendment.

WHEREAS, The Council is the true representative body of the American College of Emergency Physicians (ACEP) made up of members from all states, sections, and associated organizations, e.g., the Emergency Medicine Residents' Association (EMRA), Association of Academic Chairs of Emergency Medicine (AACEEM); and

WHEREAS, The Board of Directors, being a smaller body, is not representative of the full membership of ACEP; and

WHEREAS, The ACEP should be governed by the will of its general dues-paying membership and not a select few; and

WHEREAS, In other major physician organizations with representative bodies such as the American Medical Association (AMA) and state medical societies, resolutions referred to the Board are reported back to the representative body with recommendations that are subject to review and action by that body; and

WHEREAS, Currently, in ACEP, referred resolutions can be subject to final action by the Board with no further Council input, thereby taking material decision making and participatory power away from the Council; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 8 – Board of Directors Actions on Resolutions, be amended to read:

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.

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 45 calendar days of the adjournment of the Council meeting. This summary shall include:

1. An executive summary of the Council meeting.
2. A summary and final text of each passed and referred resolution.

Thereafter, the Board of Directors shall provide to the College written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution. A summary of the Board of Directors’ intent, discussion, and decision for each referred resolution shall be included. These communications shall be provided at quarterly intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section.

**A Board report on each resolution referred, in whole or part, by the Council to the Board of Directors, will be prepared and become business of the subsequent Council meeting. The Board report will include a summary of the discussion and the Board’s recommendations regarding the referred matter. As business of the Council, the Board’s recommendations will be subject to Council approval. The Council will review, discuss, and act on the Board report. This may include approval, rejection, amendment, or referral of the recommendations.**

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.

Reference


**Background**

This resolution seeks to amend the Bylaws to require a report on each resolution referred to the Board to become a matter of business at the subsequent Council meeting. The report to the Council will include a summary of the Board’s discussion and their recommendations regarding the referred resolution and will be subject to approval by the Council.

The options available to the Council regarding resolutions are adopt, adopt as amended, not adopt, or refer. Resolutions are referral to the Board of Directors, the Council Steering Committee, or the Bylaws Interpretation Committee (for certain provisions of the Bylaws). A resolution may be referred to the Board of Directors for a variety of reasons, including but not limited to:

- additional information is needed to inform a decision
- additional expertise, study, or data collection is required
- additional discussion is needed to consider potential unintended consequences regarding controversial or complex issues
- consider the impact of the resolution to the organization
- obtain a legal opinion
- a significant financial investment may be required that is not available in the current budget
- further analysis of fiscal impact is needed (this is particularly true regarding late or emergency resolutions when background information has not been prepared)
- the resolution asks the College to consider a decision that is contrary to current policy or creates new policy
- pending legislative or regulatory matters
- the Council was not able to reach consensus
Resolution 12(22) Council Approval of Board Actions on Referred Resolutions
Page 3

As mentioned in the Whereas statements, some physician organizations with representative bodies, such as the American Medical Association, have processes in place whereby resolutions referred to the Board of Directors may be reported to the representative body with recommendations subject to review and action by that body. The AMA House of Delegates may vote to “refer” or “refer for decision;” “refer” means the resolution or report is sent to the Board (or through the Board to the appropriate council or committee) for report back to the house, while “refer for decision” means the resolution or report is sent to the Board for disposition and the house is notified of the outcome at its next meeting.

ACEP’s Board of Directors has the authority to take action on referred resolutions as they deem appropriate. The ACEP president, on behalf of the Board of Directors, may assign the referred resolution to a committee, task force, section, workgroup of the Board, or staff to review the referred resolution and provide recommendations to the Board regarding proposed action on the resolution.

The Board of Directors is currently required, per the Bylaws Article VIII – Council, Section 8 – Board of Directors Actions on Resolutions, to provide “written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution” including “a summary of the Board of Directors’ intent, discussion, and decision for each referred resolution.” Reports on the prior year’s resolutions, as well as reports from the two previous years, are provided in the Council meeting materials. Additionally, information on the disposition of each resolution is available on the ACEP website, Actions on Council Resolutions. The resolutions are listed by year and title and include the original resolution, background information, testimony in the Reference Committee, Council action, Board action, and implementation action. The search function includes a global search across all resolutions and a search capability within each year. All resolutions since 1993 are now available. Staff are continuing to work on adding all resolutions since 1972.

Each year the Council Steering Committee reviews the implementation actions on adopted and referred resolutions to ensure that the will of the Council is followed in implementing the resolutions. Their review includes actions on all resolutions adopted and referred from the most recent Council meeting and the resolutions from the two prior years. This requirement is codified in the Council Standing Rules, “Policy Review” section:

“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.”

The Steering Committee has the authority to represent the Council between annual meetings as defined in the Bylaws Article XI – Committees, 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.

The proposed Bylaws amendment directs that referred resolutions to the Board will become a matter of business at the subsequent Council meeting. The Board typically takes action on a referred resolution within the first year, however, some resolutions may require additional time for a decision and implementation. For example, a referred resolution may require funding that is not available in the current fiscal year budget or it may take additional time for data
collection, etc. Adoption of the resolution as proposed would require the follow year’s Council to approve the Board of Director’s recommendations on how to implement the resolution. This would delay action on the referred resolution until the implementation recommendations were approved by the Council. This has the potential to impede the ability of ACEP to take action on the referred resolution.

If this resolution is adopted, it will be necessary to change the format of the Council meeting agenda. It is unclear from the resolution as written whether the intent is for the Board’s implementation recommendations to be assigned to a Reference Committee for deliberation or if the intent is for the Council to deliberate directly on the implementation recommendations. Adoption of this language creates the potential for re-debate/re-vote/re-referral for each referred resolution from the prior year's Council meeting and could expand the Council agenda significantly.

**ACEP Strategic Plan Reference**

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership

**Fiscal Impact**

Budgeted staff resources to update the Bylaws. Budgeted Council Steering Committee and staff resources to develop processes to address the amendment.

**Prior Council Action**

None that is specific to action taken by the Board on referred resolutions being subject to approval by the Council.

Amended Resolution 10(21) Board of Directors Action on Council Resolutions adopted. Amended the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

Amended Resolution 12(15) Searchable Council Resolution Database adopted. Directed ACEP to create a web-based searchable database for Council resolutions.

Substitute Resolution 30(90) Resolution Review adopted. Revised the Council Standing Rules to include a periodic review of previous resolutions adopted by the Council and the Board of Directors and provide an annual report to the Council.

**Prior Board Action**

Amended Resolution 10(21) Board of Directors Action on Council Resolutions adopted.

Amended Resolution 12(15) Searchable Council Resolution Database adopted.

Substitute Resolution 30(90) Resolution Review adopted.

**Background Information Prepared by:** Sonja Montgomery, CAE
Governance Operations Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 13(22)

SUBMITTED BY: Maine Chapter

SUBJECT: Past Leader Participation in Council Meetings

PURPOSE: Amends the Bylaws to allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

FISCAL IMPACT: Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Bylaws.

WHEREAS, Past leaders are resources for knowledge, expertise and institutional memory and those roles provide unique career fulfillment opportunities to mentor emergency physician leaders on issues of great import and consequence; and

WHEREAS, Past leaders are key to leadership development, especially in smaller chapters; and

WHEREAS, In addition to past speakers, many past directors, including past presidents and past chairs of the Board, wish to participate and help with leadership development; and

WHEREAS, Prior to the establishment of the office of Chair of the Board, past Board chairs were most often known as past directors; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two be amended to read:

ACEP Past Presidents, Members of the Board of Directors, and 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. Current Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions.

Background

This is a companion resolution to Resolution 14(22) Past Leader Seating in Council Meetings – Council Standing Rules Amendment.

This Bylaws amendment would allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

Past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity since 1989. Resolutions were adopted in 2017 allowing past chairs of the Board to sit with their Council delegations and participate in a non-voting capacity.
Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment
Page 2

Past members of the Board of Directors have an opportunity to serve as councillors or alternate councillors within their component bodies. Any member, not just councillors or alternate councillors, are allowed to testify in Reference Committees. Any member, including past members of the Board, currently may be recognized at the microphone to speak during the Council meeting.

There are currently 73 past members of the Board of Directors and of those 37 are past presidents, 6 are past speakers, and 10 are past chairs of the Board. Adoption of this resolution will potentially add 20 seats to the Council floor in 2023. Additional seats will need to be added in future years as Board members complete their term.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment adopted. The resolution amended the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted. The resolution amended the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for past presidents and past speakers to sit with their Council delegations as non-voting participants.

Prior Board Action

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.

Background Information Prepared by: Sonja Montgomery, CAE Governance Operations Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 14(22)

SUBMITTED BY: Maine Chapter

SUBJECT: Past Leader Seating in Council Meetings

PURPOSE: Amends the Council Standing Rules to allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

FISCAL IMPACT: Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Council Standing Rules.

WHEREAS, Past leaders are resources for knowledge, expertise and institutional memory and those roles provide unique career fulfillment opportunities to mentor emergency physician leaders on issues of great import and consequence; and

WHEREAS, Past leaders are key to leadership development, especially in smaller chapters; and

WHEREAS, In addition to past speakers, many past directors, including past presidents and past chairs of the Board, wish to participate and help with leadership development; and

WHEREAS, Prior to the establishment of the office of Chair of the Board, past Board chairs were most often known as past directors; therefore be it

RESOLVED, That the “Debate” section, paragraph one, of the Council Standing Rules be amended to read: “Councillors, past and current 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, past or current Board member, past president, past speaker, past chair, etc.), and whether they are speaking “for” or “against” the motion;” and be it further

RESOLVED, That the Council Standing Rules “Past Presidents, Past Speakers, and Past Chairs of the Board Seating” section be amended to read as follows with the proviso that the changes will become effective after the 2022 Council meeting and only upon adoption of the companion Bylaws amendment titled “Past Leader Participation in Council Meetings”:

Past Presidents, Members of the Board of Directors and Past Speakers, and Past Chairs of the Board Seating
Past presidents, Members of the Board of Directors 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.

PROVISO: The provisions of this resolution shall not go into effect unless Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment is adopted by the Council and the Board of Directors.
Background

This is a companion resolution to Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment.

This Council Standing Rules amendment would allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

Past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity since 1989. Resolutions were adopted in 2017 allowing past chairs of the Board to sit with their Council delegations and participate in a non-voting capacity.

Past members of the Board of Directors have an opportunity to serve as councillors or alternate councillors within their component bodies. Any member, not just councillors or alternate councillors, are allowed to testify in Reference Committees. Any member, including past members of the Board, currently may be recognized at the microphone to speak during the Council meeting.

There are currently 73 past members of the Board of Directors and of those 37 are past presidents, 6 are past speakers, and 10 are past chairs of the Board. Adoption of this resolution will potentially add 20 seats to the Council floor in 2023. Additional seats will need to be added in future years as Board members complete their term.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment adopted. The resolution amended the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted. The resolution amended the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for past presidents and past speakers to sit with their Council delegations as non-voting participants.

Prior Board Action

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.
RESOLUTION: 15(22)

SUBMITTED BY: Council Steering Committee

SUBJECT: Electronic Voting During the Council Meeting

PURPOSE: Amends Council Standing Rules to specify that voting electronically includes remote communication and voting technology; stipulates that individual connectivity issues or individual disruption of remote communication technology will not be the basis for a point of order or other challenge to any voting; and that the chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large discrepancies between votes.

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules. Cost savings of approximately $4,000 to utilize remote voting technology instead of physical keypads.

WHEREAS, In 2020 and in 2021, the Council utilized remote electronic voting technology; and

WHEREAS, The Council adopted temporary Standing Rules in 2021 that contained a provision specifying that “Individual connectivity issues will not be the basis of a Point of Order or a challenge to any votes.”; and

WHEREAS, The Council may use remote communication and voting technology in the future and the Council Standing Rules should codify that individual connectivity issues will not be the basis of a Point of Order or a challenge to any votes; therefore be it

RESOLVED, That the ACEP Council Standing Rules, “Election Procedures” section, paragraph one, and the “Voting on Resolutions and Motions” section be amended to read:

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, **which may include remote communication and voting technology**. There shall be no write-in voting. **Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, **including remote communication technology**, 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. **Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

Background

This resolution amends the Council Standing Rules to specify that voting electronically includes remote
communication and voting technology; stipulates that individual connectivity issues or individual disruption of remote
communication technology will not be the basis for a point of order or other challenge to any voting; and that the
chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large
discrepancies between votes.

During their January 24, 2022, meeting, the Council Steering Committee discussed the Council’s use of remote voting
technology for the past two years and potential changes that may be needed in the Council Standing Rules if the
Council meeting is held virtually or as a hybrid meeting in future years. The Council adopted Temporary Standing
Rules to conduct business as a virtual meeting in 2020 and as a hybrid meeting in 2021. All other provisions of the
Council Standing Rules remained in effect except as enumerated in the Temporary Standing Rules. Since a hybrid
meeting was conducted in 2021, the orange voting cards and keypads could not be used by councillors attending
the meeting virtually.

The Steering Committee supported continuing to use an online voting system instead of the keypads so that the same
system would be used whether the Council meeting is held in person, hybrid, or fully virtual. The committee agreed
that the current provisions in the Council Standing Rules that allow voting by using an electronic voting system
includes the ability to use online voting software since it is a form of electronic voting. A subcommittee was assigned
to develop a Council Standing Rules amendment. The subcommittee recommended including language that specifies
voting by electronic ballot may include remote communication and voting technology and voting by an electronic
voting system includes remote communication technology. The subcommittee discussed potential problems
individuals may have with connecting to the electronic voting system or problems with their personal internet
provider and recommended including language that individual connectivity issues or individual disruption of internet
service will not be the basis for a point of order or other challenge to any voting. The subcommittee acknowledged
that there have been a few problems during some past Council meetings with electronic voting related to Wi-Fi
capacity or disruption of internet service that had to be addressed before resuming any electronic voting. The voting
patterns were monitored by the chair of the Tellers, Credentials, & Elections Committee and reported to the Council
Speaker when problems were identified. The subcommittee believed it was important to include this information in
the amendment. The draft resolution was reviewed by the Council Steering Committee at their May 1, 2022, meeting
and it was approved for submission to the 2022 Council.

The cost for the electronic voting platform that was used during the 2021 meeting was $884. This is considerably less
than the cost for the annual software licensing fee of $4,950, and the additional costs to maintain and replace keypads.
Keypads are issued to each credentialed councillor and alternate councillors substituting for councillors use the
keypad issued to the councillor. Similarly, when the orange voting cards are used for voting, the alternate councillor
uses the voting card issued to the councillor. It is possible to generate an invalid ballot during elections when using
the keypads if a councillor votes for less than four candidates for the Board of Directors. However, there is a provision
within the Council Standing Rules “Election Procedures” section stipulating that a vote must be retaken if the number
of invalid ballots is sufficient to affect the outcome of the vote. The keypad software has been programmed to
calculate this scenario. Online voting systems are accessed by a secure web address and are programmed so that no
invalid ballots can be generated. Usually, any electronic device (cell phone, computer, tablet) can be used with online
voting systems. Online voting systems are programmed in advance with the names and credentials of the councillors
who will be voting during the Council meeting. Alternate councillors substituting for councillors must use the login
credentials of the credentialed councillor, which is similar in function to using the orange voting card or keypad of the
councillor.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at
different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules. Cost savings of approximately $4,000 to utilize
remote voting technology instead of physical keypads.
Prior Council Action

October 2021, adopted Temporary Council Standing Rules to accommodate a hybrid meeting for in-person and virtual participation, including using an online voting platform.

October 2020, adopted Temporary Council Standing Rules to accommodate the virtual meeting, including utilizing it for electronic voting.

Prior Board Action

None

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION:  16(22)

SUBMITTED BY:  Council Steering Committee

SUBJECT:   Required Candidate Campaign Materials from Floor Candidates

PURPOSE: Council Standing Rules amendment specifying the required candidate campaign materials for floor candidates and the deadline for submission.

FISCAL IMPACT: Budgeted staff resources for collection of candidate campaign materials and distribution to the Council.

WHEREAS, The Council Standing Rules do not specify the candidate campaign materials that are required to be submitted by floor candidates or the deadline to submit campaign materials; therefore be it

RESOLVED, That the ACEP Council Standing Rules, “Nominations” section, be amended to read:

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 self-nominate by declaring 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. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the Speaker of intent to seek nomination, whichever date is later. See also Election Procedures.

Background

This Council Standing Rules amendment specifies the required candidate campaign materials that must be submitted by floor candidates and the deadline for submission.

The Council Standing Rules do not currently specify the campaign materials that must be submitted by floor candidates or when those materials must be submitted. Usually, anyone planning to seek nomination from the Council floor makes this intent known well in advance of the Council meeting. The “declared floor candidate” is then included in any communications to candidates about the required (and optional) campaign materials and the deadlines to submit them. However, there is the possibility that someone will decide to seek nomination from the floor after those deadlines. The Council Steering Committee discussed the requirements of floor candidates at their January 24, 2022, meeting and tasked the Candidate Forum Subcommittee with developing a Council Standing Rules amendment to further support a transparent and equitable election process for all candidates. The Steering Committee also discussed
potential revisions to the Candidate Campaign Rules, including revisions to the “Floor Nominations” section. Similar language regarding the required candidate materials was added to the Candidate Campaign Rules. The revisions were approved by the Council Steering at their May 1, 2022, meeting and were effective immediately. The updated Candidate Campaign Rules were then distributed to the candidates. The draft resolution, which further codifies the language that was added to the Candidate Campaign Rules, was also reviewed by the Council Steering Committee on May 1 and was approved for submission to the 2022 Council.

**ACEP Strategic Plan Reference**

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

**Fiscal Impact**

Budgeted staff resources for collection of candidate campaign materials and distribution to the Council.

**Prior Council Action**

None

**Prior Board Action**

None

**Background Information Prepared by:** Sonja Montgomery, CAE
Governance Operations Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 17(22)

SUBMITTED BY: Michael Bresler, MD, FACEP
Valerie Norton, MD, FACEP
California Chapter

SUBJECT: Criteria for the Location of Future National ACEP Events

PURPOSE: 1) Study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer a full range of reproductive health care options; 2) Refrain from scheduling future national ACEP events in states that do not offer a full range of reproductive health care options; and 3) the prohibition of scheduling meetings in these states applies only to national ACEP events.

FISCAL IMPACT: Combined fiscal impact of cancelling all current meeting contracted in these states is approximately $1,760,000. Budgeted staff resources necessary to investigate, negotiate cancellations, and finalize contracting process with the new venues. Unbudgeted staff resources for sourcing and supervision of expert meeting and convention planning independent contractors to assist with securing new contracts with an estimated expense of $25,000.

WHEREAS, The American College of Emergency Physicians (ACEP) supports access to health care for all patients; and

WHEREAS, It is recognized that various members of ACEP may hold divergent views on the issue of access to abortion services; and

WHEREAS, Current law in several states restricts access to certain types of reproductive health care, including abortion services; and

WHEREAS, These laws create inequities in access to safe and timely care that are disproportionately borne by patients of lower socio-economic status, minorities, and those in rural areas; and

WHEREAS, Patients may experience complications and adverse outcomes due to the inability to access these types of care in a safe and timely manner, resulting in increased emergency department visits due to complications; and,

WHEREAS, ACEP has an interest in reducing preventable complications for all patients, including pregnant people who travel to attend the ACEP Council meeting or another ACEP event; therefore be it

RESOLVED, That ACEP study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That ACEP not schedule future national-level ACEP events in states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That with recognition of the necessity for both the College and its chapters to continue to function in states that limit access to a full range of reproductive health care options, the prohibition of scheduling meetings in these states shall apply to national-level ACEP events only, and shall not apply to individual chapters of the College.

References


### Background

This resolution asks ACEP to study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer a full range of reproductive health care options, refrain from scheduling future national ACEP events in states that do not offer a full range of reproductive health care options, and specifies that the prohibition of scheduling meetings in states without such options applies only to national ACEP events.

ACEP has contracted for Scientific Assembly in the following states with a full range of reproductive health care:

- Philadelphia, PA – 2023 and 2029 (2029 can be cancelled without penalty based upon the level of success in 2023)
- Las Vegas, NV – 2024 and 2028
- Chicago, IL – 2026 and 2031
- Boston, MA – 2027 (and potentially 2032 if approved by the Board at their 9/28/22 meeting)
- San Francisco, CA – 2030

Currently, the only state without a full range of reproductive health care contracted for Scientific Assembly is Texas when the meeting will be held in Dallas in 2025.

There are several non-Scientific Assembly meetings contracted in 2023 in states without a full range of reproductive health care that are honoring ACEP’s contractual commitment for cancelled meetings in 2022 because of COVID. These include:

**New Orleans, LA**
- Reimbursement: Trends and Strategies in Emergency Medicine and Advanced Procedure Coding for Emergency Medicine
- Teaching Fellowship for Residents and Teaching Fellowship

**Dallas, TX**
- Emergency Department Directors Academy Phase I Spring and Fall, Phase II, and Phase III
- Teaching Fellowship

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1. ACEP recognizes that references to “a full range of reproductive health care” may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.
Other non-Scientific Assembly meetings contracted for 2023 a full range of reproductive health care are:

- New York, NY – Advanced Pediatric Emergency Medicine Assembly
- Washington, DC – Leadership and Advocacy Conference.

Annual meeting venues/cities are determined based on member data of desirable cities, history of prior experiences hosting the annual meeting, airline costs, hotel and convention center function space and guest room capabilities, cost factors, walkability, restaurants, nightlife, and a variety of other factors. ACEP25 in Dallas, TX honors a contractual commitment for ACEP20 that was cancelled because of COVID prior to the city’s shut down. Sourcing a city at this point would be impossible based on the limited number of cities that can accommodate a meeting this size over the optimal dates for our members. Typical sourcing of a meeting this size must occur 10+ years out. Cancellation penalties would be in excess of $1.1 million dollars for ACEP25 and does not include the cost of staff labor to research and negotiate this citywide event in other locations.

The cities chosen to host non-SA meetings are determined based on the target audience and their preferences as well as the type of meeting and the time allotted for social and networking events. Meetings contracted in Dallas allow ACEP to remove all costs associated with staff travel and to net a higher ROI. Moving these meetings from Dallas increases the expenses by approximately $7,500 for three staff to manage each event. Cancelling these meetings would exceed $660,000 in cancellation penalties. Meetings contracted for the next 18 months must not be cancelled as education planning has begun and CME approval and marketing will occur this fall to ensure their success.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels including federal, state, and local

Fiscal Impact

The combined fiscal impact of canceling all current meeting contracts in these states is approximately $1,760,000. Budgeted staff resources necessary to investigate, negotiate cancellations, and finalize contracting process with the new venues. Unbudgeted staff resources for sourcing and supervision of expert meeting and convention planning independent contractors to assist with securing new contracts with an estimated expense of $25,000.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Debbie Smithey, CMP, CAE
Managing Director, Education Development

Toni McElhinney, CMP
Conventions & Meetings Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 18(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD

SUBJECT: Disclosure of Clinical Emergency Data Registry Revenue Sources

PURPOSE: Requests ACEP to provide information on the sources and amount of revenue for CEDR in the Treasurer’s Report to the Council.

FISCAL IMPACT: None

WHEREAS, The membership of ACEP has a very negative view of the corporatization of emergency medicine based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the Department of Justice and the Federal Trade Commission by ACEP (letter to Lina Khan and Jonathan Kanter, April 20, 2022); and

WHEREAS, According to the 2021 Treasurer’s report to the Council, ACEP receives significant revenue from “CEDR and Quality” ($4 million/12% of revenue); and

WHEREAS, The reputation and membership of the AMA has suffered greatly because of its high amount of non-dues income; and

WHEREAS, The membership of ACEP may view it as a conflict of interest for ACEP to be receiving significant income from private equity owned or backed ED staffing companies; therefore be it

RESOLVED, That information on the sources and amount of revenue for the Clinical Emergency Data Registry be disclosed in the Treasurer’s report to the Council and to the membership.

Background:

This resolution requests ACEP to provide information on the sources and amount of revenue for the Clinical Emergency Data Registry (CEDR) in the Treasurer’s Report to the Council.

ACEP’s Quality Department was started in 2013 to address emerging policy issues and threats to physician reimbursement based on pay-for-performance and value-based purchasing programs, such as, Medicare and CHIP Reauthorization Act (MACRA) of 2014. CEDR was launched in 2015 to support ACEP members and other emergency physicians fulfill data needs for reporting Merit-based Incentive Payment System (MIPS) to CMS, as well as Improvement in Medical Practice (IMP) attestations to ABEM. In 2020, 56% of CEDR physician participants were ACEP members, representing approximately 28% of ACEP members eligible to participate. Even in the face of challenges to the MIPS program due to COVID-19, such as federal waivers and the lean bonus potential, 75% of ED clinicians received a large enough bonus to cover their fees for participation in the CEDR program, and 45% did so well that the bonus also covered their cost of ACEP membership. Moreover, 19% scored a perfect MIPS score of 100 points, resulting in an estimated $1,686 bonus for each physician.

The Board of Directors has approved significant investments in the development of quality programs and products, such as CEDR, quality measures, and quality improvement initiatives, such as the Emergency Quality Network (EQUAL). ACEP’s Quality Division has strived to be fiscally self-sustaining through generation of revenue to recover part of the ongoing costs. The program, however, has required an ongoing infusion of capital investment, largely
because of the complexity of extracting data from systems often beyond the control of the independent physician group, such as the collection of clinical data from the hospital’s electronic health record.

Over the past 7 years, the maturation of the Quality Division has led to the successful procurement of quality improvement program grants through support from both government and private foundations. A significant portion of $4 million in revenue is obtained through grants and the remaining portion comes from CEDR operational revenue. CEDR is primarily focused on small and medium independent democratic groups and rural and critical access hospital based emergency departments. Most of the large groups, including those backed by private equity, have their own Qualified Clinical Data Registry (QCDR) or QualiFIED Registry (QR) or Data Warehouse and have shied away from subscribing to CEDR.

Every CEDR customer executes a Participation Agreement, as well as a Business Associate and Data Use Agreement, which contains confidentiality provisions requiring the parties request and receive written permission from the other prior to disclosing details of the contract, including the name of the customer and fees paid to the Registry. This is a standard contract provision and protects each party from unauthorized use of their name, likeness, and private financial information. As such, ACEP would need to obtain authorization from each customer before publishing any information about its participation in CEDR, including, but not limited to, announcements regarding usage of the Registry and amounts paid by the group.

**ACEP Strategic Plan Reference**

Resources and Accountability – ACEP commits to financially disciplined and modern processes and a culture that aligns sufficient and transparent stewardship of resources to strategic priorities most relevant to members and essential for the future of emergency medicine.

- Develop alternative/non-traditional revenue and in-kind sources and opportunities to achieve our strategic priorities.

**Fiscal Impact**

None

**Prior Council Action**

None

**Prior Board Action**

None that is specific to releasing CEDR revenue sources to the Council.

**Background Information Prepared by:** Pawan Goyal, MD, MHA, PMP, CBA, CPHIMS, CHIP, FAMIA, FHIMSS, FAHIMA, Fellow NLM

Senior Vice President, Quality

Leslie Patterson Moore, JD

Senior Vice President, General Counsel

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 19(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Due Process and Interaction with ACEP

PURPOSE: 1) 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 or waivers of due process for emergency physicians; and 2) create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

FISCAL IMPACT: Unbudgeted and unknown costs to create a method to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying due process, and investigate allegations. Costs could be considerable depending on the scope. Potential significant legal expenses to respond to lawsuits against ACEP for such actions. Should a plaintiff prevail in such litigation, they would be eligible for treble damages, cost of suit and attorney’s fees. Potential significant reduction in advertising, exhibit and sponsorship revenue for all ACEP activities and programs.

WHEREAS, It has been demonstrated in the American College of Emergency Physicians (“ACEP”) report to the Federal Trade Commission (“FTC”) and U.S. Department of Justice (“DOJ”) regarding mergers dated April 20, 2022 that, despite an ACEP policy in favor of due process, many ACEP members are denied due process as it pertains to their ability to see patients in the emergency department (“ED”); and

WHEREAS, The voluntary database created in response to the 2020 Resolutions on Due Process, intended to allow members to understand which entities offer due process, has been of no practical use to the members in this area; and

WHEREAS, The denial of due process is often achieved by requiring a physician, for example, by contractual agreement, 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 at a relevant facility; 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 and other hospital accrediting bodies’ prohibitions 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, ACEP’s member input in the aforementioned report to the FTC/DOJ, and recent anecdotal 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 (see 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: “Any entity that wishes to advertise in ACEP vehicles, exhibit at
its meetings, provide sponsorship, other support, or otherwise be associated with the ACEP, as of January 1, 2023,
shall remove all contractual restrictions on or waivers of 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 are not limited to physician group practices, hospitals and staffing companies.”; and be it further

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review
member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the
matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

References

3. ACEP comments to FTC/DOJ: https://www.acep.org/globalassets/acep-response-to-ftc-and-doj-rfi-on-merger-guidelines-
04.20.22.pdf
4. 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 requests ACEP to 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 or waivers of due process for emergency
physicians; and create a method for members to report incidents of denial of due process, review member-submitted
contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the
entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

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.

It should be noted that The Joint Commission (TJC) standard on due process is limited to a requirement that the
hospital makes the practitioner aware of available due process for adverse privileging decisions. There are no TJC
requirements related to due process specific to employment. Specifically, 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.

The first resolved of this resolution is almost the exact language of the last resolved of Referred Amended Resolution
44(20) Due Process in Emergency Medicine. In response to the 2020 referred resolution, ACEP Board members have
been reaching out to members and offering their time and resources to better understand and guide ACEP’s actions to
fully address the intent of the referred resolution. Throughout the year, members of the Board spoke with numerous
individuals who had been fired, taken off the schedule, transferred to other sites, or otherwise impacted by terms of
their contracts. These conversations confirmed these actions were happening across all employment models, from
large corporate groups to small democratic groups and academic groups. There were also situations where due process
protections were in place with an employer and physicians still lost hospital privileges and were removed from the
schedule at the request of the hospital CEO.
ACEP’s General Counsel engaged Powers, Pyles, Sutter & Veville, P.C. (a legal firm with specialized expertise in healthcare and representation of nonprofit organizations) as outside counsel to review Referred Amended Resolution 44(20) and provide a third-party outside legal opinion on the anti-trust risk to ACEP to carry out the resolution as written. The opinion was presented to the Board of Directors in June 2021 with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated a substantial risk to carrying out the resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products with the intent to increase transparency and demonstrate an employer’s adherence to key ACEP policy statements.

ACEP leadership and staff developed contracting and employment resources on the ACEP website to assist members and develop requirements for increasing transparency among members and entities that employ emergency physicians regarding adherence to ACEP policy statements. There are dozens of pages of resources on the ACEP website dedicated to the topics of Employment Contracts and other practice and legal issues, as well as a growing set of resources from ACEP’s Democratic Group Practice section. In an effort to better support all members as they face unprecedented challenges in hiring, ACEP staff embarked on a process to update, curate and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type. To supplement this, the Medical-Legal Committee developed a new contract resource, a checklist of “Key Considerations in an Emergency Medicine Employment Contract.” The checklist is available on the EMRA website and the ACEP website in the Medical-Legal Resources. Additionally, for just $15 per year, all ACEP members currently have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes a 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with MINES network of legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities.

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.”
Despite efforts to ensure physicians are accorded due process related to actions that may negatively impact their medical staff privileges, physicians are not 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 provided access to timely quality and other performance metrics.
8. Emergency physicians are entitled to 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.

For several years, ACEP has informed, helped draft, and advocated for legislation to support due process for emergency physicians. In fact, due process protections were one of ACEP’s three key issues at the 2022 Leadership & Advocacy Conference (LAC) in Washington, DC, with advocates going to Capitol Hill to promote the concept and urge reintroduction of the revised “ER Hero and Patient Safety Act,” legislation previously introduced in the 116th Congress by Representative (now Senator) Roger Marshall, MD (R-KS) and Raul Ruiz, MD (D-CA). Due process protections remain a key federal legislative priority for the College, and ACEP continues working with legislators in both the House and Senate to secure bipartisan sponsors prior to introduction of the bill for the current 117th Congress. Additionally, ACEP has urged the Senate Health, Education, Labor, and Pensions (HELP) Committee to include Sen. Marshall’s due process legislation in the committee’s mental health package, given the relationship of due process rights to emergency physician job satisfaction and stress and burnout, and continues working to identify any opportunities to include this provision in a larger legislative package.

As part of the recent workforce initiative, ACEP leadership began meeting with the leadership of large employer groups to have open conversations about the state of the workforce and share feedback from our members. ACEP is sharing data on member perceptions of career satisfaction, which includes concerns about billing transparency, and encouraging groups to discuss these concerns with their physicians. As a direct result of one of these conversations, an employer group agreed to change a policy in order to adhere to ACEP’s recommended standards.

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.
Resolution 19(22) Due Process and Interaction with ACEP

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.

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.”

Approximately 19% of all corporate support ACEP received in FY 2021-22 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed $541,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities. Further, ACEP uses advertising to promote employment opportunities, affinity partnerships, member benefits and resources in various channels, including our job board www.emcareers.org, our monthly publication ACEP Now, digital advertising in our e-newsletters and more. Prohibiting these types of agreements would eliminate funding used to offset the cost of key member benefits, including the Annals of Emergency Medicine, ACEP Now, and member counseling services and limit member access to employment opportunities and resources.

The second resolved would require ACEP to create and implement a means of investigating individual alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide due process to the accused entity. 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 against a corporate entity and the potential sanction required by this process could be used as a tool by the company’s competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to deny an entity’s ability to exhibit, sponsor, or advertise with ACEP may create additional potential liability risk for ACEP. Excluding an entity from being able to advertise in or sponsor any ACEP activity could subject the College to a claim of restraint of trade or business defamation. Should a court decide that the procompetitive justifications for these actions do not justify the potential anti-competitive effects and therefore conclude that the actions violate Federal law (specifically the Sherman Act, 15 U.S.C. §§1,2) governmental sanctions may result in civil penalties of up to $100 million for businesses or $1 million for individuals, and criminal penalties of up to ten years. The government can also seek injunctive relief to stop an organization from engaging in a potentially unlawful activity. Should ACEP face a lawsuit from an entity that believes it has been unfairly excluded from a College activity, should they prevail, they may be eligible to recover treble damages (three times the amount of actual financial damages as proven by the plaintiff), costs of suit, as well as attorneys’ fees. Such challenges can be mitigated by developing and adhering to strict processes.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing
their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local

**Fiscal Impact**

Unbudgeted and unknown costs to create a method to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying due process, and investigate allegations. Costs could be significant depending on the scope. Potential significant legal expenses to respond to complaints against ACEP for such actions. Potential significant reduction in outside funding support.

**Prior Council Action**

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors.

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.
Resolution 19(22) Due Process and Interaction with ACEP
Page 7

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

June 2021, discussed with outside legal counsel the implications of Referred Amended Resolution 44(20) Due Process in Emergency Medicine.


April 2021, approved the revised policy statement “Emergency Physician Rights and Responsibilities;” revised and approved October 2021, April 2008 and July 2001; originally approved September 2000

January 2021, directed the Emergency Medicine Practice Committee and the Medical-Legal Committee, with support from ACEP’s General Counsel, to review and provide a recommendation regarding further action on the resolution.


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.

September 2018, approved the policy statement “Due Process for Physician Medical Directors of Emergency Medical Services.”


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:** Mollie Pillman, MBA, CAE
Senior Vice President, Member Engagement

Leslie Moore, JD
Senior Vice President, General Counsel

Jana Nelson
Senior Vice President, Communications

Laura Wooster, MPH
Senior Vice President, Advocacy & Practice Affairs

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 20(22)

SUBMITTED BY: Deborah Fletcher, MD, FACEP
Jamie Hoitien Do Kuo, MD

SUBJECT: Expert Consultation for Employee Contracts

PURPOSE: Provide legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

FISCAL IMPACT: Possibilities range from partnership with third party services or establishing a volunteer pool (low/no cost), to contracting with attorney services and paying the fee for individual contract review directly or through an established grant fund (up to $3.5 million).

WHEREAS, All physician jobs require contracts with hospitals or contract medical groups; and
WHEREAS, Physicians receive little to no education or training in contract negotiations; and
WHEREAS, Physicians may misunderstand contract details; and
WHEREAS, Physicians may enter undesirable contracts including wages below fair market value, non-compete clauses, requirements to supervise non-physician providers, and so on; and
WHEREAS, Physicians would benefit from expert consultation; therefore be it

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

Background

This resolution calls for ACEP to provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

ACEP recognizes the importance of equipping all emergency medicine physicians, especially those new to practice, with the resources and tools needed to ensure that any potential contracts they consider include fair compensation and benefits, and protection for themselves and their patients during the course of medical practice. There is a growing number of resources available on the ACEP website dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract precautions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters.

In an effort to better support all members as they face unprecedented challenges in hiring, ACEP Membership and Practice Affairs staff embarked on a process to update, curate, and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type. To supplement this, the Medical-Legal Committee developed a new contract resource, a checklist of “Key Considerations in an Emergency Medicine Employment Contract.” The checklist is available on the ACEP website in the Medical-Legal Resources area.
ACEP’s General Counsel and other College staff cannot directly offer legal advice to chapters or individual members. Action of this type could create an attorney-client relationship, which could create both a conflict of interest and potential liability issues, as well as endangering ACEP’s insurance coverage. Currently, all ACEP members have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes unlimited 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with MINES network legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities. These services cost members $15.00 annually.

ACEP staff have been investigating options to provide additional contract review and consultation for ACEP members as they transition into practice and throughout their careers. The College has not made any determinations regarding the viability of the options; however, some under consideration, which are not mutually exclusive, include:

1. Partnering with a specialized third-party service to provide ACEP members with discounts on physician contract review services and compensation data;
2. ACEP partnership with an individual or network of recommended attorneys who could review member contracts in a limited format upon request;
3. Establishing a team of experienced ACEP member volunteers/mentors willing to assist early career and other job-seeking physicians with reviewing and negotiating contract terms, provided sufficient parameters are in place to manage risk, protect the College and its volunteers; or
4. Establishing a grant program or fund providing an avenue for ACEP members to apply for financial support which could be used for early-career contract review or for specific emergent legal needs as they arise throughout the member’s career.

**ACEP Strategic Plan Reference**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
- Implement practical solutions to provide mental wellness and resiliency support for members to manage legal, emotional, and physical challenges.
- Create and disseminate the standards, best practices and policies impacting career fulfillment required to have sustainable, well workplaces for emergency physicians.
- Place ACEP in the center of providing career fulfillment and wellness, revising recruitment or retention tools to emphasize “What will ACEP do for me?”

**Fiscal Impact**

The fiscal impact of each of the options outlined is approximated below.

<table>
<thead>
<tr>
<th>Program Option</th>
<th>Estimated Fiscal Impact</th>
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</thead>
<tbody>
<tr>
<td>Partnering with a specialized third-party service to provide ACEP members with discounts</td>
<td>Negotiations would result in 10-20% discount to ACEP members in exchange for promotion through ACEP channels. There would be minimal cost to ACEP for promoting this opportunity.</td>
</tr>
<tr>
<td>Contracting with an individual or network of recommended attorneys to pay the fees for contract review upon request</td>
<td>Estimated attorney fees for review and advisement on a single employment contract run from $1,000 to $1,500 (legal representation of the physician to the employer would be at additional cost). If each graduating resident (2,436 total) were to utilize this service individually during the fiscal year, the cost to ACEP would likely be between $2.5 million and $3.5 million. ACEP would likely be able to negotiate a discounted rate, but this would still constitute a substantial expense to the College.</td>
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</table>
Establishing a community of experienced ACEP member volunteers/mentors

This option would be low financial cost to ACEP but would require the valuable time of a strong network of volunteers and sufficient legal precautions to protect all parties.

Establishing a grant program or fund which would allow ACEP members to apply for financial support for career legal services

The cost to establish a fund would be determined by the number and amount of grants that ACEP planned to provide.

Prior Council Action

Resolution 17(21) Fair Emergency Physician Employment Contract Template not adopted. The resolution requested that ACEP develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. Directed ACEP to adopt a new policy statement addressing continuity of fair compensation including monetary compensation as well as uninterrupted provision of benefits and malpractice coverage during times of contract transitions.

Amended Resolution 17(19) Pay Transparency adopted. Directed ACEP to develop a policy statement in favor of physician salary and benefit package equity and transparency.

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 other organizations and request that it be distributed to their membership and to other entities deemed appropriate by the Board of Directors.

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested that ACEP review the policy statement “Promotion of College Policies on Contracting and Compensation” for potential revisions, realign the policy statement “Promotion of College Policies on Contracting and Compensation” with other clearly stated College policy or rescind it entirely, and provide a report to the 2003 Council.

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 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. Called for the College to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations, explore the 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.

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 Clauses 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.

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue to make efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action


October 2020, approved the policy statement “Emergency Physician Compensation Transparency.”

February 2020, approved the policy statement “Protecting Emergency Physician Compensation During Contract Transitions.”


Amended Resolution 17(19) Pay Transparency adopted.


May 2018, reviewed the information paper “Emergency Department Physician Group Staffing Contract Transition.”

April 2016, approved the revised policy statement “Fair Payment for Emergency Department Services;” originally approved April 2009.

April 2016, reviewed the information paper “Indemnification Clauses in Emergency Medicine Contracts.”

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments 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 in lieu of resolutions 52(94) Due Process Exclusion Clauses and 54(94) Due Process.

Amended Resolution 49(94) Information on Contract Issues adopted.

**Background Information Prepared by:** Mollie Pillman, MS, MBA, CAE  
Senior Vice President, Member Engagement  
Leslie Moore, JD  
Senior Vice President, General Counsel  
Jana Nelson  
Senior Vice President, Communications

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 21(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Financial Support of Litigation Involving the Corporate Practice of Medicine in California

PURPOSE: Requests ACEP to donate $1 million from members’ equity to the American Academy of Emergency Medicine Foundation to support the American Academy of Emergency Medicine – Physician Group litigation versus Envision.

FISCAL IMPACT: $1,000,000

WHEREAS, A significant number of the nation’s emergency departments (“EDs”) are controlled by one or more staffing companies with private equity backing or ownership; and

WHEREAS, Optum, a subsidiary of the United Healthcare, an insurer, through Sound Physicians, has significant ownership of emergency medicine practices; and

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states intended 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, On March 25, 2022, ACEP filed an amicus brief in support of the American Academy of Emergency Medicine – Physician Group (AAEM-PG) litigation against Envision that addresses CPOM in California; and

WHEREAS, A favorable ruling was issued by the United States District Court for the Northern District of California Federal Court on May 27, 2022, that denied the Motion to Dismiss in the litigation and allowed the claims made by the AAEM-PG regarding CPOM to proceed further; and

WHEREAS, The membership of ACEP has a very negative view of the corporatization of EM based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the DOJ and FTC by ACEP (letter to Lina Khan and Jonathan Kanter, 4/20/2022); and

WHEREAS, ACEP has detailed the grave threats to emergency medicine posed by private equity and corporate involvement in its April 18, 2022, Statement on Private Equity and Corporate Investment in Emergency Medicine; and

WHEREAS, The members of ACEP in California and likely other states would reap significant benefit if the AAEM-PG is successful in this litigation; and

WHEREAS, The legal costs for this litigation are expected to be in excess of $2 million; and

WHEREAS, ACEP has a substantial amount of funds as members’ equity; therefore be it
RESOLVED, That ACEP directly support the American Academy of Emergency Medicine – Physician Group litigation versus Envision by a donation of $1 million of the members’ equity to the American Academy of Emergency Medicine Foundation.

References
1. Denial of Motion to Dismiss: https://www.aaem.org/UserFiles/file/USDCDoc47.pdf

Background

This resolution requests ACEP to donate $1 million from members’ equity to the American Academy of Emergency Medicine Foundation to support the American Academy of Emergency Medicine Physician Group’s (AAEMPG) lawsuit against Envision Healthcare, Inc.

AAEM-PG filed suit against Envision on December 2021 and shortly thereafter, ACEP published a statement supporting AAEM-PG’s stance on physician autonomy as demonstrated by the lawsuit. ACEP then filed an amicus brief in the case on March 25, 2022. The brief sought to educate the Court on the critical importance of upholding the sanctity of physicians’ duties to their patients and the significance of allowing them to practice medicine without undue pressure from outside forces. As the largest and most influential medical society in emergency medicine, ACEP represented our more than 38,000 members in this effort to assert the physician’s right to autonomy in medical decision-making. EMRA also filed a Declaration of Interest in support of the ACEP position.

Although the plaintiff raised several issues in its complaint, the ACEP brief focused on the corporate practice of medicine doctrine and asserted:

*The principle of putting patients over profits is the bedrock of our nation’s healthcare system. This principle is preserved by ensuring clinical treatment decisions are made exclusively by physicians. ACEP recognizes the potential efficiencies associated with larger practice sizes and counts among its members many physicians practicing in large groups, including some backed by private equity investment. However, ACEP also recognizes that unregulated corporate involvement in medicine may threaten physician autonomy and adversely impact quality of care. ACEP strongly believes that, regardless of structure, physicians must focus primarily on patient care and never prioritize profits over patients.*

The brief further asserted:

*The foundational principle of CPOM is that medical decisions should be made by physicians and any structure that prevents this should be prohibited. Should the Court decide to hear this case, the Court’s decision should be guided by this foundational principle.*

The Board of Directors also approved the ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine on April 6, 2022, reaffirming ACEP’s core values and emphasizing the physician-patient relationship as the moral center of medicine.

The ACEP Legal Activity Guidelines (Guidelines) provides the criteria in determining issues that merit ACEP’s legal involvement. The Guidelines (Attachment A) specifically require that legal expenditures “will be authorized by the Board of Directors, or, in time sensitive matters, by ACEP’s president, with notification to the Board of Directors. A member or chapter seeking approval for activities or expenditures must make a written request to the Board of Directors, setting forth in detail the reasons for and significance of the matter to the specialty of emergency medicine, and the action or activity desired. The executive director of the College, in consultation with the general counsel, will
review and evaluate the request in accordance with this policy, and make a recommendation to the Board of Directors or president, as appropriate.” The Guidelines further set forth questions that should be analyzed by the individual or chapter in their written request to the Board.

It should be noted that AAEM has not requested ACEP’s participation in the lawsuit as a co-plaintiff. As ACEP is not a party to the lawsuit, it has no authority to make critical decisions in the case or contribute to strategic discussions. AAEM’s request also does not provide an estimated budget for the litigation but rather only asks that funds be donated to its foundation.

ACEP member equity is the cumulative net earnings of the organization since its inception and is reported on ACEP’s financial balance sheet. Liquid reserve, a subset of equity, is the amount of equity (available in cash and investments) that is available for contingencies after the provision for investment in fixed and other assets plus working capital. The ACEP Financial Compendium states that the member equity balance shall be no less than 30% of the total annual operating expense budget and that the liquid reserve balance shall be no less than 15% of the total annual operating expense budget. Based on the FY 2022-23 operating budget, the minimum required balance is approximately $12 million for equity and $6 million to ensure there are adequate funds in reserve to maintain operations in the event of unforeseen circumstances. The current unrestricted member equity balance is $22.1 million and includes $1.8 million of unrealized gains/losses.

Several mechanisms exist for the spending of unrestricted member equity. The Finance Committee may recommend a deficit budget or budget modification in response to the long-term directives and strategic plan established for ACEP. ACEP recently launched a new strategic plan that requires investing a portion of member equity in infrastructure and technology to support a more personalized, proactive, and exceptional experience for members. In the current fiscal year, ACEP is using $1.2 million of member equity to implement the first year of the strategic plan. Over the next five years, this financial investment will result in a measurable decrease in the member equity balance. Reserves of up to $500,000 per year may be utilized to support the financial startup and creation of new and innovative opportunities that allow ACEP to grow and advance its mission but that may be cost prohibitive within the ACEP operational budget. The guidelines for the Strategic Project Initiatives (SPI) program are contained in the Compendium of Financial Policies and Operational Guidelines. Initiatives that were approved for funding from member equity through the SPI program include the development of the Acute Unscheduled Care Model, redesign of the PEER program, development and launch of the Pain & Addiction Care in the ED (PACED) accreditation program, and quality measures development and depreciation. Additionally, in early 2022, the Board approved a $3.4 million investment from equity over the next three years to establish the Emergency Medicine Data Institute (EMDI).

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

$1,000,000

Prior Council Action

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) 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; 2) adopt as policy: “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.”; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, 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 to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

Prior Board Action

April 2022, approved the “ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine.”

January 2022, approved filing a brief in the AAEM-PG vs. Envision lawsuit.

September 2021, approved actions regarding Referred Amended Resolution 52(20) The Corporate Practice of Medicine.


Background Information Prepared by: Leslie Patterson Moore, JD
Senior Vice President, General Counsel

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
LEGAL ACTIVITY GUIDELINES

The American College of Emergency Physicians (ACEP) may elect, at the request of a chapter or a member or on its own initiative, to participate in a legal matter, including litigation, which promotes the common business interests of the members of the College and is directed toward the improvement of the profession of emergency medicine. In the course of any such activity, the College will not perform particular services for individual persons.

Participation by the College may take the form of monitoring potential or actual legal actions, providing legal advice or legal counsel, appearing as amicus curiae, intervening in or initiating litigation or other legal activity as may be appropriate.

College activities or expenditures pursuant to this policy will be authorized by the Board of Directors or, in time sensitive matters, by ACEP’s president, with notification to the Board of Directors. A member or chapter seeking approval for activities or expenditures must make a written request to the Board of Directors, setting forth in detail the reasons for and significance of the matter to the specialty of emergency medicine, and the action or activity desired. The executive director of the College, in consultation with the general counsel, will review and evaluate the request in accordance with this policy, and make a recommendation to the Board of Directors or president, as appropriate.

An individual or chapter requesting action under this policy may be required to participate financially with the College. Approval for ACEP’s participation will be for prospective activities and expenditures only, and will not be given for reimbursement of fees or expenses already incurred.

Criteria

The following criteria will serve as a guide in determining what issues merit legal involvement from ACEP:

1. Applicability of the issue to ACEP members
   - Is the issue national, regional, or local?
   - Does the issue affect all members?
   - Does the issue affect a segment of ACEP members with a significant role in emergency medicine (e.g., residency faculty, emergency department directors, EMS medical directors, etc.)?

2. Impact of this issue on emergency medicine practice or quality of care
   - How significant is the issue?
   - Is the issue long-term or ephemeral?

3. Uniqueness of ACEP’s role
   - Is ACEP in a unique position to affect the outcome of this issue?
   - Will the issue be partially addressed by others, but ACEP is needed for the best outcome?
   - Are there other reliable, appropriate sources of influence?
   - Will the issue be resolved satisfactorily by others, if ACEP does not participate?

4. Support of ACEP priorities and purpose
   - Does the issue address one of the priority achievement strategies, desired states of emergency medicine, or purposes as outlined in ACEP’s Bylaws?

5. Likelihood of positive outcome
   - How likely is it that ACEP’s involvement will affect the issue in a positive way?

6. Consequences of negative outcome
   - If the outcome is negative, what are the consequences arising from ACEP’s involvement?
Individuals or chapters requesting participation from ACEP in a legal matter should provide an analysis of how this issue addresses the questions posed above.

**Amicus Curiae**

The criteria stated above shall be applied to requests for ACEP’s participation in *amicus curiae*. In addition to such requests from ACEP members and chapters, ACEP may also initiate the submission of an *amicus curiae* or consider requests from other entities to participate in *amicus curiae* that impact emergency medicine. All requests from other entities will be screened by the executive director and general counsel for the applicability of the criteria. If the executive director determines that the scope of the *amicus curiae* substantially meets the criteria, the general counsel will forward the request to the president for review with a recommendation that the request be assigned to the Medical-Legal Committee.

Upon the president’s approval, the request will be forwarded to the Medical-Legal Committee for review and recommendation. Upon receipt of such recommendation, the president is authorized to determine whether or not ACEP files an *amicus curiae* and will report such submission to the Board. However, ACEP Board review and approval is required for any *amicus curiae* that is submitted on ACEP’s behalf to the U.S. Supreme Court.

*Revised and approved April 2009; reaffirmed May 1997; originally approved November 1987.*
RESOLUTION:  22(22)

SUBMITTED BY:  Jamie Hoitien Do Kuo, MD
               Deborah Fletcher, MD, FACEP

SUBJECT:  State Chapter Funding

PURPOSE: Requests national ACEP to return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

FISCAL IMPACT: The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be $1,218,567.87. This number would change annually as dues revenue fluctuates. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis.

WHEREAS, Numerous topics that affect emergency medicine are regulated at the state level, including but not limited to scope of practice legislation and Medicaid funding and non-compete clauses; and

WHEREAS, States, especially smaller states, have limited funding from state ACEP fees to contribute to political action including lobbying, political action committees, fundraisers, and representation in state medical societies; and

WHEREAS, National ACEP supplies no funding to state chapters for state level legislation; and

WHEREAS, States would benefit from national level financial support so that states can more effectively represent emergency medicine; and

WHEREAS, ACEP’s 2022 Strategic plan lists 5 themes including #1: Expand and strengthen the role and impact of state-level advocacy; and

WHEREAS, ACEP’s 2022 Strategic plan lists 5 themes including #2: Standardize advocacy strategies and approach at the federal, state, and workplace level; and

WHEREAS, ACEP’s 2022 Strategic plan lists 5 themes including #4: Identify, test, and adopt new fundraising strategies to support advocacy initiatives; and

WHEREAS, National ACEP financial support for state chapters for advocacy would demonstrate ACEP’s commitment to its strategic plan; therefore be it

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

Background

This resolution requests national ACEP to return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year

Late in 2021, ACEP’s state government affairs function was moved from the Clinical Affairs line of service to the
Public Affairs line of service to ensure better alignment and coordination across ACEP’s federal and state advocacy initiatives. Past state and federal advocacy efforts had, at times, been siloed and fragmented, leading to missed opportunities for stronger advocacy impact and victories.

Emergency physicians are increasingly impacted by issues (including scope of practice, Medicaid payment reforms, etc.) that are governed and regulated at the state level. A key focus of the advocacy pillar of ACEP’s new Strategic Plan is devoted to strengthening and expanding the role and impact of state-level advocacy for the College.

Acknowledging the importance of these strategic changes in focus, and to ensure these changes translate into real-world advocacy impact and improvements for emergency medicine, ACEP has almost tripled funding in the budget allocated to state government affairs in this fiscal year as compared to last year. In addition to this funding, ACEP is expanding staffing resources dedicated to state government affairs. The lead position has been elevated to a senior director role and an additional FTE has been re-allocated to expand the team size, which will enable a more proactive strategic deployment for state-level advocacy and provide direct advocacy support to chapters, especially smaller chapters with limited financial and staff resources, to ensure they are equipped with advocacy tools and resources needed to maximize impact and results.

While this growth is still in process, recent new advocacy resources ACEP has developed for chapters have included a new scope of practice advocacy campaign toolkit with talking points, sample media op-eds, social media template posts, and infographics. Additionally, public-facing videos have been developed that encourage the public to ask for an emergency physician for their care.

ACEP’s grassroots efforts (sending alerts and encouraging members to contact their legislators on a particular bill or issue) has been expanded beyond federal actions to include state-level actions. ACEP was able to offer chapters three options to leverage a new grassroots software resource: 1) ACEP can set up an action alert link for a chapter at any time that can be shared with members (complimentary) and provide detailed reports of actions taken by chapter advocates to targeted state legislators; 2) ACEP can highlight on our online Advocacy Action Center state-level alerts in addition to the existing federal (complimentary for chapters, with the fee for the add-on module paid for by national ACEP); and, 3) ACEP negotiated a discount for chapters to purchase their own software to allow them a full suite of tools and the ability to host alerts on their own website. Six chapters have moved ahead with this option. Later this fall ACEP will offer an educational session for chapters who might be considering starting their own state-level PAC to expand their advocacy reach. In addition, future programming for the Leadership & Advocacy Conference will now include an expanded focus on state policy issues and tools and tips for grassroots and political action.

Since 2006, ACEP has offered state public policy grants that chapters can apply for and the grants provide financial support to a chapter undertaking a particular public policy initiative as part of their advocacy strategy. The per-grant maximum a chapter can receive has ranged from $6,250 to $12,500 (depending on the level of total funding available in a given year). Grant criteria include demonstrating a significant chapter and member commitment to the public policy effort, including either a dollar-for-dollar match of chapter funds to the grant amount being sought from ACEP or the chapter may provide a substantial amount of in-kind services to support the project. Due to legal restrictions, the grant funding cannot be applied directly to hiring a lobbyist. The grant application can be found here. Past grant recipients have used the funds for campaigns, including to increase Medicaid reimbursement rates for emergency physicians, develop special liability protection under EMTALA, and on balance billing, however, in the last three years no chapter has submitted an application for funding despite the grant funds being available.

Last year ACEP made a significant financial commitment ($25,000 annual dues) in joining the AMA’s Scope of Practice Partnership (SOPP), a coalition of 108 national, state, and specialty medical societies working to block legislation that would provide inappropriate expansion of the medical services and procedures non-physician health professionals are allowed to perform. The SOPP has awarded more than $2 million in grants to its members to fund advocacy tools and campaigns. ACEP is eligible to apply for a grant, as member of the SOPP, on behalf of a chapter for a campaign effort in a particular state.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and
levels, including federal, state, and local.

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

**Fiscal Impact**

ACEP’s annual dues revenue for Regular members for the previous fiscal year ending June 30, 2022, was $12,185,678.76. The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be $1,218,567.87 in expense added to the bottom line. This number would change slightly on an annual basis as dues revenue fluctuates. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis.

Consideration should be given to whether there should be restrictions on how these funds are used, relation to PACs in states that have them, and any reporting requirements for accountability. Given the wide variation between chapters, it is possible that not all chapters will have the staff and/or volunteer capacity or the knowledge to use these funds effectively toward state advocacy efforts. There would be additional fiscal impact for staff time required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of these funds on a monthly or annual basis.

ACEP does not have purview over or approval of the member dues rates set at the chapter level. States that wish to raise funds for advocacy initiatives could consider a variety of options which would allow them to allocate greater resources in that area. ACEP is willing to provide operational assistance or subject matter expertise with the establishment of PACs, volunteer committees, or other sustainable methods of increasing a chapter’s ability to impact legislation.

Finally, the calculation suggested does not consider differences in dues rates between ACEP member categories and the corresponding amount paid to the chapter. For example, while Candidate members pay dues to ACEP, most do not pay dues for their state chapter (this does vary). Therefore, member count may not be the sole factor that might be considered in allocating rebates to the chapters. There are also members in the Retired, Life, Honorary, and International categories that pay different rates at the national and chapter levels. The exact method of calculating dues to be allocated to this purpose will still need to be refined.

**Prior Council Action**

None

**Prior Board Action**

January 2006, approved establishing the State Public Policy Grant Program.

**Background Information Prepared by:** Mollie Pillman, MS, MBA, CAE  
Senior Vice President, Member Engagement

Chris Johnson  
Senior Director, State Government Relations

Laura Wooster, MPH  
Senior Vice President, Advocacy & Practice Affairs

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 23(22)

SUBMITTED BY: Young Physicians Section

SUBJECT: Study of Councillor Term Limits

PURPOSE: Requests the Council Steering Committee to study limits to the number of years individuals may serve in the Council and provide a report with recommendations by the 2024 Council meeting.

FISCAL IMPACT: Budgeted Council Steering Committee and staff resources.

WHEREAS, Council involvement is one of the many ways that members can get involved in the College; and

WHEREAS, Young physician retention has been a key focus of the Membership Committee and, per the annual reports, membership in physicians under the age of 50 has been declining, with that of members over the age of 50 having risen in the past few years1,2; and

WHEREAS, Some state chapters have already designated resident and young physician positions on their delegations to the ACEP Council; and

WHEREAS, Designated positions may be easier to accomplish in larger chapters, but are more challenging for smaller chapters; and

WHEREAS, Different lengths of experience in councillors add diversity to the opinions shared and discussion that occur during our Council meetings, including the addition of institutional knowledge from longer serving councillors; and

WHEREAS, Encouraging Council turnover will continue to broaden the diversity, equity, and inclusion goals of our Council and our organization; and

WHEREAS, The Steering Committee has organized a task force in the recent past to discuss limits on the size of the Council; therefore be it

RESOLVED, That the Council Steering Committee study limits to the number of years individuals may serve in the ACEP Council and report back to the Council with actionable recommendations by the 2024 Council meeting.

References

Background

This resolution requests the Council Steering Committee to study limits to the number of years individuals may serve in the Council and provide a report with recommendations by the 2024 Council meeting.

The ACEP Bylaws, Article VIII – Council (last sentence), specify that component 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.” Additionally, Article VIII – Council, Section 1 – Composition of the Council (last sentence), requires that “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.”

The Bylaws Committee has an ongoing objective to “review chapter bylaws per the Chapter Bylaws Review Plan.” This review ensures conformity with the Model Chapter Bylaws and that there are no conflicts with national ACEP’s Bylaws. The Model Chapter Bylaws provide a template and additional guidance for chapters to use when making changes to their Bylaws, including the stipulation that a single term for a councillor cannot exceed three years. However, in accordance with national ACEP Bylaws, chapters determine any limits on consecutive terms.

Each chapter’s Bylaws include information on whether councillors and alternate councillors are elected or appointed and the duration of the term of office. Some councillors serve as elected members of the chapter’s Board of Directors, or a Board officer, such as the president, serves as a councillor. The term of office for alternate councillors may be different than the term for councillors and some chapters may have councillors elected by the membership with alternate councillors elected by the Board or appointed by the president.

Currently, 6 chapters appoint councillors and alternate councillors, 35 chapters elect councillors and alternate councillors, and 12 chapters have a combination of elected and appointed councillors and alternate councillors.

ACEP’s Section Operational Guidelines stipulate that “councillors and alternate councillors are elected positions and serve as officers of the section for a two-year term with the alternate becoming the councillor at the end of the two-year term. If unable to serve, the section must elect a member to fill both positions and resume normal progression from alternate councillor to councillor.”

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted Council Steering Committee and staff resources.

Prior Council Action

Resolution 6(10) Component Bodies and Councillor’s Terms of Office adopted. This Bylaws amendment simplified provisions concerning component bodies and limited councillor terms of office to no more than three years.

Prior Board Action

October 2021, approved the revised Model Chapter Bylaws.

April 2008, approved the Sample Operational Guidelines for sections.

Resolution 6(10) Component Bodies and Councillor’s Terms of Office adopted.

June 2010, approved cosponsoring Resolution 6(10) Component Bodies and Councillor’s Terms of Office.

Background Information Prepared by: Sonja Montgomery, CAE Governance Operations Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
2022 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-40

Abhi Mehrotra, MD, MBA, FACEP (NC) Chair
Erik Blutinger, MD, MSc (NY)
Angela P. Cornelius, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
Puneet Gupta, MD, FACEP (CA)
Diana Nordlund, DO, JD, FACEP (MI)

Jeff Davis
Ryan McBride, MPP
RESOLUTION: 24(22)

SUBMITTED BY: Michael Bresler, MD, FACEP
Valerie Norton, MD, FACEP
Lori Winston, MD, FACEP
California Chapter
Massachusetts College of Emergency Physicians

SUBJECT: Access to Reproductive Health Care Services

PURPOSE: That ACEP support nationwide access to a full array of reproductive health care options.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The United States Supreme Court in Dobbs v Jackson Women’s Health Organization has limited individuals’ rights to receive some forms of health care; therefore be it

RESOLVED, That ACEP support nationwide access to a full array of reproductive health care options.

Resolution References

Background

The resolution directs the College to support nationwide access to a full array of reproductive health care options.

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in Dobbs v. Jackson Women’s Health Organization, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the Dobbs decision is limited to the question of a “…constitutional right to abortion and no other right,” and that “…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion,” such as Griswold v. Connecticut that established the right for married couples to purchase and use contraception. More simply, the Dobbs ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the Dobbs ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, “Interference in the Physician-Patient Relationship,” approved by the Board of Directors in June 2022).
There is wide variation in state regulation of abortion and reproductive health procedures, including prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives. On July 26, when the Supreme Court took the procedural step to enter its judgment overturning Roe v Wade, the process began for some states to implement existing state statutes.

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these “conscience clauses” also prohibit discrimination against those who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

With the legal landscape in flux, there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of emergency reproductive health care. Some advocates have expressed concerns that this uncertainty may discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. ACEP recently joined amicus briefs addressing these issues. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of the U.S. Department of Justice’s challenge to an Idaho law in United States v. State of Idaho. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients’ clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services’ guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians’ obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

With respect to the issue of full spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy,” states in its entirety, “ACEP supports the availability of non-prescription emergency contraception.” Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the “Management of the Patient with the Complaint of Sexual Assault” policy, which states:

“A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion.”

Another issue in the broader debate is the challenge of misconceptions which conflate contraceptives and abortion/abortifacients, though they are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy).

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the “morning-after pill”), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is “a hypothetical that has never been proven.”
Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

See the background information for resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care for further information on these new federal and state laws and regulations and how they interact with the Emergency Medical Treatment and Labor Act (EMTALA).

**Background Reference**

1ACEP recognizes that references to “a full array of reproductive health care options” may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

**Fiscal Impact**

Budgeted staff resources for advocacy initiatives.

**Prior Council Action**

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement “Management of the Patient with the Complaint of Sexual Assault” accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.
Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) “Sexual Assault” adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

**Prior Board Action**

June 2022, approved the policy statement “Interference in the Physician-Patient Relationship."


February 2020, reaffirmed the policy statement “Management of the Patient with the Complaint of Sexual Assault;” reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.


October 2002, revised and approved policy statement “Management of the Patient with the Complaint of Sexual Assault."

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.


Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

**Background Information Prepared by:** Ryan McBride, MPP  
Congressional Affairs Director

Leslie Patterson Moore, JD  
Senior Vice President, General Council

Laura Wooster, MPH  
Senior Vice President, Advocacy and Practice Affairs

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 25(22)

SUBMITTED BY: Aislinn Black, DO, MPH, FACEP
James Blum, MD
Scott Pasichow, MD MPH
Karina Sanchez, MD
Nikkole Turgeon, MD
Daniel Udrea, MD
Jennifer Walker, MD FACEP
California Chapter
American Association of Women Emergency Physicians Section
Social Emergency Medicine Section
Young Physician Section
Emergency Medicine Residents’ Association

SUBJECT: Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care

PURPOSE: Affirm that abortion is a medical procedure and that no physician shall be required to perform an act violative of good medical judgment; that ACEP support the position that abortion is a medical procedure and as such involves shared decision making between patients and their physician regarding various criteria; that ACEP oppose criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion; that ACEP support an individual’s ability to access a full spectrum of evidence-based reproductive health care; and that ACEP oppose criminalization, penalties for, or other retaliatory efforts against patients, advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy initiatives.

WHEREAS, Many states have enacted laws that either restrict access to abortion to very early in pregnancy or make all abortions illegal without regard for the health of the mother or the viability of the pregnancy; and

WHEREAS, The American Medical Association (AMA) has asserted that abortion is health care and that all humans have a fundamental right to health care; and

WHEREAS, The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Osteopathic Association, the American College of Physicians, and the American Psychiatric Association have released a joint statement condemning the end of national abortion protections and advocating for the protection of the patient physician relationship in all health care matters; and

WHEREAS, The AMA has issued briefs in many legal cases in support of continued legal access to safe elective abortions; and

WHEREAS, Worldwide unsafe abortions due to lack of safe access account for 13% of all maternal mortality and long-term health complications for up to 5 million women annually; and

WHEREAS, About 6% of people who undergo a legally and safely performed abortion will visit the ED within 6 weeks of said abortion, indicating that a restriction on access to safe abortions will likely result in an increase in complications presenting to the ED; and
WHEREAS, The removal of legal protections for abortion will increase the number of people who seek less safe methods for abortion with less medical oversight, thereby increasing morbidity and mortality from self-induced, unsafe, and unregulated abortion practice; therefore be it

RESOLVED, That ACEP affirms that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual’s state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP supports the position that the early termination of pregnancy (publicly referred to as “abortion”) is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP opposes the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients’ medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; and be it further

RESOLVED, That ACEP supports an individual’s ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and be it further

RESOLVED, That ACEP opposes the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

References

Background

The resolution directs the College to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual’s state; and 2) no physician or other professional personnel
shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and, that ACEP support the position that the early termination of pregnancy (publicly referred to as “abortion”) is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients.

The resolution also directs the College to oppose the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients’ medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and, finally, oppose the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in Dobbs v. Jackson Women’s Health Organization, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the Dobbs decision is limited to the question of a “…constitutional right to abortion and no other right,” and that “…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion,” such as Griswold v. Connecticut that established the right for married couples to purchase and use contraception. More simply, the Dobbs ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the Dobbs ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, “Interference in the Physician-Patient Relationship,” approved by the Board of Directors in June 2022).

Given wide variation in state regulation of abortion and reproductive health procedures, including new prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of emergency reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care providers for assisting individuals in accessing abortions, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

In years prior to the Dobbs decision, there were numerous efforts at the state level to significantly limit abortions and penalize physicians and health care providers who perform the procedure. On July 26, 2022, when the Supreme Court took the procedural step to enter its judgment overturning Roe v Wade, the process began for some states to implement existing statutes. In Alabama, a law passed in 2019 makes it a felony for physicians to perform any abortion unless the pregnant patient’s life is in jeopardy, punishable by up to 99 years in prison. In Oklahoma, a 2021 law enacted a statewide ban on abortion with exceptions for the life or physical health of the pregnant patient, along with criminal penalties and up to five years in prison for any individual who advises or provides any means of accessing an abortion. After the Dobbs decision, Texas law banned abortions from fertilization with the exception of life or physical health of the pregnant patient increasing criminal and civil penalties for providing, advising, or
abetting an abortion. Twenty-six states have enacted what are known as born-alive laws, that require physicians to provide medical care and treatment to a fetus or infant born at any stage of development. Under the Texas law, passed in June 2019, physicians who fail to provide that level of treatment face fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these “conscience clauses” also prohibit discrimination against those who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

With respect to the issue of full spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy,” states in its entirety, “ACEP supports the availability of non-prescription emergency contraception.” Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the “Management of the Patient with the Complaint of Sexual Assault” policy, which states:

“A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion.”

Another issue in the broader debate is the challenge of misconceptions which conflate contraceptives and abortion/abortifacients, though they are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy).

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the “morning-after pill”), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is “a hypothetical that has never been proven.”

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

For emergency medicine specifically, much of the consideration is related to how these new federal and state laws and regulations interact with the Emergency Medical Treatment and Labor Act (EMTALA) – a law that has been in place since 1987. The law includes three main obligations: the screening requirement, the stabilization requirement, and the transfer requirement. First, the law requires hospitals to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition. If an individual is determined to have an emergency medical condition, the individual must receive stabilizing treatment within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

On July 11, 2022, the Centers for Medicare & Medicaid Services (CMS) issued additional EMTALA guidance, following up on its previous guidance from September 2021. In this updated guidance, CMS reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and
transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions. Further, with respect to what constitutes an “emergency medical condition” (EMC), the guidance states that the determination of an EMC “is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment.” Finally, the guidance states that EMTALA pre-empts “any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital.”

In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law pre-empts state law restricting access to abortion in emergency situations.

But even with this new guidance there is still significant grey area. While the guidance notes that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any proactive protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception allowing abortion if it’s to prevent the death of the pregnant patient. But EMTALA requires stabilizing treatment to prevent “serious impairment of bodily functions,” “serious dysfunction of any bodily organ or part,” or to place the health of the patient "in serious jeopardy." This is a significant area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA in order to avoid potential civil monetary penalties, or following the state law in order to avoid potential criminal charges.

ACEP is working to identify other such gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice medicine. In order to do so, ACEP President Gillian Schmitz has formed a cross-disciplinary task force of experts from across EM to help identify clinical and legal barriers to how emergency physicians practice medicine, and develop recommendations to address them.

As well, ACEP recently joined amicus briefs addressing these concerns. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of an Idaho law in United States v. State of Idaho. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients’ clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services’ guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians’ obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

In both cases, the amici have determined the law (ID) or state action (TX) will have damaging professional and legal implications for physicians and adversely impact patient safety. As such, ACEP and other amici, filed the briefs to educate the Courts regarding our physicians’ EMTALA obligations as well as the legal and ethical dilemma created by the Idaho legislature's and Texas Attorney General's actions.

Background Reference

¹ACEP recognizes that references to “a full spectrum of reproductive health care options” may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility, and administrative.
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Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources for policy development and advocacy initiatives.

Prior Council Action

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement “Management of the Patient with the Complaint of Sexual Assault” accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) “Sexual Assault” adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action

June 2022, approved the policy statement “Interference in the Physician-Patient Relationship.”


February 2020, reaffirmed the policy statement “Management of the Patient with the Complaint of Sexual Assault;” reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

October 2002, revised and approved policy statement “Management of the Patient with the Complaint of Sexual Assault.”

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.


Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

Leslie Patterson Moore, JD
Senior Vice President, General Counsel

Laura Wooster, MPH
Senior Vice President, Advocacy and Practice Affairs

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 26(22)

SUBMITTED BY: Peter Acker, MD, MPH, FACEP
Youyou Duanmu, MD, MPH
Monica Saxena, MD, JD
Kelly Quinley, MD
California Chapter
American Association of Women Emergency Physicians Section
Pediatric Emergency Medicine Section
Social Emergency Medicine Section
* See Attachment A for list of additional individual cosponsors.

SUBJECT: Promoting Safe Reproductive Health Care for Patients

PURPOSE: That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the ED irrespective of the state in which the patient is seeking care; that ACEP promote legal protections for doctors practicing within best practices; that ACEP encourage hospitals and EM residency programs to provide education and more on miscarriage and post-abortion care; that ACEP broaden its clinical policy to include considerations for miscarriage management; that ACEP continue to develop practices and policies to protect the physician-patient relationship, including legal resources; and that ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy initiatives.

WHEREAS, Reproductive health services including abortion are healthcare; and

WHEREAS, According to the Centers for Disease Control more than 600,000 American women have abortions each year with almost half of these women living at or below the poverty line; and

WHEREAS, Unplanned pregnancies are associated with higher maternal and child prenatal and perinatal morbidity, poverty and decreased education attainment for mothers and children, and as such hold health equity implications; and

WHEREAS, A federal constitutional right to abortion is no longer guaranteed and more than 26 states have passed laws regulating or prohibiting the provision of abortion care; and

WHEREAS, In December 2021 the Federal Drug Administration approved abortion pills by mail and 19 states prohibit telehealth abortion; and

WHEREAS, In light of these barriers to accessing safe health care, people will seek self-managed abortions or initiate abortions without medical management, and as these cases will clinically appear similar to miscarriages, emergency departments may see a rise in miscarriage cases; and

WHEREAS, Patients with ectopic pregnancies who present to emergency departments in abortion-restricted states may encounter physicians or hospitals who refuse to treat their ectopic pregnancy; and

WHEREAS, In June 2022, ACEP that states the doctor-patient relationship should remain free of legislative, regulatory, or judicial interference in the physician-patient relationship; therefore be it
RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortions and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

Background

The resolution directs the College to promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state or origin of their patients; encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and, promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support for adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

The issue of access to and provision of abortion, including peri-abortion and post-abortion care in the emergency department, is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women’s Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a “…constitutional right to abortion and no other right,” and that “…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion,” such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.
As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the Dobbs ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, “Interference in the Physician-Patient Relationship,” approved by the Board of Directors in June 2022).

Given wide variation in state regulation of abortion and reproductive health procedures, including new prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care providers for assisting individuals in accessing abortions, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

In years prior to the Dobbs decision, there were numerous efforts at the state level to significantly limit abortions and penalize physicians and health care providers who perform the procedure. On July 26, 2022, when the Supreme Court took the procedural step to enter its judgment overturning Roe v Wade, the process began for some states to implement existing statutes. In Alabama, a law passed in 2019 makes it a felony for physicians to perform any abortion unless the pregnant patient’s life is in jeopardy, punishable by up to 99 years in prison. In Oklahoma, a 2021 law enacted a statewide ban on abortion with exceptions for the life or physical health of the pregnant patient, along with criminal penalties and up to five years in prison for any individual who advises or provides any means of accessing an abortion. After the Dobbs decision, Texas law banned abortions from fertilization with the exception of life or physical health of the pregnant patient increasing criminal and civil penalties for providing, advising, or abetting an abortion. Twenty-six states have enacted what are known as born-alive laws, that require physicians to provide medical care and treatment to a fetus or infant born at any stage of development. Under the Texas law, passed in June 2019, physicians who fail to provide that level of treatment face fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

The Clinical Policies Committee defines a clinical policy as an evidence-based recommendation informed by a systematic review of critically appraised literature developed in accordance with accepted guideline development standards. The ACEP Clinical Policies Subcommittee on Early Pregnancy published “Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy” in February 2016. It was the most accessed clinical policy in 2021, with 1776 downloads. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO questions. The critical questions addressed in the clinical policy were:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy?

With respect to the issue of full spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy,” states in its entirety, “ACEP supports the availability of non-prescription emergency contraception.” Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the “Management of the Patient with the Complaint of Sexual Assault” policy, which states:

“A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another
Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines. For emergency medicine specifically, much of the consideration is related to how these new federal and state laws and regulations interact with the Emergency Medical Treatment and Labor Act (EMTALA) – an essential law that has been in place since 1987.

The law includes three main obligations: the screening requirement, the stabilization requirement, and the transfer requirement. First, the law requires hospitals to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition. If an individual is determined to have an emergency medical condition, the individual must receive stabilizing treatment within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

On July 11, the Centers for Medicare & Medicaid Services (CMS) issued additional EMTALA guidance, following up on its previous guidance from September 2021. In this updated guidance, CMS reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions. Further, with respect to what constitutes an “emergency medical condition” (EMC), the guidance states that the determination of an EMC “is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment." Finally, the guidance states that EMTALA pre-empts “any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital.”

In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law pre-empts state law restricting access to abortion in emergency situations. Even with this new guidance there is still significant grey area. While the guidance notes that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any proactive protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception allowing abortion if it’s to prevent the death of the pregnant patient. But EMTALA requires stabilizing treatment to prevent “serious impairment of bodily functions,” “serious dysfunction of any bodily organ or part,” or to place the health of the patient "in serious jeopardy." This is a significant area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA in order to avoid potential civil monetary penalties, or following the state law in order to avoid potential criminal charges.

ACEP is working to identify other such gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice medicine. In order to do so, ACEP President Gillian Schmitz has formed a cross-disciplinary task force of experts from across EM to help identify clinical and legal barriers to how emergency physicians practice medicine, and develop recommendations to address them.

As well, ACEP recently joined amicus briefs addressing these issues. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice’s challenge to an Idaho law in United States v. State of Idaho. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients’ clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services’ guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians’ obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.
In both cases, the amici have determined the law (ID) or state action (TX) will have damaging professional and legal implications for physicians and adversely impact patient safety. As such, ACEP and other amici, filed the briefs to educate the Courts regarding our physicians' EMTALA obligations as well as the legal and ethical dilemma created by the Idaho legislature's and Texas Attorney General's actions.

**Background Reference**

1. ACEP recognizes that references to “reproductive health services” may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

**Fiscal Impact**

Budgeted committee and staff resources for policy development and advocacy initiatives.

**Prior Council Action**

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement “Management of the Patient with the Complaint of Sexual Assault” accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

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Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.
Substitute Resolution 34(89) “Sexual Assault” adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action

June 2022, approved the policy statement “Interference in the Physician-Patient Relationship.”


February 2020, reaffirmed the policy statement “Management of the Patient with the Complaint of Sexual Assault;” reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

October 2016, approved the revised “Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy” and rescinded the 2012 clinical policy.


October 2002, revised and approved policy statement “Management of the Patient with the Complaint of Sexual Assault.”

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.


Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Background Information Prepared by:  
Ryan McBride  
Congressional Affairs Director

Leslie Moore, JD  
Senior Vice President, General Counsel

Laura Wooster, MPH  
Senior Vice President, Advocacy and Practice Affairs

Reviewed by:  
Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
<table>
<thead>
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<th>Name</th>
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<tr>
<td>Paul-Andre Abboud, MD</td>
<td>FACEP</td>
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<td>Rodney D. Altman, MD</td>
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<td>Michael Yang, MD</td>
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RESOLUTION: 27(22)

SUBMITTED BY: James Blum, MD
Diana Halloran, MD
Pranav Kaul, MD
Nicholas Melucci, MPH
Nikkole Turgeon, MD
Jennifer Walker, MD, FACEP
American Association of Women Emergency Physicians Section
Social Emergency Medicine Section

SUBJECT: Equitable Access to Emergency Contraception in the ED

PURPOSE: That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and, that ACEP advocate for universal access to emergency contraception in the emergency department.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and advocacy initiatives.

WHEREAS, Emergency medicine upholds the basic human rights principle of non-discrimination including providing medical care without bias to race, color, sex, language, religion, political, or other opinions, national or social origin, property, birth, or other status such as disability, age, marital, and family status, sexual orientation and gender identity, health status, place of residence, economic, and social situation; and

WHEREAS, 55% of patient visits to the ER are women or 72,352,000 out of 129,974,000 visits recorded most recently by the Centers for Disease Control and Prevention; and

WHEREAS, This obligation includes the right to ensure availability, accessibility, acceptability, and quality of contraceptive services without discrimination; and

WHEREAS, In the United States, 76.2% of women aged 18–49 years are considered to be at risk for unintended pregnancy, and the risk for unintended pregnancy varies significantly by age group, race/ethnicity, and urban-rural status; and

WHEREAS, Emergency contraception should be available for populations at most risk for unintended pregnancy including when no contraceptive was used, sexual assault, concern for possible contraceptive failure, or improper or incorrect use; and

WHEREAS, Emergency contraception can prevent up to 95% of pregnancies when taken within 5 days of intercourse, but is most effective when taken within 24 hours; and

WHEREAS, Many patients in the United States do not have access to primary care or gynecologic services within 24 hours; and

WHEREAS, There are many misconceptions about emergency contraceptives including confusion with abortifacients and termination of pregnancy, rather than an understanding that these medications only work prior to establishing pregnancy; and

WHEREAS, The American Medical Association (AMA):
1. Recognizes healthcare, including reproductive health services like contraception and abortion, is a human right.\textsuperscript{11}

2. Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion\textsuperscript{11}; and

WHEREAS, The American College of Obstetricians and Gynecologists (ACOG) expert consensus and practice bulletins recommend:

1. Health care providers integrate copper IUD emergency contraception into their practice with same-day availability.\textsuperscript{8}

2. Write advance prescriptions for emergency contraception to increase awareness and reduce barriers to access.\textsuperscript{8}; and

WHEREAS, The Emergency Medicine Residents’ Association (EMRA) has an existing policy stating that:

Section III-IV Protecting Access to Women’s Health, Reproductive Health, and Organizations That Provide Increased Health Access to Women: EMRA will advocate for policies that protect access to women’s health care including reproductive health care. Support increased funding for organizations that provide access to reproductive care.\textsuperscript{12}

Section IV-VIII. Healthcare as a Human Right: EMRA firmly believes that all individuals should have access to quality, affordable primary and emergency healthcare services for all people (especially vulnerable and disabled populations, including rural, elderly, and pediatric patients) as a basic human right.\textsuperscript{12}; and

WHEREAS, The American College of Emergency Physicians (ACEP) has an existing policy “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy” stating that ACEP supports the availability of non-prescription emergency contraception\textsuperscript{13}; and

WHEREAS These misconceptions can lead to further inaccessibility of medical treatment to a vulnerable population during a critical time\textsuperscript{5}; therefore be it

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

References
7. U.S. Department of Justice, Office on Violence Against Women. A national protocol for sexual assault medical forensic examinations: adults/adolescents. 2nd ed.Washington, DC: DOJ; 2013. Available at:
Resolution 27(22) Equitable Access to Emergency Contraception in the Emergency Department
Page 3


Background

The resolution directs ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments (EDs) nationwide, and would also direct ACEP to advocate for universal access to emergency contraception in the ED.

Existing ACEP policy regarding emergency contraception is succinct and narrow in scope. As noted in the resolution, the ACEP policy statement “Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy” states in its entirety, “ACEP supports the availability of non-prescription emergency contraception.” Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the “Management of the Patient with the Complaint of Sexual Assault” policy, which states:

“A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion.”

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these “conscience clauses” also prohibit discrimination against health care providers who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is also in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in Dobbs v. Jackson Women’s Health Organization, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the Dobbs decision is limited to the question of a “…constitutional right to abortion and no other right,” and that “…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion,” such as Griswold v. Connecticut that established the right for married couples to purchase and use contraception. More simply, the Dobbs ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.
However, some maintain concerns that access to contraception may also potentially be at risk given Justice Clarence Thomas’ concurring opinion in *Dobbs*. While Justice Thomas reiterates that *Dobbs* itself does not address any right beyond abortion, he does suggest that the Court should reconsider “…all of this Court’s substantive due process precedents, including *Griswold, Lawrence*, and *Obergefell*,” adding that “Because any substantive due process decision is ‘demonstrably erroneous,’…we have a duty to ‘correct the error’ established in those precedents.” These comments have led some to conclude that access to contraception may also be under threat should the Supreme Court be presented with and opt to consider a similar case that could effectively overturn *Griswold* or other related precedent.

As the resolution notes, while contraceptives and abortion/abortifacients are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy), there are often common misconceptions conflating the two. The American College of Obstetricians and Gynecologists (ACOG) states that “Intrauterine pregnancy begins when a fertilized egg implants itself in the uterus,” and, that “Emergency contraception prevents a pregnancy from occurring after sexual activity. It is not an abortifacient; it does not end a pregnancy.” Despite this distinction, much of the debate around the broader issue centers around the more fundamental disagreement of when life begins or whether pregnancy begins at conception or at implantation. Those who believe life begins at the moment of conception or fertilization oppose emergency contraception that prevents the implantation of a fertilized egg, arguing that action constitutes an abortion.

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the “morning-after pill”), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is “a hypothetical that has never been proven.”

Given wide variation in state regulation of abortion and reproductive health procedures, including “trigger” laws, newly-passed laws in several states (some of which include prohibitions on abortions even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger), and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine, including the provision of emergency contraception. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception out of an abundance of caution to avoid potential legal exposure.

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

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- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.
Fiscal Impact

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Prior Board Action


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June 1999, reviewed the “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.
Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 28(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Billing and Collections Transparency and Interaction with ACEP

PURPOSE: 1) 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. 2) 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 staff resources for advocacy initiatives. Potential significant reduction in outside funding support. Potential significant legal expenses to respond to complaints against ACEP.

WHEREAS, It is common knowledge that many American College of Emergency Physicians (“ACEP”) members are denied access to information regarding amounts that are billed and collected in their name; and

WHEREAS, As reported to the U.S. Department of Justice (“DOJ”) and Federal Trade Commission (“FTC”) by ACEP (see, letter to Lina Khan and Jonathan Kanter, dated 4/20/22), a large number of members are experiencing wage suppression and requirements for seeing an increased patient load with no associated wage increase causing members to feel they are being exploited and that their patients are being placed at risk due to these pressures; and

WHEREAS, A lack of transparency regarding data on monetary amounts that are billed and collected in a physician’s name from various payers breeds distrust and can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing the demanding specialty of emergency medicine; and

WHEREAS, The voluntary database created partially in response to 2020 Resolutions on Transparency, intended to allow members to understand which entities allow them to “see the books,” has been of no practical use to the members in this area; 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 should be able to receive financial information regarding billings and collections made in his or her name, for reasons including, a) to prevent the corporate practice of medicine (“CPOM”), b) to give the physician the ability to review or audit important data related to his or her practice, c) to ensure the following of honest and lawful billing practices, and d) to prevent instances of upcoding, overcharges, or 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 emergency department (“ED”); and

WHEREAS, The Original Bylaws of the ACEP opposed fee-splitting, stating in pertinent part that “[i]n 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 EM physician by the ACEP as demonstrated in the 1996 book published by ACEP written by David Kalifon and Daniel Sullivan


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called “Before you sign. Contract basics for the emergency physician.” 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 20% or more of the professional fee, this is a significant
economic issue for the membership of the ACEP, the value of which could run into 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[s] 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 regards to unwitting
participation in CPOM, fee-splitting, or 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 will 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 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; 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, 2023,
provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed
information on monetary amounts 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 are not limited to revenue cycle management companies, physician group practices,
hospitals, and staffing companies.”

Reference

Background
The resolution directs ACEP to petition state or federal legislative and 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 at least monthly.
The resolution also 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.

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
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 that has 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.”

The resolveds of this resolution are almost the exact language of two resolveds from Referred Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine (the last three resolveds were referred to the Board of Directors). Regarding the first resolved statement of this resolution, and in response to the 2020 referred resolution, ACEP’s Public Affairs staff contacted both Majority and Minority congressional staff to discuss potential legislative or other approaches to address billing and collections transparency. Broadly, while there was some interest from congressional staff in the overarching concept of transparency, the most common concerns raised were questions about the role of the federal government in this matter and a reluctance about stepping into contract issues between two private entities. Several congressional staff members noted that federal pushes for increased transparency are typically motivated by the direct patient/consumer impact. Additionally, Board members met with the original authors of the 2020 resolution to discuss the intent of the resolved and to brainstorm options. There were questions about what federal mechanisms could be used for implementation and enforcement, with conditions of participation (COPs), labor law, and FTC. Several staff noted that this option could be further explored, but we should anticipate there will likely be substantial pushback from the hospital community. Separate from these Congressional discussions, ACEP Public Affairs staff and General Counsel investigated whether the False Claims Act (31 U.S.C. §§ 3729–3733), or FCA, could provide a lever for physicians to secure reporting of what has been billed and collected in their name. While the FCA provides mechanisms for penalty (including a private right of action for whistleblowers) if incorrect or fraudulent billing is suspected in Medicare, Medicaid, and other federal programs, there is no specific legal requirement around billing transparency under the law. The False Claims Act only applies when a person “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” or “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent”. Under the law, “knowingly” means “a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information;” and “require no proof of specific intent to defraud.” Subsequently, ACEP engaged outside counsel to advise on whether securing regular reporting of billing in a physician’s name could inadvertently subject that physician to potential liability under the False Claims Act, since provision of this information could now leave them considered to be “knowing.” ACEP developed a primer on the False Claims Act to help empower emergency physicians to better understand their rights under federal law and empowers them to gain access to Medicare billings made in their name. The primer is organized by employment type/payment arrangement.

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.

Regarding the second resolved of this resolution, and in response to the 2020 referred resolution with almost the exact language, ACEP’s General Counsel engaged Powers, Pyles, Sutter & Veville, P.C., a legal firm with specialized expertise in healthcare and representation of nonprofit organizations, as outside counsel to review the resolution and provide a third-party outside legal opinion on the antitrust risk to ACEP to implement the referred resolution as written. At its June 2021 meeting, outside counsel presented the Board of Directors with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated that there was substantial risk to implementing the referred resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, with the intent to increase transparency and demonstrate all employers’ adherence to key ACEP policy statements related to employer best practices. Following the Board presentation, the Board and staff developed a questionnaire to all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, asking them to provide information about their organizations. The questionnaire included an attestation that the entities fully adhere to several ACEP policy statements as they pertain to the emergency physicians in their group, including “Emergency Physician Rights and Responsibilities” and “Emergency Physician Contractual Relationships”, which specifically mention due process and transparency in billing. Several iterations of the draft questionnaire were discussed with ACEP members, including the original authors of the resolution, and the final was distributed in September 2021. Completed employer survey responses were made available to all members through various channels. An employer database was developed and is available at www.acep.org/EmployerProfile. Promotion of the employer responses was made available at ACEP21 using QR codes in the onsite program for employer exhibitors, on meter boards, and on tabletop signs for each booth and Job Fair table. Additionally, promotion of the survey responses was included in the ACEP21 mobile app and promotion also occurred in EM Today, Weekend Review, social media, ACEP.org and a From the College note in ACEP Now.

Approximately 19% of all corporate support ACEP received in FY 2021-22 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed $541,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities. Further, ACEP uses advertising to promote employment opportunities, affinity partnerships, member benefits and resources in various channels, including our job board (www.emcareers.org), our monthly publication ACEP Now, digital advertising in our e-newsletters and more. Prohibiting these types of agreements would eliminate funding used to offset the cost of key member benefits, including the Annals of Emergency Medicine, ACEP Now, and member counseling services and limit member access to employment opportunities and resources.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
Bilng and Collections Transparency and Interaction with ACEP

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Potential significant reduction in outside funding support. Potential significant legal expenses to respond to complaints against ACEP.

Prior Council Action

Referred Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine (last three resolveds) referred to the Board of Directors. The resolution sought for ACEP to adopt 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.”; 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 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; and 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.”


Amended Resolution 30(20) Protection and Transparency adopted. Directed ACEP to establish policy encouraging all employers, persons or entities who contract for emergency physician services to provide information on a semi-annual basis to non-federal 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.

Prior Board Action

April 2021, approved the revised policy statement approved the revised policy statement “Compensation Arrangements for Emergency Physicians;” revised and approved April 2015, April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

April 2021, approved the revised policy statement “Emergency Physician Contractual Relationships.”

April 2021, approved the revised policy statement “Emergency Physician Rights and Responsibilities.”

Amended Resolution 29(20) Billing and Collections in Emergency Medicine (first two resolveds) adopted

Amended Resolution 30(20) Protection and Transparency adopted.

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.


Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director
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David McKenzie, CAE
Reimbursement Director

Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by:  Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 29(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section
Donald Stader, MD, FACEP
John Spartz, MD
Nathan Novotny

SUBJECT: Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

PURPOSE: 1) advocate for the FDA adding buprenorphine to its list of essential medications; 2) advocate that EDs stock buprenorphine and medications for opioid use disorder; 3) work with the AHA, AMA, state agencies, and federal agencies to promote availability of medications for opioid use disorder in EDs and hospital settings; and 4) support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The opioid crisis continues to escalate, exacerbated by the COVID-19 pandemic, with greater than 103,572 drug overdose deaths in the United States reported over the from January 2021 to January 2022; and

WHEREAS, 1.08 million (14.08%) of all drug-related ED patient visits were related to opioids in 2021, including overdose, complications of opioid use, and seeking treatment for opioid use disorder (OUD); and

WHEREAS, Buprenorphine is an effective treatment for OUD and associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and health care costs; and

WHEREAS, Disparities in timely buprenorphine prescription filling rates after opioid-related ED visits across sex, race and age persist despite a slight increase nationwide from 2014-2020, further emphasizing the need for buprenorphine administration in the ED for more uniform access to life-saving, equitable care; and

WHEREAS, Buprenorphine treatment initiated in the ED is associated with reduction in illicit opioid use and significant increase in post-ED addiction treatment; and

WHEREAS, Buprenorphine provides excellent relief of opioid withdrawal and is more effective for this than other medications such as clonidine, ondansetron, NSAIDs and other management modalities; and

WHEREAS, Many hospitals and emergency departments do not stock buprenorphine, and are not required to stock buprenorphine and other medications for opioid use disorder (MOUD) by accrediting bodies or government agencies; and

WHEREAS, Emergency departments that do not stock buprenorphine are unable to provide the highest quality of evidence based care for patients with OUD or in opioid withdrawal; and

WHEREAS, The FDA publishes a “List of Essential Medicines, Medical Countermeasures and Critical Inputs” that are medically necessary to have available at all times in an amount adequate to serve patient needs and in the appropriate dosage forms; and

WHEREAS, This FDA list does not list buprenorphine as an essential medication; and

WHEREAS, This FDA list is generally composed of medicines “most needed for patients in U.S. acute care
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medications that are “medically necessary to have available in adequate supply which can be used for the widest populations to have the greatest potential impact on public health”; and

WHEREAS, This FDA list is often used as a reference on what emergency departments are required to stock; and

WHEREAS, Buprenorphine is already listed on the World Health Organization Model List of Essential Medicines; and

WHEREAS, Buprenorphine qualifies as a medicine needed in acute care medical facilities for short-term treatment of OUD and opioid withdrawal; and

WHEREAS, Buprenorphine is a necessary treatment option for every ED patient with OUD or in opioid withdrawal, especially during the current public health crisis surrounding opioids in the United States;

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

Resolution References
Background

The resolution calls for the College to: 1) advocate for the FDA adding buprenorphine to its list of essential medications; 2) advocate that EDs stock buprenorphine and medications for opioid use disorder; 3) work with the AHA, AMA, state agencies, and federal agencies to promote availability of medications for opioid use disorder in EDs and hospital settings; and 4) support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

Buprenorphine is a partial opioid agonist approved by the FDA as a medication-assisted treatment (MAT). It helps address effects of physical dependency including reducing cravings and withdrawal symptoms, increases safety in the case of overdose, and lowers the potential for misuse. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “Buprenorphine offers several benefits to those with OUD and to others for whom treatment in a methadone clinic is not appropriate or is less convenient.” It is “the first medication to treat OUD that can be prescribed or dispensed in physician offices,” and as a result, helps to significantly expand access to OUD treatment for patients who would otherwise be unable to receive treatment.

The resolution calls for buprenorphine to be added to the FDA list of essential medicines (Drug and Biologic Essential Medicines, Medical Countermeasures, and Critical Inputs for the List Described in Section 3c) of the Executive Order 13944. In August 2020, President Donald Trump issued Executive Order 13944 to direct the U.S. Food and Drug Administration (FDA) to identify a list of essential medicines, medical countermeasures, and critical inputs that are medically necessary to have available at all times in an amount adequate to serve patient needs and in the appropriate dosage forms. The executive order seeks to ensure sufficient and reliable, long-term domestic production of these products, and to minimize potential shortages by reducing our dependence on foreign manufacturers of these products. The list was developed by the FDA in consultation with other federal partners, and the essential medicines identified “…are those that are most needed for patients in U.S. acute care medical facilities, which specialize in short-term treatment for severe injuries or illnesses, and urgent medical conditions.” As the resolution notes, buprenorphine is not currently listed as an essential medicine.

There is a significant need for effective, accessible treatments for opioid use disorder (OUD) in the United States. The 2020 National Survey on Drug Use and Health (NSDUH) showed that about 2.7 million people in the United States who are 12 years old or older, not experiencing homelessness, and not incarcerated or institutionalized, met the diagnostic criteria for a past-year OUD. This number underestimates U.S. residents living with OUD, given that more than 500,000 people are experiencing homelessness (including 1 in 3 military veterans living with OUD) and that does not survey the approximately 2.3 million people who are incarcerated in the United States. Fewer than one-third of those who initiate treatment for a substance use disorder in the United States receive medication. The need for treatment with MOUD outpaces the current capacity for care, and access to MOUD is not spread equally across the United States. Initiation of buprenorphine for the treatment of OUD in the emergency department (ED), combined with linkage to outpatient care, is a critical component of an effective strategy to reduce the national mortality and morbidity among persons living with opioid addiction.
Given the impact of OUD on ED patients, emergency physicians have unique knowledge, experience, and opportunities to help patients with OUD or other substance use disorders (SUDs). The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder. Though the ED may not be the site for long-term care for OUD, it can be an entry point into care, providing patients with immediate access to MOUD, including initiation, and warm handoff to a longer-term care. To this end, over the past several years the College has developed a robust set of OUD treatment resources and materials for emergency physicians and has taken a leading role in comprehensive federal and state advocacy efforts to address the opioid crisis.

In a survey published by RAND in 2022, researchers examined records that capture 92% of prescriptions filled at U.S. retail pharmacies, identifying buprenorphine prescriptions written by emergency physicians and filled between February 1, 2019, and November 30, 2020. The study found that during 2019 to 2020, 71.5% of patients filling buprenorphine prescriptions written by emergency physicians did not fill subsequent buprenorphine prescriptions from other clinicians. That trend was even greater after the COVID-19 public health emergency was declared. ACEP consensus recommend a direct referral or scheduling an appointment with a prescriber who accepts the patient's insurance after a buprenorphine prescription is given to a patient in an emergency department. However, this approach works only if the local clinicians are accepting new buprenorphine patients, and studies suggest that many buprenorphine-prescribing clinicians are not treating many patients or are not accepting new ones. One effective strategy to address this gap is for emergency departments to provide medication directly, however many hospitals and emergency departments do not stock buprenorphine, and are not required to stock buprenorphine and other medications for opioid use disorder (MOUD) by accrediting bodies or government agencies.

The College supports increased access to ED-initiated MAT using buprenorphine. Initiating MAT in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths. In addition, the available data demonstrate that patients with OUD who are started on buprenorphine in the ED—and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD, than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone). Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.

Furthermore, studies of patients with OUD in California and elsewhere have demonstrated an instantaneous reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available. Finally, a study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care. In all, research suggests that the sooner emergency physicians can start patients on the right path, and keep them engaged in treatment, the more successful their recovery can be.

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There are many regulatory barriers to providing MOUD. However, the federal government has been slowly chipping away at these barriers. In late April 2021, the U.S. Department of Health and Human Services released new buprenorphine practice guidelines that removed the need for an 8-hour training course previously required to get a waiver to administer the addiction medication. Emergency physicians have cited this training as a barrier to treating more people with OUDs. The new guidelines exempt emergency physicians and other eligible practitioners from federal certification requirements related to training, counseling and other services that are part of the process for obtaining a waiver (known as the X-waiver). If providers utilize the exception of the practice guidelines, they may only prescribe up to 30 patients at a time. These 30 patients are counted against the provider limit until they are transitioned to a community provider or 30 days from the last prescription if not transitioned.

Despite the effectiveness of utilizing buprenorphine for treatment purposes, there are currently significant barriers to its use—the greatest of which is the “X-waiver” requirement mandated by the Drug Addiction Treatment Act (DATA) of 2000. Originally, under the DATA 2000 law, physicians wishing to prescribe buprenorphine outside of opioid treatment programs (OTPs) were required take an 8-hour course and receive a waiver from the Drug Enforcement Administration (DEA). While the Biden Administration released guidance in April 2021 effectively eliminating the training and mandatory certification requirements, this exception still comes with a 30-patient limit and physicians who wish to prescribe buprenorphine still need to obtain an X-waiver. Additionally, if practitioners want to treat more than 30 patients at one time, they must still complete the training and meet all other requirements that are in place around counseling and other ancillary services.

It also often takes 60 to 90 days to receive the waiver once the course is completed and the license application is submitted. ACEP and others have argued X-waiver requirement has led to misperceptions about MAT and has maintained or increased stigma about OUD and the treatment of this disease. Due to the stigma, some clinicians are not willing to pursue this DEA license or even engage in treatment of patients with OUD.

For several years, the College has actively advocated for policies to help reduce barriers to ED-initiated MAT, including the “Easy Medication Access and Treatment for Opioid Addiction Act” (Easy MAT Act) to allow emergency physicians without an X-waiver to dispense from the ED up to a three-day supply of buprenorphine at one time to a patient suffering from acute withdrawal symptoms, and the bipartisan “Mainstreaming Addiction Treatment Act” (MAT Act) to effectively fully eliminate the X-waiver. The Easy MAT Act was included as a provision in a stopgap federal funding bill in December 2020 and is now law. Meanwhile, ACEP advocacy on the MAT Act to eliminate the X-waiver continues – the bill was recently included as part of a larger legislative package of mental health and substance use disorder legislation, the “Restoring Hope for Mental Health and Well-Being Act of 2022” (H.R. 7666), which passed the House of Representatives on June 22, 2022, in a broadly bipartisan 402-20 vote and now awaits further action in the Senate.

The resolution also calls for ACEP to work with organizations like the AHA, AMA, and state and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings. While not specific to the issue of adding buprenorphine to the FDA list of essential medications, the AMA also supports legislative efforts to remove the X-waiver requirements altogether, and AMA Policy “Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972” states support for “eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.” The AHA provides a toolkit, “Stem the Tide: Addressing the Opioid Epidemic” that includes a section on options to identify and treat OUDs, including information on MAT as well as buprenorphine training programs.

In June 2022, the U.S. House passed the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7666), which included the Mainstreaming Addiction Treatment (MAT) Act (H.R. 1384/S. 445). ACEP has strongly supported efforts in Congress to advance and pass the Mainstreaming Addiction Treatment (MAT) Act legislation as it improves emergency physicians’ ability to treat opioid use disorder and calls for removal of the buprenorphine X-waiver.

On January 23, 2020, ACEP convened a Summit, Addressing the Opioid Stigma in the Emergency Department, gathering a diverse group of organizations and representatives to discuss and share ideas to gain insight into the
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Prevalence, effect, and targeted solutions to limit the impact of stigma on the care of ED patients with OUD.

In June 2020, the ACEP Board approved Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department, and in February 2021, the ACEP Board of Directors approved the "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." These recommendations that emergency physicians offer to initiate OUD treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with untreated OUD and provide strategies for OUD treatment initiation and ED program implementation, including harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

ACEP continues to advocate for access to and initiation of OUD treatment with buprenorphine in appropriate patients and increased provision of direct linkage to ongoing treatment for patients. ACEP leaders and subject matter experts developed the Emergency Medicine Medications for Addiction Treatment waiver training, along with an EM MAT "Core" Training (a shortened EM MAT waiver training covering all topics relevant to and essential for care on OUD patients in the ED).

In August 2022, ACEP launched the EM Opioid Advisory Network. This is a new ACEP initiative formed by leaders and experts from the Pain Management & Addiction Medicine Section and the Pain & Addiction Care in the Emergency Department (PACED) accreditation program that connects emergency physicians combating the opioid crisis with expert advice on managing Opioid Use Disorder patients presenting in the ED, creating a protocol to initiate buprenorphine, and more. This is a free, open access service that is available to emergency health care professionals.

ACEP has also developed:

- **Buprenorphine in the ED Point of Care tool** that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.
- **Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes**
- **Opioid Regulations: State by State Guide (PDF)**
- A series of free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED.
- **Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop**, Topics covered in the workshop covered everything from setting up an ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- **EM Substance Use Disorder Residency Curriculum**
- **E-QUAL Network Opioid Initiative**

Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program. The primary aim of this program is to accelerate the transfer of knowledge about acute pain management and secure appropriate resources to care for patients.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed
Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

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ACEP to support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training; and develop an online peer mentoring platform for emergency physicians that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. The resolution called for ACEP to recommit to the goal of reducing overdose deaths by working with various federal and state agencies, legislatures, and other stakeholders and that ACEP continue to advocate for actions to decrease the supply of fentanyl and other drugs and to highlight the continued increase in overdoses and overdose deaths.

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted. Directed ACEP to oppose legislation to add naloxone to the PDMP and work with chapters in developing strategies and supporting materials to stop such legislation.

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and continue to advocate for removal of the X-waiver requirement to prescribe buprenorphine for OUD from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of insurance status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow-up.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research
Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

February 2021, approved “Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department.” The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.


Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

April 2019, reviewed the draft criteria for the ED Pain Management Accreditation Program.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

September 2018, approved creation of the Emergency Department Pain & Addiction Management Accreditation Program.

February 2018, revised and approved the policy statement “Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;” originally approved October 2012.

April 2017, approved the revised policy statement “Optimizing the Treatment of Acute Pain in the Emergency Department;” originally approved June 2009 with the title “Optimizing the Treatment of Pain in Patients with Acute Presentations.” This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.
Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.


June 2016, approved the revised policy statement “Naloxone Access and Utilization for Suspected Opioid Overdoses;” originally approved October 2015.

October 2015, approved the policy statement “Naloxone Prescriptions by Emergency Physicians.”

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

**Background Information Prepared by:** Fred Essis, MBA, MA
Congressional Lobbyist

Ryan McBride, MPP
Congressional Affairs Director

Sam Shahid, MBBS, MPH
Practice Management Manager

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 30(22)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Compassionate Access to Medical Cannabis Act – “Ryan’s Law”

PURPOSE: Support allowing patients access to medical cannabis; endorse and support passage of Ryan’s Law across the U.S.; and, endorse, support, and assist chapters in the passage of Ryan’s Law legislation in their states.

FISCAL IMPACT: Budgeted committee and staff resources for federal and state advocacy initiatives.

WHEREAS, In 1996 California became the first state to legalize the use of medical cannabis when citizens passed the Compassionate Use Act; and

WHEREAS, 36 states, the District of Columbia, and four U.S. territories allow medical cannabis use; and

WHEREAS, The fastest growing demography of people using medical cannabis is people 65 and older; and

Whereas Medical organizations that have issued statements in support of allowing access to medical cannabis include the American Nurses Association, American Public Health Association, American Medical Student Association, National Multiple Sclerosis Society, Epilepsy Foundation, and Leukemia & Lymphoma Society; and

WHEREAS, On January 12, 2017 the National Academies of Science, Engineering & Medicine released a report entitled “Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for Research”, which concluded there was conclusive or substantial scientific evidence that medical cannabis was an effective treatment for chronic pain in adults, anti-emetics in chemotherapy-induced nausea and spasticity symptoms in MS and moderate scientific evidence that medical cannabis was an effective treatment for obstructive sleep apnea and

WHEREAS, Many terminally ill patients are admitted to acute care hospitals with chronic pain and nausea due to chemotherapy; and

WHEREAS, According to a survey from Morse Life Health System Hospice and Palliative Care 87% of Americans support medical cannabis as an option for treatment in cases where the patient has received a terminal diagnosis; and

WHEREAS, Hospitals in Israel, Germany, Canada and other countries have developed policy and procedures for inpatient use of medicinal cannabis; and

WHEREAS, The AMA Code of Ethics, Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship that states “The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.” should apply to inpatients; and

WHEREAS, Ryan’s Law allows terminal ill patients to use medical cannabis in hospitals; and

WHEREAS, Ryan’s Law specifically prohibit the smoking or vaping of medical cannabis for hospitalized terminally ill patients; and

WHEREAS, Ryan’s Law allows any hospital investigated by the federal government for using a scheduled 1 drug to immediately prohibit the use of medical cannabis in the hospital; and
WHEREAS, The Ryan’s Law team is advocating for a version of Ryan’s Law in 14 other states and the United States Congress for 2022 and if approved these laws will also require health care facilities and hospitals to allow terminally ill patients use of some types of medical cannabis; therefore be it

RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further

RESOLVED, That ACEP endorse and support the passage of Ryan’s Law across the entire United States; and be it further

RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan’s Law legislation in their states.

Background

The resolution calls for ACEP to support allowing patients access to medical cannabis; endorse and support the passage of Ryan’s Law across the U.S.; and, endorse, support, and assist ACEP chapters in the passage of Ryan’s Law legislation in their states.

The Compassionate Access to Medical Cannabis Act, or “Ryan’s Law,” is a California law requiring health care facilities to allow the use of medical cannabis on their premises for terminally ill patients with a valid medical cannabis card or recommendation from their physician. The law requires health care facilities to not interfere with or prohibit eligible patients from consuming medical cannabis on-site (smoked or vaped cannabis products are excluded); list medical cannabis use in a patient’s record; obtain a copy of the patient’s valid medical cannabis license or physician recommendation before allowing any consumption; write and distribute guidelines detailing the new protocols; and, ensure that the patient’s cannabis is stored and secured in a locked container when not being consumed.

However, recognizing the current legal disparities between state laws and federal law, a provision was added to the law. This provision was included to ensure that hospitals and facilities are not forced to choose between complying with state law and not federal law (or vice versa), ensuring they do not face the threat of potentially losing access to federal funds for operating in accordance with state law. Hospitals may comply with federal demands in the case of a federal agency ordering a facility to stop allowing a patient to consume medical cannabis.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. The medical use of cannabis is legalized in 37 states, three territories, and the District of Columbia. Twelve other states have laws that limit THC content for the purpose of allowing access to products that are rich in cannabidiol (CBD). The recreational use of cannabis is legalized in 19 states, the District of Columbia, the Northern Mariana Islands, and Guam. Another 13 states and the U.S. Virgin Islands have decriminalized its use. Although the use of cannabis remains federally illegal, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. For non-prescription use, cannabidiol derived from industrial hemp is legal at the federal level, but legality and enforcement varies by state.

Despite legalization in several states, marijuana remains a Schedule I drug under the federal Controlled Substances Act, along with drugs like cocaine, LSD, heroin, MDMA (ecstasy), and psilocybin, among others. Schedule I drugs are those with a high potential for abuse, no current accepted medical treatment use within the U.S., and a lack of accepted safety for use under medical supervision.

Last year, the Council adopted Amended Resolution 50(21) Complications of Marijuana Use directing ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED, provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis-related ED diagnoses, and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department. In response to the resolution, the Clinical Policies Committee is in the process of
developing practice guidelines and the Public Health & Injury Prevention Committee has developed patient information on the risks and potential effects of marijuana use and physician information on the management of THC presentations in the ED that will soon be available on the ACEP website.

ACEP’s policy statement “Medical Cannabis,” states:

The American College of Emergency Physicians (ACEP) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including cannabis and cannabis derivative products, for medical use. Currently, in many states, cannabis and related cannabinoids are being recommended for patient use by physicians when little evidence has been provided regarding appropriate indications, efficacy, dosages, and precautions of these drugs. ACEP supports the rescheduling of cannabis and encourages the Food & Drug Administration (FDA), Drug Enforcement Administration (DEA), and other appropriate organizations to facilitate scientifically valid, well-controlled studies of the use of cannabis and cannabis derivative products for treatment of disease and of its impact on societal health.

ACEP members have published multiple articles and editorials:

- **The perils of recreational marijuana use: relationships with mental health among emergency department patients** (JACEP Open; March 8, 2020)
- **Indications and preference considerations for using medical Cannabis in an emergency department: A National Survey** (The American Journal of Emergency Medicine; July 10, 2020)
- **Letter to Editor: A National Survey of US Medicine Physicians on their Knowledge Regarding State and Federal Cannabis Laws** (Cannabis & Cannabinoid Research; December 2020)
- **The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review** (International Journal of Emergency Medicine; February 2021)

ACEP has developed education that is available on demand related to ED presentations related to marijuana, which include:

- **Deadly Spice: A CME Now Case Study** (352 enrollments)
- **Legal and Legit? Vices of the Young**:
  - ACEP20 course (30 enrollments)
  - ACEP19 on demand course (68 enrollments)
- **Still Dope: New on the Scene 2020**:
  - ACEP20 course (95 enrollments)
  - ACEP19 on demand course (64 enrollments)

Based on direction in Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis and recommendation from the Federal Government Affairs Committee, ACEP Supported H.R. 3797, the “Medical Marijuana Research Act of 2019.”. This legislation is consistent with ACEP policy, amending the Controlled Substances Act to establish a less burdensome registration process specifically for marijuana research, and providing approved researchers with the ability to acquire cannabis needed for their studies. This legislation is also intended to ensure a supply of marijuana for research purposes through the National Institute on Drug Abuse Drug Supply Program, directed the FDA to issue guidelines on the production of marijuana, and encouraged authorized researchers and manufacturers to produce marijuana. ACEP continues to monitor legislative efforts in the 117th Congress to expand clinical trials of the effects of medical-grade cannabis on the health outcomes of covered veterans diagnosed with chronic pain and those diagnosed with PTSD.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.
Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.
- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff time and resources, potential costs associated with assisting chapters.

Prior Council Action

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to “Recreational” Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.
Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

Amended Resolution 50(21) Complications of Marijuana Use adopted.

June 2019, approved the policy statement “Medical Cannabis.”

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee’s recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 31(22)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Decriminalization of All Illicit Drugs

PURPOSE: Endorse and support decriminalization of personal possession and use of small amounts of all illicit drugs in the U.S. and endorse and support chapters to develop and introduce state legislation decriminalizing personal possession and use of small amounts of all illicit drugs.

FISCAL IMPACT: Budgeted committee and staff resources. Potential unbudgeted costs for legislative drafting or consulting for development of model legislation.

WHEREAS, In 2001 Portugal became the first country to decriminalize the personal possession and use of small amounts of all illicit drugs; and

WHEREAS, Since it decriminalized all illicit drugs, Portugal has seen a dramatic declines in drug use, HIV and hepatitis infection rates, overdose deaths, drug-related crime, and incarceration rates; and

WHEREAS, The following countries have decriminalized drug use: Antigua + Barbuda, Argentina, Armenia, Australian States: South Australia, Australian Capital Territory, Northern Australia, Belize, Bolivia, Chile, Colombia, Costa Rica, Croatia, Czech Republic, Estonia, Germany, Italy, Jamaica, Mexico, Netherlands, Paraguay, Peru, Poland, Portugal, Russian Federation, South Africa, Spain, Switzerland, Uruguay, Virgin Islands (US Territory); and

WHEREAS, On Election Day 2020, Oreganians overwhelmingly passed Measure 110 that made the possession of small amounts of cocaine, heroin, LSD, and methamphetamine, among other drugs, punishable by a civil citation – akin to a parking ticket – and a $100 fine; and

WHEREAS, Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington DC have decriminalized to some degree the personal possession and use of illicit drugs; therefore be it

RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment; and

RESOLVED, That ACEP endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs and instead making that a civil penalty with referral to treatment.

Background

The resolution directs the College to endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment, and also directs the College to endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs and instead making that a civil penalty with referral to treatment.
Decriminalization of drugs typically refers to the elimination of criminal penalties for the possession and use of illicit drugs, possession and use of paraphernalia and related equipment used to introduce drugs into the body, and low-level drug sales (i.e., not large-scale trafficking). To date, twenty-six states in the U.S. and the District of Columbia (D.C.) have decriminalized the possession of small amounts of marijuana, and in November 2020, Oregon became the first state in the country to decriminalize possession of all drugs and increase access to support services. Since the passage of this ballot measure (the “Drug Addiction Treatment and Recovery Act,” Measure 110), similar efforts have been either introduced or initiatives have been launched in several states and the U.S. Congress. Such efforts include bills aimed specifically at decriminalization of marijuana and others, like the “Drug Policy Reform Act” (H.R. 4020), that would decriminalize drug possession at the federal level, promote evidence-based treatment- and recovery-focused health approaches, and expunge criminal records and provide resentencing opportunities.

Worldwide, Portugal is considered the primary case study for decriminalization, having decriminalized the personal use and possession of all illicit drugs in 2001. Portugal’s law did not make illicit drugs legal, nor did it decriminalize drug trafficking. Instead of incarceration or criminal penalties, law enforcement officers encountering individuals in possession of drugs may confiscate the drug and refers the individual to substance use disorder (SUD) services, managed under regional networks of “dissuasion commissions” operated through the Portugal Ministry of Health. These commissions consist of health, social, and legal services workers who connect individuals directly with SUD treatment, harm reduction services, and therapy, depending on an individual’s needs or desires. While there are no longer any criminal penalties, individuals may be served with fines or required to provide community service or attend required therapy interventions.

The success or failure of Portugal’s decriminalization example is still a matter of debate more than two decades later, with disagreement among proponents and opponents on what lessons can be learned from the country’s experience given the available data. Some, like the U.S. Office of National Drug Control Policy, suggest that “[i]t is difficult, however, to draw any clear, reliable conclusions…regarding the impact of Portugal’s drug policy changes.” A more recent review of the available scientific literature published in the Current Opinion in Psychiatry journal (July 2018) concluded that:

“[s]cientific evidence supporting drug addiction as a health disorder and the endorsement by the [United Nations] strengthen the case for decriminalization. However, studies reporting the positive outcomes of decriminalization remain scarce. The evidence needs to be more widespread in order to support the case for decriminalization.”

According to the Drug Policy Alliance, while Portugal’s rate of drug use has stayed about the same, arrests, incarceration, disease, overdoses, and other associated harms with drug use and SUD are all down. Additionally, Portugal’s drug use rates are below the average in Europe and far lower than drug use rates in the U.S. Within the first decade after the law was enacted, three-quarters of individuals with opioid use disorder (OUD) were in medication-assisted treatment (MAT) programs, the number of people in drug treatment programs increased by more than 60 percent, overdose fatalities dropped significantly, incarceration rates and prison overcrowding were dramatically reduced, and bloodborne disease diagnoses like HIV also fell.

However, there were also negative effects in the years following decriminalization. One study found that after the law was enacted, drug experimentation increased even though it did not lead to regular drug use. Murders increased by 41 percent in the first five years following passage, but began to fall again after, and large-scale drug trafficking increased. Further complicating efforts to analyze the full effects of the law is the fact that even prior to enactment, drug consumption and possession convictions typically resulted in fines, not incarceration, and the country already had low rates of incarceration for drug use.

Proponents of drug decriminalization focus on the relatively recent shift in understanding substance use disorder as a health issue, rather than a criminal justice issue or as a personal failing. Supporters also note that drug arrests are the most commonly arrested offense in the U.S. with one drug arrest every 23 seconds, and that there are significant long-term consequences that may limit an individual’s ability to secure public benefits, employment, housing, child welfare services, immigration, and others, if they have a criminal drug offense on their record. Supporters argue that removing criminal penalties would reduce incarceration and the associated public costs, allow law enforcement to reprioritize resources for other purposes, promote health care, treatment, and safety efforts rather than criminal punishment,
reduce stigma for both drug use and treatment, and would reduce or eliminate barriers to evidence-based harm reduction strategies. Additionally, with more accessible community services, such as safe use/injection facilities, needle exchange programs/services, and more, proponents suggest there will be a significant public health impact in reduced bloodborne pathogen and disease transmission, lower rates of overdose and overdose deaths, and higher rates of successful long-term recovery given access to treatment and recovery programs.

Opponents of decriminalization note that there remains limited data on the effects of decriminalization, including a lack of reporting of adverse trends such as increases in drug-related deaths and overall safety of the drug supply. With respect to the safety of the drug supply, many communities throughout the U.S. have witnessed increases in fentanyl contamination in heroin, opioids, benzodiazepines, cocaine, and other stimulants (along with other effects of the COVID-19 pandemic, the volatility of the illicit drug supply is presumed to be a likely contributing factor in the estimated 107,622 overdose deaths recorded in 2021, a 15 percent increase compared to 2020). Additionally, some (particularly law enforcement) are concerned about the potential for increased rates of violent crime and drug trafficking, especially given the substantial influx of illicit fentanyl and other synthetic opioids in the U.S. drug supply. Others note concerns about the current lack of health care, SUD/OUD treatment, and social service infrastructure needed to support decriminalization laws (a challenge noted in Oregon even by supporters of the state’s decriminalization effort). Other persistent challenges remain as well, including continued stigma and bias among health care providers who may have received little or no training on providing SUD/OUD treatment.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

**Fiscal Impact**

Budgeted committee and staff resources. Potential unbudgeted costs for legislative drafting or consulting for development of model legislation

**Prior Council Action**

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to “Recreational” Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.
Resolution 31(22) Decriminalization of All Illicit Drugs

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.
Prior Board Action

Amended Resolution 50(21) Complications of Marijuana Use adopted.

June 2019, approved the policy statement “Medical Cannabis.”

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee’s recommendation to take no further action on Resolves 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Ryan McBride, MPP
ACEP Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
WHEREAS, The United States is in an epidemic of drug overdose deaths, and it is clearly and compellingly
evident that current policies are not working; and

WHEREAS, Supervised Consumption Facilities (SCF), also known as Supervised Injection Sites (SIS), are
medically supervised facilities designed to provide a hygienic environment in which people are able to consume illicit
recreational drugs intravenously and prevent deaths due to drug overdoses and these sites are part of a proven harm
reduction strategy to reduce substance use problems and the facilities provide immediate access to rescuer medical
staff, sterile injection equipment, information about drugs and basic health care, treatment referrals, and counseling; and

WHEREAS, The benefits of SCF/SIS are well established, they reduce overdose deaths because a rescuer is always present, they decrease infectious disease transmission (primarily HIV and hepatitis C), they increase the number of individuals initiating treatment for substance use disorders, they decrease the number of IV drug users using in public settings and who discard their used syringe and needles there; and

WHEREAS, The first modern SCF/SIS was opened in Berne, Switzerland in June 1986; and

WHEREAS, There are 39 government authorized SCF in Canada as of July 2019; and

WHEREAS, Currently there are approved SCF/SIS operating in 11 countries globally, including Canada,
Germany, and Switzerland; and

WHEREAS, In the United States the first government-authorized supervised injection site began operating in
New York City on November 30, 2021; and

WHEREAS, SCF/SIS, besides saving lives, are cost effective and in San Francisco, for example, one analysis concluded that for every dollar spent on such sites, $2.33 in emergency medical, law enforcement, and other costs would be reduced, producing a yearly net savings of $3.5 million; and

WHEREAS, Recent articles in the New England Journal of Medicine (May 26, 2022) and the Journal of the American Medical Association (April 26, 2022) illustrate the value of SCF/SIS as an additional method of reducing the ravages of substance use disorders on users and communities; and

WHEREAS, American Medical Association policy supports the development and implementation of pilot supervised injection facilities in the United States that are designed, monitored, and evaluated to generate data to
inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harms and health care costs related to injection drug use; therefore it be

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

Background

This resolution directs the College to support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

Supervised Consumption Facilities or Supervised Injection Sites (also known as Overdose Prevention Centers (OPCs), Drug Consumption Rooms (DCRs), and Supervised Consumption Services (SCS)) are locations where individuals can inject self-provided intravenous drugs under medical supervision in order to prevent drug overdoses and overdose deaths. SCF/SISs are intended as harm reduction strategies – in addition to providing a safe location to consume self-provided drugs staffed with trained medical personnel, they typically offer sterile consumption equipment, fentanyl test strips or other testing equipment, as well as counseling and referrals for health care, substance use treatment, and other social services. According to the Drug Policy Alliance, there are approximately 200 SIFs operating in 14 countries throughout the world. In the United States, New York City launched the country’s first such facilities in November 2021, and several other cities (including San Francisco, Boston, Seattle, and Philadelphia, among others) continue to consider them. However, since September 2014, at least one unsanctioned safe consumption site was in operation in an undisclosed U.S. city, and it is possible that other unsanctioned facilities have existed or continue to operate.

The use of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 902,000 report having used heroin in the past 12 months, according to the NIH National Survey on Drug Use and Health. According to the Centers for Disease Control and Prevention (CDC), there were an estimated estimated 107,622 overdose deaths recorded in 2021, a 15 percent increase compared to 2020. In fact, the CDC highlights that more than 932,000 people have died since 1999 from a drug overdose. This is part of an overall trend of increasing opioid overdose deaths that are directly related to overdoses from prescription opioids.

The concept of SCF/SIS have been proposed as a public health intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, hepatitis C and soft tissue infections. The establishment of these facilities in the U.S. remains a controversial topic as critics argue such policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related crime (and in fact may increase it), while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced overdose rates that help contribute to a reduced need for emergency services. Recent medical literature and study does appear to provide evidence of harm reduction, including reduced overdose deaths, lower rates of infectious disease transmission, and greater initiation of substance use disorder (SUD) treatment, without corresponding increases in crime or nuisance in the surrounding area.

There are also additional legal aspects with regard to possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that will need to be addressed if SIFs are to be established in the U.S. Several U.S. cities and the state of Rhode Island have approved the concept, but no authorized sites were actually operating until New York’s opened in November 2021. And even despite New York’s experience, their legal status under federal law remains a barrier due to recent court rulings regarding a 1986 federal law against running a venue for
illicit drug use that has, to date, prevented a similar SIS from opening in Philadelphia.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot SIFs in the U.S. that are designed, monitored and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)). Since adoption of this policy, AMA publicly supported a new Rhode Island law (including helping develop the regulations) for new sites that are expected to go into operation soon. AMA also provided background and technical assistance to multiple state medical societies considering similar legislation, including a California bill several years ago to authorize pilot sites that but was vetoed by the governor. A new bill to authorize pilot sites is currently awaiting the governor’s signature (AMA discussed with the California Medical Association but did not directly engage on the bill). And in December, 2020, the Litigation Center of the American Medical Association and State Medical Societies joined the Pennsylvania Medical Society, Philadelphia County Medical Society and about a dozen other organizations in an amicus brief, to provide information to the U.S. Court of Appeals for the 3rd Circuit that years of evidence show that these facilities provide evidenced-based medical and health interventions that help save lives, offer access to necessary services, and provide support to people who use drugs. The case continues to be battled in the courts.

The College supports the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision, and endorses SIFs as an effective public health intervention in areas and communities heavily impacted by IV drug use (Amended Resolution 31(17) Development and Study of Supervised Injection Facilities). Per this resolution, the ACEP Public Health & Injury Prevention 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.” The College also supports federal funding for syringe services programs and advocates for changes to laws to permit syringe services programs in addition to access to naloxone and educational material, as well as informing patients of the risks of fentanyl analogues and other harmful admixtures and the utilization and limitations of fentanyl test strips and other methods for testing for contaminants and adulterants (Amended Resolution 26(21) Advocacy for Syringe Service Programs and Fentanyl Test Strips).

ACEP Strategic Plan Reference

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- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Amended Resolution 26(21) Advocacy for Syringe Service Programs and Fentanyl Test Strips adopted. Directed the College to support federal funding of syringe services programs; develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use in addition to naloxone and educational material; and update harm reduction materials and resources available to members to include informing patients of the risks of fentanyl analogues and other potential harmful admixtures and the utilization and limitations of fentanyl test strips and other methods of testing for contaminants and adulterants.
Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted. Directed the College to endorse syringe services programs, promote access to these programs for people who inject drugs, educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted. Directed the College to work with the AMA in supporting the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities as an effective public health intervention in areas and communities heavily impacted by IV drug use.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to appropriate potential treatment resources after receiving medical care from the ED.

Prior Board Action

Amended Resolution 26(21) Advocacy for Syringe Services Programs and Fentanyl Test Strips adopted.

June 2019, reviewed the information paper “After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use.”

Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted.


Background Information Prepared by: Fred Essis, MBA, MA
Congressional Lobbyist

Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 33(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Telehealth Bridge Model for the Treatment of Opioid Use Disorder

PURPOSE: Support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care and advocate for state and federal regulatory and legislative solutions to permit ongoing integration of opioid use disorder treatment including medication therapy through telehealth.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, More than 100,000 Americans died of an overdose in 2021, primarily due to illicit opioids1; and

WHEREAS, The staggering number of preventable overdose deaths requires utilization of every tool at our disposal to mitigate this tragic loss of life; and

WHEREAS, Medication treatment for opioid use disorder (OUD), including buprenorphine, is associated with significant improvements in outcomes including reductions in overdose mortality, illicit substance use, incidence of infectious hepatitis and HIV, and criminal justice involvement2; and

WHEREAS, Low barrier access to buprenorphine therapy is evidence-based and recommended by the National Academy of Medicine and the American Society of Addiction Medicine2-3; and

WHEREAS, Patients evaluated on the same day as presentation are 7x more likely to engage in treatment than those who are forced to wait 2 or more days4; and

WHEREAS, Gaps in knowing where to go for treatment, difficulty accessing care, long wait times, and geographical distance from treatment providers are significant barriers to accessing evidence-based medication treatment for OUD5-8; and

WHEREAS, Delivery of buprenorphine therapy via telehealth has been found to result in comparable outcomes, report higher patient satisfaction, reduce healthcare costs, and increase access to buprenorphine therapy9; and

WHEREAS, Telehealth offers a feasible, evidence-based mechanism to overcome some barriers to care, and

WHEREAS, Emergency Department (ED) initiation of buprenorphine coupled with referral to close outpatient follow up is recommended for patients with OUD10; and

WHEREAS, A commonly cited barrier to implementing ED buprenorphine induction processes is lack of rapidly accessible follow up care11; and

WHEREAS, Only 12% of patients treated in the ED for nonfatal opioid overdoses subsequently receive medication treatment for OUD and only 28.5% of patients prescribed buprenorphine from the ED fill another buprenorphine prescription within 30 days12; and

WHEREAS, Low barrier telehealth buprenorphine treatment programs, many implemented by emergency medicine physicians, have demonstrated excellent engagement and retention in evidence-based OUD treatment using both audiovisual and audio-only platforms13; and
WHEREAS, A telehealth bridge clinic model developed and implemented by emergency physicians rapidly engaged 96% of vulnerable patients referred to it for opioid use disorder treatment on buprenorphine therapy with no significant difference between audiovisual or audio-only telehealth14; and

WHEREAS, Current low-barrier telehealth programs have been established under temporary waivers of The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 under the COVID-19 Public Health Emergency declaration; and

WHEREAS, Solutions to permit the establishment of a practitioner-patient relationship through telehealth have been proposed by emergency physicians in order to maintain access to evidence-based care for patients with opioid use disorder15; and

WHEREAS, Rapidly accessible, low barrier telehealth programs may serve as a reliable and readily available solution for ED referral for ongoing buprenorphine care following discharge regardless of geography and local addiction treatment capacity allowing for broader implementation of evidence-based ED opioid use disorder care; therefore be it

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

References
Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder

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Background

This resolution calls on ACEP to support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder (OUD) care and to advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of OUD treatment including medication therapy through telehealth into the continuum of addiction care.

ACEP believes buprenorphine is an extremely valuable tool in the emergency department (ED) to help start patients on the path towards recovery. Initiating medication assisted treatment (MAT) in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths. In addition, the available data demonstrate that patients with OUD who are started on buprenorphine in the ED – and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone). Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.

Furthermore, studies of patients with OUD have demonstrated a reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available. Finally, a study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care. In all, research suggests that the sooner we can start patients on the right path and keep them engaged in treatment, the more successful their recovery.

Despite the demonstrated effectiveness of buprenorphine, there are many regulatory barriers in place. Currently, the Drug Addiction Treatment Act of 2000 (DATA 2000), requires physicians and other health care practitioners must have an “X-waiver,” to prescribe buprenorphine to patients with OUD

Advocacy efforts by ACEP and others have been working to chip away at these barriers. ACEP believes that the X-waiver requirement is a significant barrier to MAT initiation in the emergency department. In April 2021, the government released guidance that effectively eliminated the training and mandatory certification requirements for the X-waiver.

ACEP’s lobbying efforts continue to support the Mainstreaming Addiction Treatment (MAT) Act, which would fully eliminate the waiver requirement. On June 22, 2022, the U.S. House of Representatives passed the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7660), which included the MAT Act. Current advocacy efforts are focusing on introduction and passage of a companion bill in the U.S. Senate and a final signature from the President of the United States.

ACEP has long supported legislation sponsored by emergency physician and U.S. Representative Raul Ruiz (D-CA/36th) to refine the Three-Day Rule called the Easy MAT Act. The Easy MAT Act was incorporated into a short-term funding bill that was signed into law on December 11, 2020. The law requires the Attorney General (who will delegate this to the Drug Enforcement Administration or DEA) to revise the Three-day Rule within six months so that “practitioners, in accordance with applicable State, Federal, or local laws relating to controlled substances, are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person’s use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both).” This Act required a change in the current restriction against dispensing more than one day’s worth of medication at a time, thus allowing patients to receive one day’s worth of medication while at the emergency department (ED) and then take the two remaining days of medication home. As of the date of this writing, the Attorney General has not issued this revision. In the meantime, the DEA announced on March 23, 2022, that in line with the objective of the Easy MAT Act, practitioners who wish to dispense the full three days of medication to patients at one time can make a request to DEA to receive permission to do so. Practitioners have to email the DEA to obtain approval. Requests for exception must be emailed to ODLP@dea.gov under the subject line: “Request for Exception to Limitations on Dispensing for OUD.”

Despite some regulatory successes, barriers to the treatment of OUD still exist. Existing ACEP policy supports the use of telehealth services by board-certified emergency physicians. ACEP believes that use of telehealth reduces barriers to care. With respect to telehealth and opioid use disorder (the topic of the resolution) there are few specific references in ACEP policy to the use of telehealth in this context. ACEP President Mark Rosenberg, DO, FACEP, convened a Telehealth Task Force in 2021. Contained within the task force report was a statement that ACEP should advocate for expanded use of telehealth, including prescribing of controlled substances for opioid use disorder via telehealth during the COVID-19 public health emergency (PHE).

At the beginning of the PHE, the DEA issued waivers to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients. Under the DEA’s policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with OUD without having to first conduct an examination of the patient in person or via telehealth.

The DEA also plans to issue two regulations regarding the use of telehealth to prescribe controlled substances. One rule relates to the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. The Act required an in-person medical evaluation as a prerequisite to prescribing or dispensing controlled substances, except in the case of practitioners engaged in the practice of telemedicine. The definition of the “practice of telemedicine” includes seven distinct categories that involve circumstances in which the clinician might be unable to satisfy the Act’s in-person medical evaluation requirement yet nonetheless has sufficient medical information to prescribe a controlled substance. One specific category within the Act’s definition of the “practice of telemedicine” includes a practitioner who has obtained a special registration from the DEA. However, the DEA must issue regulations to effectuate this special registration provisions. This proposed rule would permit such a special registration. The other rule would clarify the ability of clinicians with X-waivers to prescribe buprenorphine to patients with OUD via an audio-only encounter (i.e., by telephone).

Both rules are being reviewed by the Office of Management and Budget within the White House, but it is unclear when they will be issued.
ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Create awareness around the business of emergency medicine and have difficult discussions about possibilities and protections.

Fiscal Impact:

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. Directed ACEP to Recommit to the goal of reducing overdose deaths by working with various federal and state agencies, legislatures, and other stakeholders; and that ACEP continue to advocate for actions to decrease the supply of fentanyl and other drugs and to highlight the continued increase in overdoses and overdose deaths.

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 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted. Directed ACEP to oppose legislation to add naloxone to the PDMP and work with chapters in developing strategies and supporting materials to stop such legislation.

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and continue to advocate for removal of the X-waiver requirement to prescribe buprenorphine for OUD from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow-up.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment
of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

**Prior Board Action**

January 2022, discussed the recommendations contained in the Telehealth Task Force report.

October 2021, filed the Telehealth Task Force report. A workgroup of Board members was assigned to review the recommendations in the report and provide an analysis to the Board of Directors at their January 27-28, 2022, meeting.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP’s Strategic Plan was updated to include tactics to address recommendations in the report.

February 2020, approved the revised policy statement “Emergency Medicine Telehealth;” originally approved June 2016.

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

June 2019, approved the governance charter, revised accreditation criteria, and funding for the ED Pain & Addiction Management Accreditation Program.
Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder

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April 2019, reviewed the draft criteria for the ED Pain Management Accreditation Program.’

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

September 2018, approved creation of the Emergency Department Pain & Addiction Management Accreditation Program.

February 2018, approved the revised policy statement “Ensuring Emergency Department Patient Access to Appropriate Pain Treatment,” originally approved October 2012.

April 2017, approved the revised policy statement “Optimizing the Treatment of Acute Pain in the Emergency Department;” originally approved June 2009 with the title “Optimizing the Treatment of Pain in Patients with Acute Presentations.” This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.


June 2016, approved the revised policy statement “Naloxone Access and Utilization for Suspected Opioid Overdoses;” originally approved October 2015.

October 2015, approved the policy statement “Naloxone Prescriptions by Emergency Physicians.”

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.


Background Information Prepared by: Jeffrey Davis

Regulatory and External Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 34(22)

SUBMITTED BY: New York Chapter

SUBJECT: Emergency Department Safety

PURPOSE: Work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The safety of patients and staff in the Emergency Department is of utmost importance; and

WHEREAS, A 35 year-old man was shot in the arm while in the ED waiting room at Jacobi Hospital in Bronx, NY, on January 25, 2022, at 12:30 pm; and

WHEREAS, There have since been numerous additional incidents; therefore be it

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

Background

This resolution calls on ACEP to work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the emergency department (ED).

Violence in health care is a common occurrence. An ACEP survey from 2018 showed that nearly half of emergency physicians have experienced violence and 80 percent of emergency physicians said that violence was harming patient care. These trends have not improved, and we still continuously hear stories about attacks or other violent episodes from health care workers across the country. In fact, since the onset of the pandemic, violence against hospital employees has markedly increased — and there is no sign it is receding. Studies indicate that 44 percent of nurses report experiencing physical violence and 68 percent report experiencing verbal abuse during the pandemic.1

ACEP has taken an active role in trying to address the problem of violence in the ED. In 2019, ACEP partnered with the Emergency Nurses Association (ENA) to launch an ongoing campaign called “No Silence on ED Violence” to equip and empower our respective members to effect needed safety improvements at their hospitals, while engaging state and federal policymakers, stakeholder organizations and the public at large to generate action to address this crisis. A webpage was created, stopedviolence.org, to serve as a resource and advocacy hub for violence in the ED.

Furthermore, in 2020, ACEP was part of an Action Team sponsored by the National Quality Forum to identify and propose ways to overcome key barriers to appropriately responding to and reporting violent incidents in health care settings and preventing future ones from occurring. The work of the Action Team culminated with the release of an issue brief that included a specific set of priority challenges for policymakers and other stakeholders to address.

ACEP supports the “Workplace Violence Prevention for Health Care and Social Service Workers Act” (H.R. 1195, S.4182) that passed the House of Representatives in April of 2021 and was introduced in the Senate in May of 2022. This bipartisan effort takes critical steps to address ED violence by requiring the Occupational Safety and Health
Administration (OSHA) to issue enforceable standards to ensure health care and social services workplaces implement violence prevention, tracking, and response systems. ACEP also supports the Safety from Violence for Healthcare Employees (SAVE) Act, which was introduced in the House of Representatives in June of 2022. This bipartisan bill would help curb violence in the emergency department and criminalize assault or intimidation against health workers.

One of the main focuses of the 2022 Leadership & Advocacy Conference was protecting emergency physicians from ED violence. Emergency physicians at all career levels met with legislators about ED violence and asked legislators to establish important, common sense procedures to protect emergency physicians, health care workers, and patients from violence in the health care workplace.

ACEP and the American Nurses Association sent a letter to and subsequently met with the National District Attorneys Association in April 2022 to discuss state-level prosecutorial approaches to offenders who assault health care workers, asking that assailants be subject to the same penalties of those who assault airline workers.

In early 2022, The Joint Commission established and started enforcing new workplace violence prevention requirements to guide hospitals in developing strong workplace violence prevention programs. ACEP contributed to the development of these new requirements by participating in an expert workgroup and supplying comments.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement “Protection from Violence in the Emergency Department” calls workplace violence “a preventable and significant public health problem” and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled “Violence in the Emergency Department: Resources for a Safer Workplace.” The site includes links to information papers on the “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED” and “Emergency Department Violence: An Overview and Compilation of Resources.”

ACEP policy also addresses the issue of gun violence. The policy statement “Firearm Safety and Injury Prevention” calls for “funding, research, and protocols” to address the public health issue of injury and death from firearms. The policy lists six legislative and regulatory actions that ACEP supports, including funding for firearm injury prevention research, protecting physicians’ ability to discuss firearm safety with patients, universal background checks, prohibiting high-risk and prohibited individuals from obtaining firearms, restricting the sale and ownership of weapons and munitions designed for military or law enforcement use, and prohibiting 3-D printing of firearms and their components. The policy statement “Violence-Free Society” also notes that “ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives.”

In 2018, the Public Health and Injury Prevention Committee developed the information paper “Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention” that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

Reference

1E.g., Byon H, et al., Nurses’ experience with Type II workplace violence and underreporting during the COVID-19 pandemic. Workplace Health Saf. 2021 21650799211031233.

**ACEP Strategic Plan Reference**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Amended Resolution 32(21) Firearm Ban in EDs Excluding Active Duty Law Enforcement adopted. Directed ACEP to promote and endorse that EDs become “Firearm Free” Zones, with the exception of active-duty law enforcement officers, hospital security, military policy and federal agents; endorse and promote screening for weapons in the emergency department; and promote public education and academic research to decrease workplace.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths and to support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Substitute Resolution 21(14) Emergency Department Mental Health Information Exchange adopted. This resolution called for ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence and devise strategies to help emergency care providers with stakeholders to mitigate patients’ risk of self-directed for interpersonal harm and investigate the feasibility and functionality of sharing patient information under HIPAA.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Program adopted. Directed ACEP to promote awareness of hospital-based violence intervention programs and coordinate with relevant shareholders to provide resources to those wishing to establish such programs.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital’s emergency department.

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 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

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.

Amended Resolution 44(91) Health Care Worker Safety adopted. It directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

Amended Resolution 32(21) Firearm Ban in EDs Excluding Active Duty Law Enforcement adopted.

October 2019, approved the revised policy statement “Firearm Safety and Injury Prevention;” approved April 2013 with current title, replacing rescinded policy statement titled “Firearm Injury Prevention;” revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

April 2019, approved the revised policy statement “Violence-Free Society;” reaffirmed June 2013; revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).


May 2016, reviewed the information paper “Emergency Department Violence: An Overview and Compilation of Resources.”

April 2016, approved the revised policy statement “Protection from Violence in the Emergency Department;” revised and approved June 2011; revised and approved with the title “Protection from Physical Violence in the Emergency Department Environment” April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

November 2015, reviewed the information paper “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED.”

Substitute Resolution 21(14) Emergency Department Mental Health Information Exchange adopted.

August 2014, reviewed the information paper “Hospital-Based Violence Intervention Programs.”

Resolution 37(13) Establishing Hospital-Based Violence Intervention Program adopted

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Amended Resolution 11(93) Violence-Free Society adopted.

Background Information Prepared by: Erin Grossman
External Affairs Coordinator

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 35(22)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: Workplace Violence Towards Health Care Workers

PURPOSE: Advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker while at work and delivering care.

FISCAL IMPACT: Budgeted staff time and resources.

1. WHEREAS, Per the Bureau of Labor Statistics, workers in the healthcare and social service industries experience the highest rates of injuries caused by workplace violence and are five times as likely to get injured at work than workers overall1; and

2. WHEREAS, Staffing shortages throughout our healthcare workforce continue to decrease our ability to safely care for patients; and

3. WHEREAS, Safety concerns around workplace violence are a significant factor predicting who leaves the healthcare professions2; and

4. WHEREAS, Two states – Wisconsin and Utah – have been able to codify penalties against those who assault healthcare workers; and

5. WHEREAS, There are currently no federal laws penalizing violence against healthcare workers3; and

6. WHEREAS, The goal in codifying the consequent penalty for assaulting a healthcare worker is to increase workers’ sense of safety and security in order to perform their jobs; therefore be it

RESOLVED, That ACEP advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker who is at work and delivering care.

References
   - No penalty language
   - Primarily asks employers to enact policies to prevent violence and protect workers; OSHA to enforce

Background

The resolution directs ACEP to advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker while at work and delivering care.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assualted at work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening. ACEP recently completed a similar survey, intended to assess the effects of the COVID-19 pandemic on violence against emergency physicians. The results of this survey are expected to be published sometime near the 2022 ACEP Scientific Assembly.

Workplace violence continues to be a top legislative priority for ACEP’s federal advocacy efforts and was one of the three key advocacy priorities during the 2022 Leadership & Advocacy Conference in Washington, D.C. ACEP helped inform and supports the “Workplace Violence Prevention for Health Care and Social Service Workers,” (H.R. 1195/S. 4182) ensuring that the legislation gives appropriate consideration to emergency department needs, and has advocated for this legislation for several years. The legislation, which would require OSHA to require health care employers to implement violence prevention programs, was passed in the House of Representatives in April 2021 and awaits further action in the Senate. ACEP’s support for the legislation was also specifically noted during committee consideration of the bill and on the House floor during debate and final passage.

ACEP also helped inform and supports the “Safety from Violence for Healthcare Employees (SAVE) Act,” (H.R. 7961), recently-introduced bipartisan legislation that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the press release issued by the sponsors of the legislation on June 7, 2022.

In 2021, ACEP also provided input on The Joint Commission’s “Workplace Violence Prevention” project and, as a result of that work, TJC announced in June new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that went into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

In 2019, ACEP began a partnership with ENA to launch the “No Silence on ED Violence” campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED. ACEP continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better
understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers.”

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement “Protection from Violence in the Emergency Department” calls workplace violence “a preventable and significant public health problem” and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled “Violence in the Emergency Department: Resources for a Safer Workplace.” The site includes links to information papers on the “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED” and “Emergency Department Violence: An Overview and Compilation of Resources.”

ACEP Strategic Plan Reference

Advocacy – ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

Fiscal Impact

Budgeted staff time and resources.

Prior Council Action

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers, advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital’s emergency department.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.
Prior Board Action

June 2022, approved the revised policy statement “Protection from Violence and the Threat of Violence in the Emergency Department;” revised and approved with the title “Protection from Violence in the Emergency Department” April 2016; revised and approved June 2011; revised and approved with the title “Protection from Physical Violence in the Emergency Department Environment” April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.


May 2016, reviewed the information paper “Emergency Department Violence: An Overview and Compilation of Resources.”

November 2015, reviewed the information paper, “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED.”

August 2014, reviewed the information paper “Hospital-Based Violence Intervention Programs.”

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 36(22)

SUBMITTED BY: New York Chapter
EMS-Prehospital Care Section

SUBJECT: Emergency Medical Services Are Essential Services

PURPOSE: Declare EMS an essential service and engage in a public education campaign and work with the AMA and other stakeholders to actively promote the inclusion of EMS among federally- and locally-funded essential services.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Unbudgeted resources of $50,000 – $100,000, or possibly more, for a public education campaign depending on the scope and duration of the campaign.

WHEREAS, Emergency Medical Services (EMS) is widely viewed as an essential public service, as it ensures public health and safety and provides equal access to medical services; and

WHEREAS, Unlike other first responders like fire and police departments, EMS has not been defined as an essential service by the federal government; and

WHEREAS, In 39 states, EMS is not considered an essential service so local government is not required to provide it to constituents; and

WHEREAS, Not being defined as an essential service, EMS has not been supported by sustainable funding strategies; and

WHEREAS, Since the 1980s, federal support and leadership in EMS have been incrementally eroded; and

WHEREAS, In the absence of consistent and adequate funding, the result has been highly variable, fractured systems increasingly dependent on volunteer workforces; and

WHEREAS, Inconsistent funding has disproportionately impacted access to emergency services both in rural areas where system development lagged, and in urban areas where demand may outstrip available resources; and

WHEREAS, Currently access to services, training, and quality of EMS response vary greatly and exacerbate disparities in access to care; and

WHEREAS, No Federal agency oversees EMS administration, system integration and coordination, training, and quality; and

WHEREAS, Poor coordination of response may lead to inefficient practices including potentially unnecessary transports to hospitals, increased interhospital transfers, and delays in definitive intervention; and

WHEREAS, EMS providers are not required to accept insurance, and reimbursement structures have not been well defined or standardized, often resulting in outsized patient bills; and

WHEREAS, In the wake of the COVID pandemic, we have recognized that a well-organized EMS system can function as a force multiplier for local health and public health systems, and that an overwhelmed EMS system constitutes a public health hazard; therefore be it...
RESOLVED, That ACEP declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally- and locally-funded essential services.

References


Background

The resolution directs the College to declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and, work with the American Medical Association (AMA) and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services (EMS) among federally- and locally-funded essential services.

As the resolution notes, EMS is deemed an essential service in only 11 states: Connecticut, Delaware, Hawaii, Indiana, Louisiana, Nebraska, Nevada, Oregon, Pennsylvania, Virginia, and West Virginia. EMS is also not deemed an essential service at the federal level.
While no federal agency oversees EMS administration, system integration and coordination, training, and quality, in 2005, Congress established the Federal Interagency Committee on Emergency Medical Systems (FICEMS) to “ensure coordination among Federal agencies supporting local, regional, State, tribal, and territorial EMS and 911 systems. FICEMS was also created to improve the delivery of emergency medical services (EMS) throughout the nation.” The U.S. Department of Defense (DoD), Department of Health and Human Services (HHS), Department of Homeland Security (DHS), Federal Communications Commission (FCC), and Department of Transportation are all member agencies of FICEMS.

Nearly since the inception of structured EMS in the 1970s, EMS funding has been left to states and local governments, leading to a lack of national coordination and inconsistencies in EMS systems, resulting in disparate training, capabilities, personnel, and pay. Even prior to the COVID-19 pandemic, EMS agencies throughout the country have struggled with these issues and increasing difficulty in retaining volunteer EMTs, and the stresses of the COVID-19 pandemic only exacerbated these problems. As a result, the challenges of already-strained state and local budgets coupled with extreme surges in EMS demand without additional capacity (and in some cases, reduced capacity due to staffing challenges associated with COVID-19) have pushed many EMS systems to the breaking point or beyond.

However, the ability to manage EMS at the local or state levels also provides medical directors and administration of the local hospitals and EMS services the ability to meet and agree on a plan to address the specific needs of the local system. Coordination between all involved parties and an agreement to follow a planned solution is essential to the success of the system.

A 2014 analysis identified three advantages and one disadvantage to designating EMS as an essential service. The advantages are ensuring a minimum capability throughout a state, providing flexibility to organize and finance EMS systems to reflect local circumstances, and providing resources to support voluntary improvement over time, while a disadvantage is the financial burden that a statutory mandate to provide EMS imposes on counties. The paper also observed that EMS is perhaps best understood as a “‘common’ good (a good where it is difficult or impossible to exclude users from the benefit, but where there is a marginal cost to provide the benefit to additional individuals,” and as a common good, EMS systems face the challenges of financing and limiting overuse (i.e., non-urgent calls). Potential approaches to address these challenges include funding EMS maintenance and readiness costs through taxation and the marginal cost of delivering services through user fees, and that user fees could be used to deter overuse (but this effect is dependent on whether such fees are paid directly by users rather than insurers).

ACEP’s policy statement “Emergency Medical Services Interfaces with Health Care Systems” states that ACEP believes that emergency medical services (EMS) constitute an integral component in the continuum of acute medical care, and lays out a variety of principles supported by the College. Among others, these principles include acknowledging that EMS plays an essential role in the clinically effective, fiscally responsible regionalization of health care, providing acute medical assessment and interventional care contemporaneous with navigation of patients, and that appropriate funding of coordinated continuum of care systems (e.g. trauma systems) is essential to promoting the availability of regionalization of health care. Additionally, EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of health care to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients.

**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.
- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

**Fiscal Impact**

Budgeted staff resources for advocacy initiatives. Unbudgeted resources of $50,000 – $100,000, or possibly more, for a public education campaign depending on the scope and duration of the campaign.

**Prior Council Action**

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed the College to champion the principle that emergency care is an essential public service and make it a key concept in advocacy efforts on behalf of America’s emergency medical services safety net.

**Prior Board Action**

February 2018, approved the policy statement “Emergency Medical Services Interfaces with Health Care Systems.”

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 37(22)

SUBMITTED BY: New York Chapter

SUBJECT: Enhance Patient Safety and Physician Wellness

**PURPOSE:** Support the protection of the integrity of the quality improvement/patient safety/peer review process and its participants and work with chapters to identify and lobby against state laws that limit these important discussions

**FISCAL IMPACT:** Budgeted committee and staff resources for state advocacy initiatives.

WHEREAS, Medical error causes 250,000 excess deaths annually in the USA (per National Patient Safety Board); and

WHEREAS, Medical error causes “second victim syndrome,” which multiplies physician stress, impacts wellness, and factors into a disproportionately high physician suicide rate; and

WHEREAS, The medical profession’s shift from a culture of “shame and blame” to one of accepting human fallibility and building peer support (as noted in the American Medical Association (AMA) peer support declaration) is hamstrung by several state laws (such as those in CA, NY, and FL) which limit or effectively prohibit the participation of physicians in Quality Assurance (QA) reviews and Morbidity and Mortality (M&M) discussions of cases in which they were involved; and

WHEREAS, Such state laws deny physicians a safe space in which to process their feelings and take part in debriefings that would enhance coping with traumatic events; and

WHEREAS, A culture of openness and free discussion of problematic cases, especially by those directly involved, will contribute to patient safety, physician support, and enhanced learning, and must include not only institutional peer review activities, but also individual wellness sessions; and

WHEREAS, A model of full disclosure and openness exists in the airline industry and has dramatically improved airline safety, while the toll from medical error remains unacceptably high; therefore be it

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum, from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

**Background**

This resolution calls for ACEP to support the protection of all participants in discussions of cases of potential medical errors such as quality assurance (QA)/quality improvement (QI), M&M, RCA, and other patient safety forums from legal discovery. It also asks ACEP to work with state chapters to identify pending or existing state laws that will pierce the protections afforded to these patient safety discussions.
The conceptual framework of evaluating poor outcomes can be traced back to Florence Nightingale and the Crimean war. Dr. Ernest Amory Codman, a surgeon from Massachusetts General Hospital, is credited with creating a transparent process that examined patient outcomes that would later become M&M. The anesthesia study commission improved the process by discussing the cases in a confidential open forum. In 1952, the Centers for Disease Control and Prevention’s *Morbidity and Mortality Weekly Report* was first published. In 1983, the Accreditation Council for Graduate Medical Education (ACGME) recognized the importance of these patient safety discussions in physician education and they became a requirement for all training programs.

The Health Care Quality Improvement Act (HCQIA) of 1986 was designed to protect peer review activities from discoverability and established the National Practitioner Data Bank, an information clearinghouse, to collect and release certain information related to the professional competence and conduct of physicians and other designated healthcare professionals.

The Institute for Medicine (IOM) published its landmark report “To Err Is Human: Building a Safer Health System in 2000. The magnitude of the problem of medical error became clear. The report estimated that between 44,000 and 98,000 deaths per year in U.S. hospitals were attributable to medical error. The report also framed medical errors as a systems issue rather than mistakes by individuals. Creating an environment where physicians and other healthcare workers can report and examine patient safety events is essential to improving systems and patient care. Greater reporting and analysis of patient safety events will yield increased data and better understanding of patient safety events. One barrier to these discussions has been the fear of increased liability risk for physicians.

ACEP’s policy statement “Disclosure of Medical Errors” states:

“ACEP recognizes that substantial obstacles, including unrealistic expectations of physician infallibility, lack of training about disclosure of errors, and fear of increased malpractice exposure, may obstruct the free disclosure to patients of medical errors. To overcome these obstacles, ACEP recommends the following initiatives:

- Health care institutions should develop and implement policies and procedures for identifying and responding to medical errors, including continuous quality improvement (CQI) systems and procedures for disclosing significant errors to patients.
- Medical educators should develop and provide specific instruction to trainees at all levels on identifying and preventing medical errors and on communicating truthfully and sensitively with patients or their representatives about errors.
- States should enact legislation that makes apology statements by physicians related to disclosure of medical errors inadmissible in malpractice actions.”

Several other ACEP policy statements address reporting and analysis of errors, near miss, or adverse events:

“*Pediatric Readiness in the Emergency Department*”
“encourage establishing a culture of safety that encourages reporting of near miss or other adverse events that can be analyzed to provide feedback into the system in a continuous quality improvement mode.”

“*Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided*”
“Quality improvement efforts focus on peer protection and blame free disclosure to improve future processes, which would be hindered by the specter of criminal liability for routine patient care events.”

“A Culture of Safety in EMS Systems”
“EMS systems should implement and support the Just Culture approach to facilitate honest and prompt reporting of risk and error and to support analysis of near miss and adverse events in an environment of professionalism and accountability for systems and individuals.”
The Patient Safety and Quality Improvement Act (PSQIA) of 2005 passed in response to the IOM report and these concerns. It was designed to facilitate the confidential review and reporting of adverse patient events. The PSQIA created a federal peer review privilege and thereby affording substantial protections from the discovery of information related to adverse events when provided to a patient safety organization (PSO). In addition, the collection of patient safety information in relation to reporting to a PSO is also protected.

There is variability in state-based peer review protections for patient safety work. All 50 states and the District of Columbia have laws granting confidentiality and privilege protections for peer review activities. In almost all states there are exemptions from legal protections if the information is relevant to complaints involving criminal activity or discipline against a physician. The District of Columbia and 17 other states have additional gaps in protection. In the 2017 case Charles v. Southern Baptist, the Supreme Court of Florida ruled that patient safety documents were not protected from discovery. Other states (including Florida in many cases) protect patient safety documents within the Patient Safety Organization (PSO) models.

The degree to which protections are lacking for emergency medicine physicians participating in patient safety activities is unknown. Further investigation is needed to identify priority states and opportunities for policy improvement in the short- and long-term at the national, state and chapter levels.

**Background Reference**


**ACEP Strategic Plan Reference**

**Career Fulfillment** – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.

**Advocacy** – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Expand and strengthen the role, approach, and impact of state-level advocacy.

**Fiscal Impact**

Budgeted committee and staff resources for state advocacy initiatives.

**Prior Council Action**

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted. called for the College to support initiatives in several areas of peer review including that information discovered during the peer review process be kept confidential and not discoverable in any legal action.

**Prior Board Action**

June 2022, approved the policy statement “Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided.”

April 2021, approved the revised policy statement “A Culture of Safety in EMS Systems;” originally approved March 2014.

June 2018, approved the revised policy statement “Pediatric Readiness in the Emergency Department” with
Resolution 37(22) Enhance Patient Safety and Physician Wellness

the current title; revised and approved April 2009; originally approved December 2000 titled “Guidelines for the Care of Children in the Emergency Department.

April 2017, approved the revised policy statement “Disclosure of Medical Errors;” revised and approved April 2010; originally approved September 2003.

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted.

**Background Information Prepared by:**  Jonathan Fisher, MD, MPH, FACEP
Senior Director, Workforce and EM Practice

**Reviewed by:**  Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 38(22)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Focus on Emergency Department Patient Boarding as a Health Equity Issue

PURPOSE: Use legislative venues and lobbying efforts, focus regulatory bodies to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve ED capacity; and, define criteria to determine when an ED is considered over capacity and hospital action plans are triggered to activate.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives and committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed. Unbudgeted and unknown additional costs could be required if data is needed from third-party sources.

WHEREAS, Health care is focusing on social determinants of health and health equity is a primary public health concern; and

WHEREAS, Emergency department boarding has grown significantly in the last several years; and

WHEREAS, Emergency department boarding is a widespread problem and a source of patient harm, and thus health inequity; therefore be it

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

References
https://www.healthaffairs.org/do/10.1377/forefront.20220325.151088/

Background

The resolution directs the College use legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services (CMS), the Joint Commission, etc., to establish a reasonable matrix of standards including boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Emergency department boarding is a scenario where patients are kept in the ED for extended periods of time because of a lack of available inpatient beds or space in other facilities where they could be transferred. Shortages of physicians, nurses, and other health care providers across the health care continuum, exacerbated by an influx of extremely sick patients (both due to COVID-19 cases as well as non-COVID-19-related cases resulting from delayed
care during the pandemic), have significantly contributed to the growing issue of boarding.

Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location—away from the active and disruptive ED setting—have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). The EDBA report is in progress and is expected to be released by fall 2022. It is anticipated that this study will address Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding. The resolution directed the College to study financial and other incentives that might be used to reduce emergency department crowding. ACEP will assess the next steps needed to further address the resolution once the report coordinated by the EDBA is released.

ACEP issued a report in 2016, developed by the Emergency Medicine Practice Committee, “Emergency Department Crowding: High Impact Solutions.” The report was developed to identify and disseminate proven ways to decrease input, as well as novel approaches to increase throughput and increase output. This document is available on ACEP’s resource page, “Crowding & Boarding,” along with links to other relevant information papers, policy statements, resources regarding state approaches, and others.

Addressing boarding and crowding have been longstanding priorities of the College, and federal legislative and regulatory advocacy efforts continue as well. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding have also been included as key priorities in communications with Congress during the 117th Congress as legislators in both the House and Senate develop legislative efforts to address the nation’s mental health crisis, and ACEP staff continue to discuss potential solutions with legislators in both chambers.

Recently, in the Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) final rule, CMS decided to remove the electronic clinical quality measure (eCQM) version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure from the Hospital Inpatient Quality Reporting (IQR) program beginning in the calendar year 2024 reporting period. In ACEP’s comments on the FY 2022 IPPS proposed rule, we strongly opposed the removal of this measure to track how long patients wait before a decision is made to admit them—especially since ED boarding represents one of the single greatest threats to patient safety in the ED setting. ACEP’s comments also noted that unlike other clinical areas for which multiple measures may exist, ED-2 is one of only measures to track this statistic and provide incentives or enforcement to help reduce wait times and boarding.

CMS’ decision relied heavily on one meta-analysis of 12 studies that did not find a clear association between ED boarding and in-hospital mortality, thus concluding the costs associated with the measure outweigh its continued use in the program. Despite being provided with nearly 70 studies that clearly establish a link between boarding and patient mortality (many of which also detail the prevalence of psychiatric boarding), CMS finalized the policy and eliminated one of the only available measures to help track and mitigate boarding. We believe there was and continues to be validity and value in this measure and ACEP has asked Congress to work with CMS to reverse this decision, or alternatively, whether through legislative or regulatory action, develop a new and meaningful measure to determine how long an ED patient has waited before a medical decision has been made to admit the patient.
**ACEP Strategic Plan Reference**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

**Fiscal Impact**

Budgeted staff resources for advocacy initiatives and committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed. Unbudgeted and unknown additional costs could be required if data is needed from third-party sources.

**Prior Council Action**

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce Boarding of admitted patients in the emergency department.

Resolution 21(21) Diversity, Equity, and Inclusion. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and 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.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate
mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement “Boarding of Admitted and Intensive Care Patients in the ED,” work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department ‘Boarders’ adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP’s policy “Boarding of Admitted and Intensive Care Patients in the Emergency Department.” The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Prior Board Action

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

April 2021, approved the revised policy statement “Cultural Awareness and Emergency Care;” revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing “Cultural Competence and Emergency Care” approved October 2001.

April 2021, approved the revised policy statement “Non-Discrimination and Harassment;” revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled “Non-Discrimination.”

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

April 2019, approved the revised policy statement “Crowding;” revised and approved February 2013; originally approved January 2006.

October 2017, reviewed the information paper “Disparities in Emergency Care.”

April 2017, reviewed the information paper “Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management.”

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper “Emergency Department Crowding High-Impact Solutions”

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper “Crowding and Surge Capacity Resources for EDs.”

October 2006, reviewed the information paper “Approaching Full Capacity in the Emergency Department.”

Substitute Resolution 18(04) Caring for Emergency Department ‘Boarders’ adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 39(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Signage at Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs Without Onsite Physicians

PURPOSE: Advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs without onsite emergency physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, ACEP defines an emergency physician as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians; and

WHEREAS, Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety; and

WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, The 2021 ACEP EM Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; and

WHEREAS, Currently, there are workforce limitations to providing the gold standard of care in certain rural or frontier areas; and

WHEREAS, Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs) and Outpatient Emergency Departments (OEDs) have provided emergency service care to patients in rural and frontier areas; and

WHEREAS, ACEP has a policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” most recently approved March 2022; therefore be it

RESOLVED, That ACEP advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

References
3. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
Background

This resolution calls for ACEP to advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” states that ACEP “believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams.” The policy includes a set of principles that mirror the points in the “whereas” statements of the resolution.

Although the “whereas” statements reiterate ACEP’s previous-stated policies, the resolution itself focuses specifically on signs in the emergency department (ED). Therefore, it is important to understand the signage requirements under the Emergency Medical Treatment and Labor Act (EMTALA).

Section 1866(a)(1)(N)(iii) of the Social Security Act details the EMTALA-required signage for all Medicare-participating hospitals offering emergency services. Additionally, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS) have indicated that some signs are not allowed under the law.

ACEP staff emailed with the EMTALA compliance office within CMS about what signs are permitted/prohibited and received the following response:

“CMS, along with our colleagues in the Office of Inspector General of Health & Human Services, has discouraged hospitals from placing additional signage in the ED or other required hospital locations that may in any way act to deter or discourage individuals from staying for medical screening examinations and stabilizing treatment. This does not mean that all signage is prohibited. If signage is identified as a concern, hospitals would be expected to demonstrate how it is in compliance with CMS requirements and does not deter or discourage individuals from staying for statutorily required medical screening examinations.”

CMS also notes that signs posted in an ED are evaluated on a case-by-case basis. Given this, if an individual surveyor finds that the signs contemplated by this resolution “deter or discourage” patients from seeking emergency care, facilities would be subject to EMTALA related penalties/fines.

Finally, it is important to note, while EMTALA only applies to Medicare-participating hospitals, some states, such as Texas, have laws in place that impose EMTALA-type regulations on non-Medicare facilities as well. This further expands the number of facilities that may run into difficulties with the specific signage contemplated in the resolved.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
- Create awareness around the business of emergency medicine and have difficult discussions about possibilities and protections.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.
Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement by removing “offsite” supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 68(21): Patient’s Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. It directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process and provide a of findings to the Council by July 1, 2022.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Directed ACEP to review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” and to develop tools and strategies to highlight importance of EP staffing of EDs, oppose independent practice by non-physician providers (NPPs) and work to require on-site supervision of NPPs by an emergency physician.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms “Emergency Department” and “Emergency Room” as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms “emergency” or “ER” by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. Directed ACEP to define an “emergency physician” as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;” revised and approved June 2020 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;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”
Resolution 39(22) Signage at CAH, REH, and Outpatient EDs Without Onsite Physicians

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP’s Strategic Plan was updated to include tactics to address recommendations in the report.

April 2020, approved revised policy statement “Freestanding Emergency Departments;” originally approved June 2014.

January 2019, reaffirmed the policy statement “Providers of Unsupervised Emergency Department Care;” revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.


November 2015, reviewed the information paper “Freestanding Emergency Departments and Urgent Care Centers.”

July 2013, reviewed the revised information paper “Freestanding Emergency Departments;” originally developed in August 2009.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 40(22)

SUBMITTED BY: Andrew Bern, MD, FACEP
James Blum, MD
Neal Cohen, MD
Cedric Dark, MD, MPH, FACEP
Herbert Duber, MD, MPH FACEP
Steven Hardy, MD, MS
Dennis Hsieh, MD, JD
James Maloy, MD, MPH
Lisa Maurer, MD, FACEP
Sar Medoff, MD, MPP, FACEP
James Mitchiner, MD, MPH, FACEP
Utsav Nandi, MD, MSCE, FACEP
Ashley Ryles Nicholson, MD, MPH, FACEP
D.W. “Chip” Pettigrew, MD, FACEP
Kirstin Woody Scott, MD, MPhil, PhD
Thomas J Sugarman, MD, FACEP
Nikkole Turgeon, MD
Brad Uren, MD, FACEP
Mississippi Chapter
Tennessee College of Emergency Physicians
Michigan College of Emergency Physicians
Wisconsin Chapter
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Support for Medicaid Expansion

PURPOSE: Develop a policy statement in support of the expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP affirms that “all Americans must have health care coverage1;” and

WHEREAS, Provisions of the Patient Protection and Affordable Care Act intended for adults with incomes up to 138% of the federal poverty level to be eligible for Medicaid benefits in all states, and provided states that opted to expand Medicaid with enhanced federal funds for the newly Medicaid-eligible population2; and

WHEREAS, As of July 2022, 12 states have not yet expanded their Medicaid program2; and

WHEREAS, As of 2019, the uninsured rate in the 12 non-expansion states was nearly double (15.5%) as compared to the uninsured rate in expansion states (8.3%)3; and

WHEREAS, There are an estimated 3.8 million people across the 12 non-expansion states who are currently uninsured and would be newly eligible for Medicaid should it be expanded as intended by federal law3,4; and

WHEREAS, Medicaid expansion has provided coverage to millions of uninsured individuals and has shown
WHEREAS, Medicaid plays a significant role in funding emergency departments nationally as it is the primary payer for the majority of emergency department visits; and

WHEREAS, States that expanded Medicaid witnessed significant changes to emergency department payer mix, including a reduction in uninsured visits; and

WHEREAS, Follow-up care after an emergency department visit is more likely to be optimized for patients with stable Medicaid coverage relative to the uninsured; evidence has shown better access to medical care, prescription drugs, dental care, and completion of outside referrals among those with continuous Medicaid coverage relative to the uninsured who only have access at community health centers; and

WHEREAS, Follow-up care coordination and discharge planning after an emergency department visit may be more readily achievable among an increasing share of patients with stable insurance coverage, including Medicaid, which would have implications for emergency department reimbursement under alternative payment models such as the ACEP-developed Acute Unscheduled Care Model (AUCM); and

WHEREAS, Evidence has shown reductions in all-cause mortality, decreased uninsurance rates, decreased rates in delayed care due to costs, and improvements in self-reported health, as well as reductions in suicide rates among states that expanded Medicaid relative to those that have not; therefore be it

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

Resolution References
11. B. D. Sommers, K. Baicker, and A. M. Epstein, “Mortality and Access to Care among Adults after State Medicaid...
Resolution 40(22) Support for Medicaid Expansion
Page 3


Background

The resolution asks the College to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

The Affordable Care Act (ACA; P.L. 111-141-148) expanded eligibility for the Medicaid program in order to increase access to healthcare coverage for all low-income individuals and families, up to 138 percent of the federal poverty level (FPL), regardless of age, family status, or health. Prior to the ACA, Medicaid was traditionally limited to low-income children, pregnant women, adults with disabilities, and nursing home residents.

While the expansion was originally intended to apply nationwide, part of the U.S. Supreme Court’s decision in National Federation of Independent Business v. Sebelius in 2012 ruled that the Medicaid expansion in the ACA was an unconstitutionally coercive use of Congress’ spending power, as it required states to significantly and rapidly extend Medicaid coverage to new beneficiaries or lose all federal Medicaid funding. As a result, Medicaid expansion is voluntary, and as of 2022, thirty-eight states and the District of Columbia have expanded Medicaid. The states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

As a result, there are more than an estimated 2.2 million American adults in what is known as the “Medicaid Coverage Gap,” where their incomes are below the federal poverty level (i.e.: too low to qualify for tax credits through the ACA marketplaces), but too high to qualify for their state’s Medicaid program. Additionally, many individuals have seasonal, sporadic, or otherwise temporary employment that can lead to eligibility fluctuations or “churn” within the Medicaid program. These fluctuations can disrupt patient access to care, negatively affect health outcomes, and add substantial administrative burden to state Medicaid programs. While children under 19 years of age have continuous eligibility for twelve months either through the Children’s Health Insurance Program (CHIP) or Medicaid, the vast majority of states do not offer continuous eligibility for adults. Analysis indicates that continuous eligibility can stabilize coverage for adults with only a modest increase in total medical costs, but this may balance out due to lower administrative costs associated with churn.

The federal government pays 90 percent of the costs of covering individuals eligible as a result of the expansion, with states covering the remaining 10 percent. States that have not expanded Medicaid receive only their normal Medicaid funding. Since 2013, Medicaid and CHIP enrollment has increased by 53 percent, and a 2022 report indicates that more than 21 million people have gained health insurance coverage since the passage of the ACA in 2010. The COVID-19 pandemic also drove a significant increase in Medicaid enrollment due to the financial impact of job loss and income disruption. In order to provide stability, given the uncertainties for the economy and labor market due to the pandemic, the federal government required states to maintain continuous Medicaid coverage until the end of the COVID-19 public health emergency (PHE). After the end of the PHE, Medicaid enrollees will have their eligibility redetermined, but states will have 12 months to perform those eligibility redeterminations.

Proponents of Medicaid expansion note that there are many added benefits of expansion besides just the increased access to health care for vulnerable populations. These include lower overall health care spending in expansion states, lower rates of evictions, lower amounts of debt sent to collections, a greater likelihood of children receiving their annual checkups, greater adherence to medication, increased early detection of cancer due to wider access to screenings and preventive care, lower mortality rates, and increased access to opioid and substance use disorder treatment.

The resolution authors accurately note that specifically for the emergency department, expanded Medicaid coverage results in a decrease in uninsured visits that are often unpaid or low-pay. While some states initially experienced higher ED volumes post-expansion, the longer-term trends appear to reduce hospitalizations and increase overall
professional revenue due to the increased number of patients with some form of insurance coverage. Additionally, there have been reductions health care disparities for minority populations, though these reductions are lower than what had been expected by policymakers and analysts. Additionally, expansion states were better positioned to respond to the COVID-19 public health emergency, especially for minority and other historically underserved populations that experienced significant disparities in impacts and health effects of COVID-19.

Opponents of Medicaid expansion cite ongoing state budget challenges, noting that covering even the 10 percent portion of the costs associated with the expansion population amounts to a significant or unfeasible additional cost for already-strained state budgets, with some further noting that Medicaid costs often grow faster than overall revenue. Some also view Medicaid as a low-quality option for healthcare coverage that is higher cost, has low competition, features limited healthcare options, and does not increase access to quality care. Others have noted that Medicaid payment rates to physicians are substantially lower than other payers and often only cover a small fraction of the actual costs of providing care, so increasing Medicaid coverage rather than increasing access to other private coverage options will cost Medicaid providers more in the long run.

ACEP’s policy statement, “Universal Health Care Coverage,” states that ACEP believes:

- All Americans must have health care coverage;
- Health care coverage will contain a benefits package that provides for timely, unrestricted access to quality emergency care;
- Any benefit package should reflect generally accepted standards of medical practice supported by outcome-based evidence, where available.

Specifically related to Medicaid, ACEP policy opposes the imposition of copays for Medicaid beneficiaries seeking care in the ED, as well as the imposition of work requirements mandating employment or the pursuit of employment for Medicaid beneficiaries to obtain or retain access to health insurance coverage. ACEP also supports the extension of Medicaid coverage to 12-months post-partum and developed resources that were distributed to chapters for state advocacy initiatives. ACEP has not taken an overall public position in favor or in opposition to Medicaid expansion specifically.

Background Reference

1 Wisconsin is a unique case as the only non-expansion state that does not have a coverage gap. Though the state has not opted to expand Medicaid under the ACA, Wisconsin’s Medicaid program covers all low-income adults up to 100% FPL (and thus only receives its normal level of federal Medicaid funding).

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.
- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources.
Resolution 40(22) Support for Medicaid Expansion
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**Prior Council Action**

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted. Directed ACEP to oppose mandatory work requirements for Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted. The resolution directed that ACEP support the extension of Medicaid coverage to 12 months postpartum.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted. Directed ACEP to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED and submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

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.

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.

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.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Prior Board Action**

June 2022, approved the policy statement “Work Requirements for Medicaid Beneficiaries.”


October 2019, approved the policy statement “Opposition to Copays for Medicaid Beneficiaries.”

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted.
Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted.

July 2018, reviewed the information paper “Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine.”

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.


Substitute Resolution 31(14) Financing 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.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.


Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Congressional Affairs Director

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
2022 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 41-58

Reference Committee C – Emergency Medicine Practice
Resolutions 41-58

Dan Freess, MD, FACEP (CT) Chair
Andrea Austin, MD, FACEP (CA)
Lisa M. Bundy, MD, FACEP (MS)
Antony P. Hsu, MD, FACEP (MI)
James D. Maloy, MD, MPH (DC)
David Nestler, MD, MS, FACEP (MN)

Jonathan Fisher, MD, FACEP
Travis Schulz, MLS, AHIP
RESOLUTION: 41(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section

SUBJECT: Addressing Stigma in the Emergency Department

PURPOSE: Develop an educational program to identify and address stigma in the ED that can be provided to residency programs as a standard part of residency training.

FISCAL IMPACT: Budgeted committee and section resources. Unbudgeted additional staff resources of potentially 10-50 hours depending on the scope of the project and potential partnership with EMRA and CORD. There may also be an opportunity for grant funding.

WHEREAS, Stigma is a negative attitude or idea about a mental, physical, or social feature of a person or group of people; and

WHEREAS, Stigma, in healthcare, is a set of negative and often unfair beliefs held by clinicians about patients with a particular condition; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions can be associated with higher rates of unemployment, higher rates of homelessness, decreased self-esteem, and lower quality of life for those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions is associated with a higher mortality for those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions can result in clinicians withholding certain treatments from those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions causes patients to feel shame about their conditions and not disclose those conditions to their treating providers; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions causes patients to avoid medical care so as to avoid feeling stigma; and

WHEREAS, Stigma by clinicians against patients with substance use has contributed to rising rates of overdose deaths in the United States; and

WHEREAS, Providing education to clinicians about stigma against patients reduces the amount of stigma that patients experience; and

WHEREAS, Using person-first language such as “patient with diabetes” instead of labeling language such as “diabetic” can reduce amount of stigma that patients experience; and

WHEREAS, Avoiding the use of inherently judgmental terms in healthcare such as “dirty urine” and replacing them with objective terms such as “abnormal urine toxicology screen” can reduce the amount of stigma that patients experience; therefore be it

RESOLVED, That ACEP develop an educational program on identifying and addressing stigma in the emergency department that can be provided to residency programs as a standard part of residency training, highlighting the role of important practices such as person-first language.
Background

This resolution requests ACEP to develop an educational program to identify and address stigma in the ED that can be provided to residency programs as a standard part of residency training.

Stigma in health facilities undermines diagnosis, treatment, and successful health outcomes. Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health. Health condition-related stigma may be experienced in all spheres of life; however, stigma in health facilities is particularly egregious, negatively affecting people seeking health services at a time when they are at their most vulnerable, such as patients presenting to emergency departments. Within the health system, stigma toward a person living with a specific disease undermines access to diagnosis, treatment, and successful health outcomes. Additionally, stigma is a threat to public health as it influences health outcomes in many ways by carving pathways to health disparities.

ACEP has worked to address stigma in various patient populations such as patients with substance use disorder, sickle cell disorders, and patients who are part of the LGBTQ community. The ACEP Public Health & Injury Prevention Committee also developed the information paper Stigma in the Emergency Department.

On January 23, 2020, ACEP convened a summit, “Addressing the Opioid Stigma in the Emergency Department.” The summit gathered a diverse group of organizations and representatives to discuss and share ideas to gain insight into the prevalence, effect, and targeted solutions to limit the impact of stigma on the care of ED patients with opioid use disorder (OUD). ACEP is part of a large coalition of national professional organizations that make up the Opioid Response Network (ORN), which is led by the American Academy of Addiction Psychiatry and funded by the Substance Abuse and Mental Health Services Administration. Through targeted breakout sessions that developed specific recommendations based on consensus, attendees developed concrete strategies to reduce stigma and improve the experience for ED patients with opioid use. Attendees used stories from ED patients with OUD and recommendations for previously enacted successful strategies from other professional organizations to develop these strategies. ACEP also hosted the Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop and topics covered in the workshop included everything from setting up a ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.

Sickle cell disease (SCD), while considered a rare disease, is the most common genetic blood disorder and affects approximately 100,000 Americans, primarily of African and Hispanic descent. Individuals with SCD can experience multiple life-threatening problems during their lifetime. Much of their acute care is delivered in the emergency department (ED), yet patients often relate poor experiences in this setting. In recognition of the need to improve the care offered to patients with SCD in the ED, ACEP collaborated with multiple public, private, and professional partners and created the Emergency Department Sickle Cell Care Coalition (EDSC3). Its purpose is to provide a national forum dedicated to the improvement of the emergency care of patients with SCD in the United States.

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.

Development of an education program could include involvement with several ACEP committees (Academic Affairs, Education, Public Health & Injury Prevention, Diversity, Equity, & Inclusion) and sections (Pain Management & Addiction Medicine and Social Emergency Medicine) as well as partnership with the Emergency Medicine Residents’ Association (EMRA) and the Council of Residency Directors in Emergency Medicine (CORD). The scope of the project could range from a PowerPoint presentation to a comprehensive education module, development of a paper, development of a webinar, etc.
ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
  - Objective 2 – Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.
  - Objective 3 – Empower members, through tools and information, to advocate for themselves within their own workplaces, regardless of employment model.

Fiscal Impact

Budgeted committee and section resources. Unbudgeted additional staff resources of potentially 10-50 hours depending on the scope of the project and potential partnership with EMRA and CORD. There may also be an opportunity for grant funding.

Prior Council Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed ACEP to support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training; and develop an online peer mentoring platform for emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted. Directed ACEP to 1) amend the policy statement “Naloxone Prescriptions by Emergency Physicians” to include endorsement for Take Home Naloxone programs; 2) seek to increase distribution of naloxone from the ED; 3) promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose; 4) advocate for regulatory and payment reform for reimbursement to hospitals and EDs for naloxone dispensed directly to patients; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and 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.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP to work directly with the DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis; advocate to the DEA and SAMHSA for ED-specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; and 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 ED setting.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. It called for ACEP to promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues, work with the AMA and state medical societies to advocate for changes by state medical boards for protections for licensure for physicians that seek help and treatment, and partner with other stakeholders to investigate the effectiveness and quality of Physician Health Programs.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care was adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about a
physician’s mental health to more appropriately address impairment vs. illness.

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

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted.

April 2021, approved the revised policy statement “Non-Discrimination and Harassment;” revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled “Non-Discrimination.”

October 2020, reviewed the information paper Stigma in the Emergency Department.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders was adopted.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.

October 2017, reviewed the information paper “Disparities in Emergency Care.”

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 42(22)

SUBMITTED BY: Arkansas Chapter

SUBJECT: Emergency Department/Emergency Medicine Experience for Residents from Other Specialties

PURPOSE: Develop a policy statement supporting a required rotation in emergency medicine for residents in other specialties and further collaborate with the ACGME Review Committees to include requirements for emergency medicine rotations for residents in other specialties.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine or emergency department experience is an important part of the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements of many specialties; and

WHEREAS, The ACGME Program Requirements for Emergency Medicine residencies provide clear and concrete requirements for training site resources, patient volume, patient acuity, and faculty qualifications; and

WHEREAS, The ACGME Program Requirements of other specialties lack these requirements, leading many residents from other specialties to receive inadequate Emergency Medicine experience in low resource, low volume, and/or low acuity departments from unqualified faculty; and

WHEREAS, The ACGME Program Requirements for Emergency Medicine make little mention of residents from other programs, stating only that they shall not interfere with the education of Emergency Medicine residents; therefore, be it

RESOLVED, That ACEP establish policy to appreciate and support the efforts of other specialties to require emergency department or emergency medicine experience of their residents, with specific support for the equity of their experience with that of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to reaffirm existing requirements that residents from other specialties do not detract from the education of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to expand the program requirements for emergency medicine regarding the education of residents from other services; specifically stating that the following requirements apply equally:

a. Training site resources (e.g., clinical support personnel).
b. Training site volume and acuity, with sites for these residents subject to the same requirements as the primary clinical site for emergency medicine residents.
c. Qualifications of faculty members supervising these residents.
d. Designation of a physician qualified to supervise emergency medicine residents as a core faculty member of the other residency or residencies who is responsible for the emergency medicine experience of that residency.; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and other specialties to reference emergency medicine new requirements in the requirements for other residencies that require emergency department or emergency medicine experience (e.g., internal medicine, family medicine, transitional year, etc.) such that the required experience is substantially similar for all residents and specifically all residents who
require emergency medicine or emergency department experience should receive a substantially similar experience at training sites with or without an emergency medicine residency regarding:

a. Training site resources.
b. Training site volume and acuity.
c. Faculty qualifications.
d. Designation of a core faculty member, qualified to supervise emergency medicine residents, responsible for the emergency medicine experience of the residency.

Background

This resolution asks ACEP to develop a policy statement supporting a required rotation in emergency medicine for residents in other specialties and further collaborate with the Accreditation Council for Graduate Medical Education (ACGME) Review Committees to include requirements for emergency medicine rotations for residents in other specialties.

The ACGME is an independent not-for-profit organization that sets and monitors educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. The ACGME oversees the accreditation of residency and fellowship programs in the US. In the 2021-2022 academic year, there are 12,740 accredited residency and fellowship programs in 182 specialties and subspecialties. Specialty-specific committees (Review Committees) create a uniform set of high standards for each accredited specialty and subspecialty applied across all accredited US residency and fellowship programs educating and training physicians in those fields to ensure the highest quality physicians and patient care.1

Residents from other specialties who rotate in the emergency department are often referred to as off-service residents. An emergency medicine rotation provides off-service residents with an appreciation of the unique aspects of the specialty. Off-service residents will gain an understanding of the treatment approach to the undifferentiated patient, the concept of an appropriate ED work-up, the process of decision making with incomplete information in a time-sensitive manner, and the skills for effective communication with consultants and colleagues. They will also learn about the constraints that drive this different approach and the strategies emergency physicians use to provide excellent patient care. In the past, the ACEP Academic Affairs Committee developed a national standardized curriculum for off-service resident education during an emergency medicine rotation.2

ACEP has a related policy statement focusing on medical students, “Guidelines for Undergraduate Education in Emergency Medicine.” The policy states that ACEP “believes that all medical students should be taught the basic principles of emergency medicine in order to recognize a patient requiring urgent or emergency care, initiate evaluation and management, and provide basic emergency care.” It also states that, “every medical student should receive clinical exposure to emergency department patients and care” and “should be driven by experts board certified in the field of emergency medicine.”

The Council and the Board of Directors adopted Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools that directed ACEP to advocate that all U.S. medical schools, allopathic and osteopathic, require formal exposure to the specialty of emergency medicine, including but not limited to a formal clerkship or other activities to ensure that graduating medical students understand the role of emergency departments and the practice of emergency medicine. Over the last year, ACEP has met with ACGME leadership multiple times. We have leveraged our relationship with the organization, as well as other emergency medicine partners, to identify and enforce new standards that will sustain the highest quality, comprehensive training for all emergency medicine residencies. ACEP will continue to build on this foundation and will continue working to ensure all residents receive quality training in emergency medicine.

Background References

1https://www.acgme.org/about-us/overview/

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools adopted. ACEP to advocate that all U.S. medical schools, allopathic and osteopathic, require formal exposure to the specialty of emergency medicine, including but not limited to a formal clerkship or other activities to ensure that graduating medical students understand the role of emergency departments and the practice of emergency medicine.

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted. Directed ACEP to continue to promote the development of academic divisions/departments of emergency medicine in all medical schools, work with UA/EM to encourage the implementation of the published “Guidelines for Undergraduate Education in Emergency Medicine” by all medical schools and adopt a position statement encouraging the requirement of a clinical rotation in emergency medicine as a graduation criterion for all medical schools.

Prior Board Action

June 2021 approved the revised policy statement “Guidelines for Undergraduate Education in Emergency Medicine;” revised June 2015 and April 2008; reaffirmed October 2001; revised January 1997; originally approved September 1986.

Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools adopted.

June 2017, approved the revised policy statement “Academic Departments of Emergency Medicine in Medical Schools;” reaffirmed April 2011 and September 2005; approved March 1999; originally approved November 1974.

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 43(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section

SUBJECT: Endorsing ED Resident Competency in Buprenorphine Initiation

PURPOSE: 1) Support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and 2) coordinate with other organizations in emergency medicine to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The opioid crisis continues to escalate, exacerbated by the COVID-19 pandemic, with > 107,000 U.S. deaths in the past 12 months; and

WHEREAS, Patients present to the ED with opioid overdose, complications of opioid use, and seeking treatment for opioid use disorder (OUD) and with few options for treatment initiation 24/7 as the ED can provide; and

WHEREAS, Buprenorphine treatment is associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and health care costs1-6; and

WHEREAS, Buprenorphine treatment initiated in the ED is associated with reduction in illicit opioid use and significant increase in post-ED addiction treatment8; and

WHEREAS, Regulations governing buprenorphine treatment and, specifically, ED buprenorphine treatment continue to evolve; and

WHEREAS, The Department of Health and Human Services released practice guideline exemptions on April 27, 2021, indicating that physicians are no longer required to complete dedicated buprenorphine or opioid use disorder treatment training in order to apply for an X-waiver9; and

WHEREAS, Many emergency physicians are not comfortable with initiating or prescribing buprenorphine treatment due, in part, to a lack of experience or training10; and

WHEREAS, Emergency medicine residents may care for patients with opioid withdrawal and opioid use disorder who will need initiation of opioid agonist treatment and will provide care for patients with opioid use disorder after residency in many practice locations whether urban or rural; and

WHEREAS, Increasing the comfort level and implementation of evidence-based buprenorphine and other opioid use disorder interventions in the ED will improve the care provided to patients and reduce individual and societal harms associated with opioid use and overdose; and

WHEREAS, Current residency training requirements are not adequately preparing residents to treat patients with OUD, as highlighted by responses from a 2020 survey in which only 135/288 (46.9%) reported any experience prescribing buprenorphine in the ED and 140/288 (48.6%) reported they have or will receive X-waiver training during residency for readiness to provide buprenorphine with referral to treatment11; and

WHEREAS, Brief trainings focused on buprenorphine initiation targeting EM clinicians have been shown to promote understanding of the ED use of buprenorphine and translate into clinical practice12; and
WHEREAS, The ACEP Board has supported the development of consensus recommendations on the treatment of ED patients with OUD, including the initiation of buprenorphine13; and

WHEREAS, The ACEP Council has consistently reaffirmed the importance of ED buprenorphine treatment in recognition of the large and growing body of evidence supporting such interventions; therefore be it

RESOLVED, That ACEP support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources such as clean syringes, naloxone, and fentanyl test strips, depending on local practice and availability.

References

Background

The resolution calls for ACEP to support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.
Residency training is structured to systematically address the pathology and treatment of disease encountered in the emergency department. Residents are trained to make lifesaving diagnoses and perform complex procedures. The data supporting the initiation of buprenorphine in the emergency department are clear and compelling, but many current EM residents have not received training on its use. Current residency training requirements are not adequately preparing residents to treat patients with OUD, as highlighted by responses from a 2020 survey in which only 135/288 (46.9%) reported any experience prescribing buprenorphine in the ED and 140/288 (48.6%) reported they have or will receive X-waiver training during residency for readiness to provide buprenorphine with referral to treatment.

Emergency medicine residents care for patients with opioid withdrawal and opioid use disorder who need initiation of opioid agonist treatment and brief trainings focused on buprenorphine initiation targeting EM clinicians have been shown to promote understanding of the ED use of buprenorphine and translate into clinical practice. They will provide care for patients with opioid use disorder after residency in many practice locations whether urban or rural and increasing the comfort level and implementation of evidence-based buprenorphine and other opioid use disorder interventions in the ED within residents will improve the care provided to patients and reduce individual and societal harms associated with opioid use and overdose.

ACEP recently launched the Substance Use Disorder Emergency Medicine Residency Curriculum. This was a collaboration between ACEP, ABEM, CORD, and EMRA that led to the development of a curriculum for emergency medicine residency programs. This curriculum aims to teach residents about SUD disease processes and evidence-based treatment options, reduce stigma, and empower emergency physicians to actively engage patients in treatment. The learning objectives for the Substance Use Disorder (SUD) Curriculum with the focus on Emergency Medicine (EM) and EM Residents were identified using the objectives from the comprehensive SUD curriculum for Medical Professionals and conducting a two-part modified Delphi to prioritize and focus objectives pertinent to and relevant for EM. The curriculum is comprised of approximately 20-minute modules covering: Introduction to Opioids, Treatment and Management of Opioid Use Disorder, Alcohol and Benzodiazepines, Tobacco, Cannabis and Vaping, Stimulants, and Special Populations.

In addition, ACEP has also developed:

- [Buprenorphine in the ED Point of Care tool](#) that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.
- [Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes](#)
- A series of [free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED](#).
- [Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop](#). Topics covered in the workshop covered everything from setting up an ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- [E-QUAL Network Opioid Initiative](#)

The American Board of Emergency Medicine (ABEM) Model of the Clinical Practice of Emergency Medicine (EM Model) serves as the basis for the content specifications for all ABEM examinations. The ABEM 2019 EM Model lists and classifies the following relevant topics in Medical Knowledge, Patient Care, and Procedural Skills:

- Opioid use disorder (14.1.6 and 17.1.2.3) – Critical
- Medication-assisted treatment (MAT) – Emergent

**ACEP Strategic Plan Reference**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.
Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed ACEP to support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training; and develop an online peer mentoring platform for emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. The resolution called for ACEP to recommit to the goal of reducing overdose deaths by working with various federal and state agencies, legislatures, and other stakeholders and that ACEP continue to advocate for actions to decrease the supply of fentanyl and other drugs and to highlight the continued increase in overdoses and overdose deaths.

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted. Directed ACEP to oppose legislation to add naloxone to the PDMP and work with chapters in developing strategies and supporting materials to stop such legislation.

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and continue to advocate for removal of the X-waiver requirement to prescribe buprenorphine for OUD from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of insurance status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow-up.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.
Resolution 43(22) Endorsing ED Resident Competency in Buprenorphine Initiation

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

February 2021, approved “Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department.” The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.


Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

June 2019, approved the governance charter, revised accreditation criteria, and funding for the ED Pain & Addiction Management Accreditation Program.

April 2019, reviewed the draft criteria for the ED Pain Management Accreditation Program.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

September 2018, approved creation of the Emergency Department Pain & Addiction Management Accreditation Program.

February 2018, revised and approved the policy statement “Ensuring Emergency Department Patient Access to
**Appropriate Pain Treatment;**” originally approved October 2012.

April 2017, approved the revised policy statement “Optimizing the Treatment of Acute Pain in the Emergency Department;” originally approved June 2009 with the title “Optimizing the Treatment of Pain in Patients with Acute Presentations.” This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.


June 2016, approved the revised policy statement “Naloxone Access and Utilization for Suspected Opioid Overdoses;” originally approved October 2015.

October 2015, approved the policy statement “Naloxone Prescriptions by Emergency Physicians.”

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

**Background Information Prepared by:** Sam Shahid, MBBS, MPH  
Practice Management Manager

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 44(22)

SUBMITTED BY: Amit Arwindekar, MD, FACEP
Howard K Mell, MD, FACEP

SUBJECT: Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants

PURPOSE: 1) Revise current policy statements regarding the role of NPs and PAs working in the ED; 2) Advocate with CMS and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing/reimbursement purposes.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Nurse practitioners (NPs) and physician assistants (PAs) have become increasingly present in emergency departments (ED) across the country over the last 10 years; and

WHEREAS, The original intent of using NPs and PAs in EDs was to augment emergency care with physician-led teams; and

WHEREAS, NPs and PAs are now being used to displace qualified emergency physicians even where there is an adequate supply of such physicians; and

WHEREAS, The practice of replacing board-certified/eligible emergency physicians (EPs) with NPs and PAs is being increasingly used by staffing organizations to improve their financial position and not to ensure quality of care; and

WHEREAS, The training, experience, and competencies of a qualified emergency NP and PA is undefined and therefore inconsistent; and

WHEREAS, NPs and PAs are increasingly handling the full scope of medical cases, including critically ill and complicated patients; and

WHEREAS, The essential training, knowledge, and skills required to handle the full scope of emergency medical problems is clearly defined by the American Board of Emergency Medicine as necessary to diagnose and manage serious emergency conditions; and

WHEREAS, ACEP has a responsibility to the specialty of emergency medicine, both patients and board-certified EPs, to advocate for the essential credentials of NPs and PAs qualified to treat all patients in EDs; and

WHEREAS, Those EPs who are charged with working alongside NPs and PAs may be held responsible for the care provided by such NPPs as well as to provide back-up management of NP and PA patients as well as primary care of their own patient load; and

WHEREAS, This supervisory responsibility may exceed that capacity of EPs working as well as confer excessive liability; therefore be it

RESOLVED, That ACEP adopt as policy, a position that every patient presenting to an emergency department should be assessed, in person, by a board-certified/board-eligible emergency physician as defined by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine
Resolution 44(22) Competencies of Independent Emergency Medicine NPs and PAs
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RESOLVED, That ACEP adopt as policy a position that if no board-certified/board-eligible emergency physician is available, that the absolute minimum standard to providing emergency care is that every patient presenting to an emergency department is assessed, in person, by a licensed physician who is board certified/board eligible in an medical specialty as defined by the American Board of Medical Specialties or the American Osteopathic Association, or who was formerly so certified and is now a member of an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy, a position that nurse practitioners and physician assistants should never practice emergency medicine without in-person, real-time physician supervision; and be it further

RESOLVED, That ACEP advocate with the Centers for Medicare & Medicaid Services and third-party payers to exclude care provided by a nurse practitioners and physician assistants without in-person, real-time physician supervision from the definition of emergency medicine for the purposes of billing or reimbursement.

Background

This resolution calls for the College to adopt as policy three positions pertaining to the use of only physicians to assess, in person, every patient presenting to an emergency department.

- The first position would establish that every patient presenting to the ED be assessed, in person, by a Board certified/board-eligible emergency physician.
- Barring that, the second position would establish that every patient presenting to the ED be assessed, in person, by another licensed physician.
- The third position further asserts that NPs and PAs should never practice emergency medicine without in-person, real-time physician supervision.

These positions are discordant with two current ACEP policies:


Specific changes requested in this resolution would:

1. Remove the current exception that permits off-site, real-time supervision by an emergency physician via telemedicine for CMS-designated Critical Access Hospitals and Rural Emergency Hospitals.
2. Add ‘formerly (ABEM/AOBEM) board-certified’ individuals to the group of emergency physicians (as defined by ACEP) who can care for patients and provide supervision.
3. Add non-EPs to provide supervision when an EP is not available, provided they are licensed, board certified in some medical specialty as defined by ABMS or AOA and a member of an alternative board.

In addition, it calls for the College to advocate with the Centers for Medicare and Medicaid Services (CMS) and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing/reimbursement purposes.

ACEP’s existing policy regarding the role of NPs and PAs was revised in March 2022. The policy states unequivocally that NPs and PAs should not practice independently in the ED.

“ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.”

The policy further states that the gold standard for care in the ED is the emergency physician as defined by ACEP.
“Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine. ²”

The policy also states that the emergency physician who supervises a PA or NP should be on-site and have the opportunity to be involved in the care of all patients seen by that PA or NP.

“The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided “Onsite” or “Offsite” as defined below.¹

For all patients being cared for by a PA or NP within the ED, the on-duty emergency physician should solely determine which level of supervision is appropriate. ¹”

However, current policy does allow for “off-site” supervision through telemedicine in federally designated Critical Access Hospitals and Rural Emergency Hospitals.

“The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided “Offsite” by telehealth means are as follows:

○ Critical Access Hospitals (CAHs)
○ Rural Emergency Hospitals (REHs). ¹”

ACEP’s policy statement “Definition of an Emergency Physician” states:

“An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.

It should be noted that residents in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency in Emergency Medicine are “Emergency Medicine Resident Physicians.” ²”

The multi-organizational Emergency Physician Workforce Task Force reported on a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Despite an increased supply of emergency physicians and higher salaries, in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

In terms of the fourth resolved, ACEP does not have the authority to dictate the billing or reimbursement practices of the government’s regulatory agencies, particularly in terms of how it reimburses other medical groups.

**Background References**

Resolution 44(22) Competencies of Independent Emergency Medicine NPs and PAs

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ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty’s future.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement by removing “offsite” supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) Review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department.” 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 25(14) CME for Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP develop a policy statement recommending that NPs and PAs working in EDs or urgent care settings obtain 25 CME credits in emergency care annually.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. The resolution asked ACEP to develop a define an emergency physician as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.
Prior Board Action

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;” revised and approved June 2020 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;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement.

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers (APP) in the emergency department (ED).


June 2012, reviewed the information paper “Physician Assistants and Nurse Practitioners in Emergency Medicine.”

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, discussed the recommendations of the Staffing Task Force.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the survey results.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 45(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Offsite Supervision of Nurse Practitioners and Physician Assistants

PURPOSE: Revise the current policy “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The American College of Emergency Physicians (ACEP) defines an emergency physician as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians; and

WHEREAS, Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety; and

WHEREAS, ACEP has long supported physician-led teams in the emergency department, where emergency nurses (RNs), nurse practitioners (NPs), physician assistants (PAs), pharmacists and others play an integral role as part of a multidisciplinary team; and

WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, ACEP has a policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” most recently approved March 2022; therefore be it

RESOLVED, That the ACEP policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

References
3. [https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/](https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/)

Background

This resolution asks the College to revise the current policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department,” so that onsite emergency physician presence to supervise nurse practitioners and physicians be stated as the gold standard for staffing all emergency departments.
ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” states unequivocally that nurse practitioners (NPs) and physician assistants (PAs) should not practice independently in the ED:

“ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.”

It further states that the gold standard for care in the ED is the emergency physician as defined by ACEP:

“Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.”

It also states that the emergency physician who supervised a PA or NP should be on-site and have the opportunity to be involved in the care of all patients seen by the PA or NP:

“The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided “Onsite” or “Offsite” as defined below.

For all patients being cared for by a PA or NP within the ED, the on-duty emergency physician should solely determine which level of supervision is appropriate.”

However, the current policy statement does permit “off-site” supervision through telemedicine in federally designated Critical Access Hospitals and Rural Emergency Hospitals:

“The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided “Offsite” by telehealth means are as follows:
○ Critical Access Hospitals (CAHs)
○ Rural Emergency Hospitals (REHs).”

This resolution seeks to clarify that such off-site, real-time supervision by an emergency physician via telehealth for CMS-designated Critical Access Hospitals and Rural Emergency Hospitals is not the gold standard.

There is on-going work to establish an ED accreditation program within ACEP. A task force, created in early 2021, has completed its work and presented its report to the Board in June 2022. Their recommendations were based on current ACEP policy statements including the updated “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department.” A second task force has been appointed to further develop proposed criteria and develop a business plan for the program. It is anticipated that such a program will have greater impact than our policy statements.

The task force report included a discussion of the lack of emergency physicians in rural areas. This subject has also been addressed in all of the previous rural emergency medicine task forces. All of the prior rural EM task forces have supported the concept of supervision of NPs and PAs via telehealth in rural, low volume hospitals. The most recent task force highlighted a few sites where this has been implemented, such as Mayo. It should be noted, however, that currently these rural programs do not require telehealth supervision of all patients. The emergency physician is able to view patient information such as age and chief complaint and may request involvement in any patient care.

The multi-organizational Emergency Physician Workforce Task Force report in 2020 included a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Even with the increased supply of emergency physicians
and higher salaries, there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

**ACEP Strategic Plan Reference**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement by removing “offsite” supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department.” 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

**Prior Board Action**

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all
tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;” revised and approved June 2020 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;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.


April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement “Providers of Unsupervised Emergency Department Care;” revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the ED.

June 2012, reviewed the information paper “Physician Assistants and Nurse Practitioners in Emergency Medicine.”

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the results of the surveys.

**Background Information Prepared by:** Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs
Reviewed by:  Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
               Melissa W. Costello, MD, FACEP, Vice Speaker
               Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION:  46(22)

SUBMITTED BY:  Illinois College of Emergency Physicians

SUBJECT:  Safe Staffing for Nurse Practitioner and Physician Assistant Supervision

PURPOSE: Make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Nurse Practitioners (NPs) and physician assistants (PAs) have become increasingly common in emergency departments; and

WHEREAS, Physician-led teams in emergency medicine are critical to patient safety; and

WHEREAS, Board-certified/eligible emergency physicians are often asked to supervise more NPs and PAs and more patients than is safe for patient care; and

WHEREAS, Those emergency physicians who are charged with working alongside NPs and PAs may be held responsible for the care provided by such NPs and PAs as well as to provide back-up management of NPP patients in addition to the primary care of their own patient load; and

WHEREAS, Such supervisory responsibility confers significant liability on the emergency physician; therefore be it

RESOLVED, That ACEP research and make recommendations regarding the minimum staffing ratios of physicians to nurse practitioners and physician assistants, taking into account appropriate variables (such as patient acuity, non-physician provider competencies, available clinical resources, etc.) to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Background

This resolution calls for the College to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

ACEP’s policy statement “Staffing Models and the Role of the Emergency Department Medical Director” places the responsibility for staffing models (ratios) on the local ED medical director.

“...it is the responsibility of the emergency department (ED) medical director to identify the most appropriate local staffing model to achieve operational efficiency while maintaining clinical quality and physician-directed or supervised care.”

“Though multiple staffing models utilizing physicians and other clinicians exist, the needs of each individual ED are unique. The utilization and distribution of staff within the ED should be determined at the site level by local ED leadership, who are responsible for and/or have a role in staff hiring, training/onboarding, and supervision.”

“The medical director and other local physician leaders should be responsible for establishing local
processes and practices that ensure both sufficient physician training/onboarding and availability, as well as the opportunity for safe supervision of other clinicians to ensure clinical quality.”

ACEP’s policy statement “Emergency Department Planning and Resource Guidelines” states “the medical director of the ED and the director of emergency nursing should assess staffing needs on a regular basis.” It further states:

“staffing patterns should accommodate the potential for unexpected arrival of additional critically ill or injured patients. A plan should exist for the provision of additional nursing, physician assistant, advanced practice registered nurse, and physician support in times of disaster, natural or man-made.”

Additionally, the policy statement “Emergency Physician Rights and Responsibilities” states that:

“Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment.”

ACEPs recently revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” affirms that PAs and NPs should not perform independent, unsupervised care in the ED:

“The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided “Onsite” or “Offsite” as defined below.”

“The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided “Offsite” by telehealth means are as follows:

- Critical Access Hospitals (CAHs)
- Rural Emergency Hospitals (REHs)”

“Since the supervising emergency physician is not physically present when providing “Offsite Supervision,” the PA or NP caring for the patient MUST discuss ALL patients with the supervising physician.”

“Emergency physicians should always have the authority and opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP while they are on duty. Emergency physicians must be allowed to determine their level of interaction, care, and involvement for patients seen by a PA or NP under their supervision.”

This policy also notes that:

“Multiple staffing models utilizing PAs and NPs exist. The use of PAs and NPs in the ED should be determined at the site level by local ED physician leadership, who are responsible for PA/NP hiring, supervision, and credentialing of clinical privileges. These emergency physician leaders should be responsible for establishing processes and practice standards that ensure both sufficient physician availability for PA and NP supervision as well as adequate physician opportunity to supervise.”

ACEP policy does not address specific ratios for emergency physicians or other staff. Currently, only California specifies a set nurse:patient ratio based on a unit’s specialty. For the ED, that is one nurse for every four patients. Massachusetts has a set ratio of nurse:patient for the ICU. During the pandemic, over half of California’s hospitals
were granted waivers that permitted nurse:patient ratios in the ED of 1:6. Looking at other specialties, anesthesia has several models of providing oversight to Certified Registered Nurse Anesthetists (CRNAs). In the medical direction where anesthesiologists are involved in key portions of the patient’s care, there is a physician:CRNA ratio of 1:4.1 The Accreditation Council for Graduate Medical Education (ACGME) has a guideline for supervision of residents based on a patient per hour model that the attending physician would have to oversee. This ratio is set at 4.0 patients per faculty hour or less averaged over the year, but applies these to only adult critical care areas, not fast track or urgent care areas.2

A recent multi-organization emergency medicine work group led by ACEP to raise the bar on ACGME emergency medicine program requirements recommended reducing this number to 3.0 patients per hour as part of a set of recommendations to improve resident education.

Background References

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement by removing “offsite” supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1) Review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department.” 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the
development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

**Prior Board Action**

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” revised and approved June 2020 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;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement.


April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

April 2020, approved the policy statement “Staffing Models and the Role of the Emergency Department Medical Director.”

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments.

**Background Information Prepared by:** Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs
Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 47(22)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Unbiased Outside Agency Report for Nurse Practitioner Schools

PURPOSE: Work with the AMA to call for an unbiased outside agency survey and report of NP schools to provide recommendations for NP reform to improve the quality of NP education and to improve patient care.

FISCAL IMPACT: Budgeted AMA Section Council on Emergency Medicine and staff resources.

WHEREAS, Medical school education had a rapid proliferation of schools in the early 1900s; and
WHEREAS, Medical education was not nationally standardized, which led to the decrease in quality of physicians, decrease in quality of patient care, and decrease in confidence patients had for physicians; and
WHEREAS, The AMA created the Council on Medical Education in 1904, which contracted with an outside agency, the Carnegie Foundation for the Advancement of Teaching, which chose an unbiased surveyor Abraham Flexner to evaluate all medical schools and provide recommendations for medical school reform; and
WHEREAS, The Flexner Report recommended that American medical schools enact higher admission and graduation standards, and higher standards for medical school teachers and teaching facilities; and
WHEREAS, The Flexner Report recommendations helped standardize medical school education for the United States, and improved the quality of medical education and patient care; and
WHEREAS, Nurse practitioner education has had a significant proliferation of schools, including online programs; and
WHEREAS, Nurse practitioner schools do not have national standards for admissions and graduation; and
WHEREAS, Nurse practitioner schools do not have national standards for clinical education, clinical preceptors, and clinical locations; and
WHEREAS, ACEP has joined the AMA Scope of Practice Partnership (SOPP); therefore be it
RESOLVED, That ACEP work with the American Medical Association and call for an unbiased outside agency survey and report of nurse practitioner schools to provide recommendations for nurse practitioner reform to improve the quality of nurse practitioner education and to improve patient care.

Background

This resolution calls for the College to work with the American Medical Association (AMA) to call for an independent agency to review and make recommendations for standards for the education of Nurse Practitioners (NPs).

There has been tremendous growth in the use of NPs in the emergency department (ED). According to Medicare claims data, the numbers of NPs submitting emergency medicine (EM) claims each year increased 99 percent between the years 2012 and 2018. It is estimated that EDs employ between 14,000-16,000 NPs. Currently, 24 states have granted NPs independent practice, which is also known as “full practice authority.” This growth has been even more dramatic in rural...
settings where NPs may see patients without an onsite physician.

ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” states unequivocally that NPs and PAs should not practice independently in the ED.

“ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.

The policy further states that the gold standard for care in the ED is the emergency physician as defined by ACEP:

“Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.”

When the role of NPs was originally envisioned in the 1960s, it was designed to fill the void in primary care. However, now NPs practice in a variety of clinical settings. NPs must choose a population to focus on – family, adult, pediatrics, psychiatry, or women’s health – each with different credentialing bodies. Family NPs (FNP) is the most common pathway to emergency medicine as it provides exposure to a wide range of age groups; however, the training is focused mostly on outpatient primary care. NPs graduate with either a master’s degree or doctorate of nursing practice. There is no standard around education or population focus required to work in the ED. While many NP programs call for 500-1000 hours of post bachelor’s healthcare experience, this is not a standardized requirement. There are NP programs that allow direct entry without any prior nursing experience. NPs can be hired to work in the ED immediately upon completion of schooling, as opposed to physicians who require an additional 3-4 years of residency training in emergency medicine after medical school. NP schools typically require 500 clinical hours as opposed to the 5,000 hours of medical school and 10,000 hours of EM residency.1 There is currently a pathway to emergency NP (ENP) certification based on training in FNP. As of September 2021, only 1,514 NPs are certified as ENPs, meaning that about 90% of NPs working in EDs are not certified.

A recent study by Lavin, et al, analyzed the education of NPs practicing in the ED and found wide variation in training. Further, there is no uniform consensus over education and certification standards. There are multiple accrediting bodies for NP programs, each with different standards and requirements. Students graduating from FNP programs are able to choose two different accrediting bodies to sit for certification. Often programs lack alignment between education and future scope of practice.3

When it comes to licensure, each state has its own legal scope of practice. In some states, NPs have the authority to diagnose, order, and interpret diagnostic tests, manage treatments, and prescribe medications, while other states place restrictions on these activities, requiring either collaborative agreements or delegation/supervision from other health care professionals.

Independent review of current training, educational, standards, certification, and scope of practice for nurse practitioners would help identify strengths, weaknesses, and inconsistencies in preparation for practice in the ED setting and provide useful information to ACEP members involved in training, hiring, supervising, or evaluating ED nurse practitioners.

Background References
2. Analysis of Nurse Practitioners’ Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments
ACEP Strategic Plan

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted AMA Section Council on Emergency Medicine and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement by removing “offsite” supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department”; 2) develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs; 3) oppose the independent practice of emergency medicine by non-physician providers; and 4) develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 25(14) CME for Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP develop a policy statement recommending that NPs and PAs working in EDs or urgent care settings obtain 25 CME credits in emergency care annually.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically-based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

January 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” policy statement.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2012, reviewed the information paper “Physician Assistants and Nurse Practitioners in Emergency Medicine.”

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take no further action on Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, discussed the recommendations of the Staffing Task Force.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the survey results.

**Background Information Prepared by:** Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 48(22)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: ED Staffing at Critical Access Hospitals, Rural Emergency Hospitals, Outpatient EDs
PURPOSE: Endorse that PAs or NPs have a minimum of 5-years experience working in an ED with onsite supervision before working in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH), or Outpatient Emergency Department (OED).
FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP defines an emergency physician as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians; and

WHEREAS, Emergency physicians and their patients have a right to adequate emergency physician, nurse and ancillary staffing, resources, and equipment to meet the acuity and volume needs of the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety; and

WHEREAS, ACEP has long supported physician-led teams in the emergency department, where emergency nurses (RNs), nurse practitioners (NPs), physician assistants (PAs), pharmacists and others play an integral role as part of a multidisciplinary team; and

WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, The 2021 ACEP EM Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; and

WHEREAS, Currently, there are workforce limitations to providing the gold standard of care in certain rural or frontier areas; and

WHEREAS, Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs) and Outpatient Emergency Departments (OEDs) have provided emergency service care to patients in rural and frontier areas; and

WHEREAS, ACEP has a policy statement “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department” most recently approved March 2022; therefore be it

RESOLVED, That ACEP endorse that before a physician assistant or nurse practitioner can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH) or Outpatient Emergency Department (OED) that they have a minimum of five years of experience working in an emergency department with onsite supervision.

References
3. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
Background

This resolution asks ACEP to endorse as a standard that physician assistants (PAs) or nurse practitioners (NPs) have a minimum of five years experience working in an emergency department with onsite supervision before they can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH), or Outpatient Emergency Department (OED).

A CAH is a designation by CMS to provide essential access to high-quality healthcare in rural communities. A REH is a new classification established by the Consolidated Appropriations Act 2020 that allows a CAH to convert to REH. Under this designation, REH would provide emergency services, observation care, and additional medical and health outpatient services vital to the rural community. An OED is an outpatient location of a hospital that offers only emergency services and is not located on the grounds of a main licensed hospital. OEDs are governed at the state level and generally restricted to underserved areas and rural settings.

CAH, REH, and OEDs function in rural environments where there is a shortage of qualified emergency physicians. Rural EDs represent 53% of all hospitals in the U.S. and 24% of total ED patient volume. Only 8% of all EPs (not necessarily ABEM/AOBEM certified) work in rural EDs and only about 2% work in very low volume ED’s.¹

ACEP’s Rural Emergency Care Task Force Report in 2020 highlighted some important challenges facing rural emergency medicine. The task force recognized the discrepancies in the quality of care between urban and rural sites and work to encourage emergency medicine residency trained/emergency medicine board certified physicians to migrate to those rural EDs. Despite a 28% increase in emergency medicine residency positions over the past 10 years, there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. A survey conducted by the task force revealed that “31% of NPs and 45% of PAs reported that they work independently in their ED (no physician onsite and virtually no presence of a supervising physician)” The task force actions items included that ACEP “develop a recommended knowledge and experience base for PAs and NPs who are working in rural areas.”

ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” delineates the importance of real-time supervision of PAs and NPs and creates an allowance for qualified emergency physicians to provide supervision “Offsite” by telehealth in CAHs and REHs. This policy also states “the ED Medical Director should have the authority to approve both departmental credentialing and for the granting of clinical privileges for PAs and NPs working in the ED.”

A public opinion poll performed in August 2021 demonstrated that the vast majority of patients (78%) most trust physicians to lead their medical care in an emergency. Additionally, people view 24/7 access to the ED as one of the most essential services the community can provide.²

ACEP’s ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, “Definition of an Emergency Physician.” ACEP’s policy statement “Emergency Department Planning and Resource Guidelines” states “the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force’s recommendations.”
Resolution 48(22) ED Staffing at CAH, REH, and Outpatient EDs
Page 3

Background References
1 https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/
2 ACEP. Poll: adults view 24/7 access to the ER essential and prefer care lead by physicians in a crisis. https://www.emergencyphysicians.org

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.
- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact
Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) review and update the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;” 2) develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs; 3) Oppose the independent practice of emergency medicine by non-physician providers; and 4) Develop strategies, including legislative solutions, to require onsite supervision of non-physicians by an emergency physician.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to 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 in legislation that impacts rural communities; seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

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.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.
Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

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 Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations to establish a curriculum and clinically based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

**Prior Board Action**

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.


Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.


October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.
August 2017, reviewed the information paper “Delivery of Emergency Care in Rural Settings.”

April 2017, reaffirmed policy statement, Definition of an Emergency Physician; originally approved June 2011.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2012, reviewed the information paper “Physician Assistants and Nurse Practitioners in Emergency Medicine.”

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP’s potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit.

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP’s role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

May 2001, accepted the report of the Staffing Task Force.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the results of the surveys.
Resolution 48(22) ED Staffing at CAH, REH, and Outpatient EDs

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**Background Information Prepared by:** Kelly Peasley
ED Pain & Addiction Management Accreditation Manager
Staff Liaison, Rural Emergency Medicine Section

Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 49(22)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Enhancing Rural Emergency Medicine Patient Care

PURPOSE: 1) support initiatives to encourage placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; 2) support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and 3) support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-boarded physicians, physician assistants, and nurse practitioners already working in rural EDs.

FISCAL IMPACT: Budgeted staff resources for committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed.

WHEREAS, Patients in many rural emergency departments (EDs) are not afforded care provided by an emergency medicine (EM)-trained/boarded physician; and

WHEREAS, The national standard outside ACEP has already been determined to allow for non-boarded emergency medicine physicians to serve in rural facilities; and

WHEREAS, Patients in rural EDs deserve care that is consistent with emergency care provided in urban counterparts (or locations with 24/7 board-certified emergency medicine coverage); and

WHEREAS, Rural EDs, compared to their urban counterparts, are resource limited, financially stressed, experience higher interfacility transfer rates, and are more likely to experience prolonged ED holds due to an under-resourced EMS system; and

WHEREAS, Current technology exists to support opportunities to provide a virtual emergency medicine evaluation by a board-certified emergency medicine physician; and

WHEREAS, The current threshold for credentialing privileges to work in a rural ED, for physicians, physician assistants, and nurse practitioners, commonly consists of simply holding certifications in ACLS, ATLS, and PALS; therefore be it

RESOLVED, That ACEP support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; and be it further

RESOLVED, That ACEP support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and be it further

RESOLVED, That ACEP support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

References
Background

This resolution asks the College to:

1. Support initiatives that encourage the placement of emergency medicine-trained and board-certified medical directors in all U.S. EDs, whether in person or virtual.
2. Support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board-certified physicians.
3. Support the creation of a minimum standard for training partnered with emergency medicine trained and board-certified local or virtual bedside support for all non-boarded physicians, physician assistants, and nurse practitioners already working in rural EDs.

ACEPs policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” addresses the first resolved. It states:

- EDs should have a Medical Director who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.” It also states that care by an emergency physician is the “gold standard.”

ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” addresses the second resolved. It states:

- ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.
- The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided “Onsite” or “Offsite” as defined below.
- While there are ongoing efforts to achieve the gold standard of all ED care being provided by an emergency physician, ACEP believes that there are, at the present time, workforce limitations to specific types of CMS-designated facilities located in rural or frontier areas where emergency physicians may provide supervision of an PA/NP in an ED through telehealth means.
- The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided “Offsite” by telehealth means are as follows:
  ○ Critical Access Hospitals (CAHs)
  ○ Rural Emergency Hospitals (REHs).

ACEP has had three separate task forces in the past several years to address the issue of attracting emergency physicians to practice in a rural area. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates, conducted by Ed Salsberg, PhD, at George Washington showed that few, if any, of those who answered the survey took jobs in the rural area, despite the fact that those jobs paid an average of $100,000 more in compensation and included loan forgiveness programs. Though they were not asked directly why they did not take rural positions, they
were asked the major factors for their decision. The most common responses were spouse job needs and to be near family.

ACEP’s ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, “Definition of an Emergency Physician.” ACEP’s policy statement “Emergency Department Planning and Resource Guidelines” states “the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force’s recommendations.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
- Provide resources, roadmaps, education, and networks to assist members in identifying career opportunities and having career fulfillment based on different interests or at different life stages.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty’s future.

Fiscal Impact

Budgeted staff resources for committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to 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 in legislation that impacts rural communities; seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

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.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.
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 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 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

June 2022, approved the revised policy statement “Rural Emergency Medical Care;” originally approved June 2017 titled “Definition of Rural Emergency Medicine.”

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;” revised and approved June 2020 with the current title; revised and approved June 2013 titled “Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.


October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.


Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

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.

August 2017, reviewed the information paper “Delivery of Emergency Care in Rural Settings.”

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP’s role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

**Background Information Prepared by:** Sandra M. Schneider, MD, FACEP  
Senior Vice President, Clinical Affairs

**Reviewed by:**  Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 50(22)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Supporting Emergency Physicians to Work Rural

PURPOSE: 1) support and encourage emergency medicine trained and board-certified emergency physicians to work in rural EDs; 2) work with CORD to establish a training program for EM residents with an interest to work rural; and 3) ACEP work with the ACGME to increase resident exposure to rural EM.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine (EM) workforce is saturated in urban and suburban EDs; and

WHEREAS, EM trained and board certified physicians are under-represented in rural EDs; and

WHEREAS, Patients in rural areas are especially vulnerable, suffering from higher age adjusted mortality, greater rates of chronic disease, increased high risk behaviors and decreased life expectancy when compared to urban patients1-3; and

WHEREAS, Many rural EDs have unique care challenges that may not be part of standard EM residency training (e.g., inpatient care, labor and delivery care, neonatal resuscitation, emergency medicine observation care); and

WHEREAS Delays in transfer of EM patients (EMS limitations, hub site capacity, workforce shortages) require prolonged and extended care in the ED; therefore be it

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work rural; and be it further

RESOLVED, That ACEP support working with the Accreditation Council for Graduate Medical Education to increase resident exposure to rural emergency medicine.

Resolution References
Background

This resolution calls for ACEP to encourage emergency trained and board-certified emergency physicians to work in rural EDs; work with the Council of Residency Directors in Emergency Medicine (CORD) to establish a training program for emergency medicine residents with interests to work in rural areas; and work with the Accreditation Council for Graduate Medical Education (ACGME) to increase resident exposure to rural emergency medicine.

Attracting emergency physicians to a rural area is an ongoing concern. In 2020, the Rural Emergency Care Task Force Report highlighted the important challenges facing rural emergency medicine. Rural EDs represent 53% of all hospitals in the U.S. and 24% of total ED patient volume. Only 8% of all emergency physicians (not necessarily ABEM/AOBEM certified) work in rural EDs and only about 2% work in very low volume EDs. The task force recognized the discrepancies in quality of care between urban and rural sites and the existing work to encourage emergency medicine residency trained/emergency medicine board certified physicians to practice in rural EDs.

Despite the rapid growth in emergency medicine residency programs, and the need for emergency medicine trained physicians in rural areas, a recent analysis shows that the majority of new EM residency positions/programs were added to states where training programs already exist. Rural states continue to have limited, or even, no emergency medicine residencies.

The multi-organizational Emergency Physician Workforce Task Force reported on a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Despite an increased supply of emergency physicians and higher salaries, in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

The Rural Task Force actions items included a goal to “reduce barriers involving the credentials of a “supervising physician with the ACGME Review Committee for Emergency Medicine (RC-EM)” and to “collaborate with CORD and EMRA to increase the options for rural ED rotations.” A recent multi-organization emergency medicine work group led by ACEP to raise the bar on ACGME emergency medicine program requirements also recommended residencies should provide exposure/training in rural emergency medicine and an opportunity for a rural elective.

ACEP’s ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, “Definition of an Emergency Physician.” ACEP’s policy statement “Emergency Department Planning and Resource Guidelines” states “the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force’s recommendations.

Background References
1https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.
Resolution 50(22) Supporting Emergency Physicians to Work Rural
Page 3

- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to 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 in legislation that impacts rural communities; seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

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.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

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 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.
Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

June 2022, approved revised policy statement with revised title “Rural Emergency Medical Care,” June 2017, originally approved policy statement titled “Definition of Rural Emergency Medicine.”


Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.


Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.


January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper “Delivery of Emergency Care in Rural Settings.”

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

April 2017, Reaffirmed policy statement, Definition of an Emergency Physician; originally approved June 2011.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit.
February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP’s role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

**Background Information Prepared by:**  Kelly Peasley
ED Pain & Addiction Management Accreditation Manager
Staff Liaison, Rural Emergency Medicine Section

Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

**Reviewed by:**  Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 51(22)

SUBMITTED BY: Dennis Hsieh, MD, JD
Laura Janneck, MD, FACEP
Nikkole Turgeon, MD
Social Emergency Medicine Section

SUBJECT: Implementation of Social Determinants of Health Screening in the ED

PURPOSE: Support and encourage screening for social determinants of health with validated tools paired with feasible and appropriate responses.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Social determinants of health (SDH) influence overall health outcomes to a greater degree than medical care alone1; and

WHEREAS, ACEP seeks to improve the recognition of, and attention to, social determinants of health (SDH) by supporting research of evidence-based SDH screening and interventions in the ED3; and

WHEREAS Changes in reimbursement may incentivize emergency departments to implement screening tools for social determinants of health; and

WHEREAS, The field of emergency medicine is still developing evidence-based, comprehensive, and standardized ED screenings to SDH; and

WHEREAS, Effectively addressing SDH includes not only screening but also interventions, including advocacy, community collaboration, and program development; therefore be it

RESOLVED, That ACEP support screening for social determinants of health with validated tools; and be it

RESOLVED, That ACEP encourage screening for social determinants of health to be paired with feasible and appropriate responses.

References
1. Centers for Disease Control and Prevention // Social Determinants of Health

Background

This resolution calls for ACEP to support and encourage screening for social determinants of health with validated tools paired with feasible and appropriate responses.

The World Health Organization (WHO) defines SDH as “the non-medical factors that influence health outcomes.
They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.” The WHO further notes the influence of these factors and notes that numerous studies suggest that SDH account for between 30-55% of health outcomes.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians handle more than 25% of all acute care encounters in the U.S. and more than half of such visits for the uninsured. The ED functions as society’s “safety net,” and thus, has been identified by some to be an ideal environment for identifying and intervening upon SDH that play a role in overall patient health. EDs are seeing a growing demand to better respond to patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) include categories of potential health hazards related to a patient’s socioeconomic or psychosocial environment, and other factors that can influence their health status. Despite the growing knowledge surrounding the health implications of unaddressed SDH and disparities in care, some in emergency medicine are concerned that increasing the focus on SDH could overburden already overwhelmed EDs and interfere with the ED’s primary mission of caring for acute medical issues. Advocates for SDH screening inclusion argue that treating patients adequately without addressing SDH increases the likelihood that patients will return. However, many emergency physicians express concerns that screening will add costs, identify issues for which there is a lack of available follow up services, and the potential for a negative impact on ED throughput. One study of a SDH screening process found that while they were able to systematically screen and refer for needs, that an effective SDH screening program needed to ensure buy-in from staff as well as the availability of referral resources within the community.

EDs already do some screening for certain social determinants of health. For example, many nursing triage protocols include a screen for intimate partner violence. However, there is no widely accepted systematic screen for social determinants of health, nor consensus on what domains to screen for. Different screens over the years have examined different domains, including tobacco use, alcohol use, financial problems, and food insecurity and examples of these are Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences (PRAPARE), HealthBegins Upstream Risks Screening Tool & Guide and the Health Leads Screening Toolkit.

In 2017, ACEP hosted thought leaders in social emergency medicine to hold a consensus conference to establish the framework for how to incorporate social context within the structure and practice of emergency medicine. Around the same time, the Social Emergency Medicine Section was formed. Other efforts within the College include calling on the House Committee on Ways and Means to address SDH and racial health inequalities, responding to RFIs addressing health equity, and working through other regulatory processes to address structural SDH issues.

ACEP’s policy statement “Safe Discharge from the Emergency Department” states: “ACEP recognizes the social, societal, and physical determinants of health that often affect patients discharged after an emergency encounter, but also recognizes that there are unique procedural and resource limitations that differentiate inpatient and emergency department (ED) discharges. As such, ACEP believes the decision to discharge a patient from the ED should be a clinical decision by the emergency department physician or provider who cares for that patient and deems the patient stable and safe for discharge. ACEP opposes local, state, federal, and other externally mandated “safe” discharge requirements that supersede the clinical judgment of a treating emergency physician or provider.”

ACEP’s policy statement Social Work and Case Management in the ED” and the Policy Resource & Education Paper (PREP) “Social Work and Case Management in the Emergency Department” address the importance of access to community resources for medical and social reasons after discharge from the emergency department. The policy statement affirms that ACEP “supports the development and maintenance of case management services that are available to ED patients, that such services include appropriate clinical personnel as well as partnerships with community-based organizations, governmental agencies, and other appropriate entities to ensure prompt access to community services for its patients.”

ACEP’s policy statement “Human Trafficking” supports EDs including approaches to interfacing with outside entities such as social service organizations to care for patients.

ACEP also launched the educational module: “Determining What Matters: A Pragmatic Approach to Social Determinants of Health In and Outside of the ED” and microeducation: Social Determinants of Health.
Resolution 51(22) Implementation of Social Determinants of Health Screening in the ED

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ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients
- Provide resources, roadmaps, education, and networks to assist members in identifying career opportunities and having career fulfillment based on different interests or at different life stages.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- Using a systematic approach, identify two or three viable career options for emergency physicians that expand the practice of acute, unscheduled care

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Amended Resolution 56 (21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.


Amended Resolution 26 Addressing Systemic Racism as a Public Health Crisis adopted. The resolution directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health, including systemic racism as it pertains to emergency care; continue to explore models of health care that would make equitable health care accessible to all; and continue to use its voice as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed ACEP to promote the inclusion of social workers and/or care coordinators within the ED team, educate hospitals on including social workers in team-based care, compile best practices on ED care models that included social workers or care coordinators, and advocate for payment for care coordination services in emergency medicine.

Prior Board Action

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department was adopted.

Amended Resolution 56 (21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.
Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

October 2020, approved the revised policy statement “Social Work and Case Management in the ED” with the current title; revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled “Patient Support Services.”


February 2020, approved the revised policy statement “Human Trafficking;” originally approved April 2016.

Amended Resolution 50(19) Social Work in the Emergency Department was adopted.

June 2019, approved the policy statement “Safe Discharge from the Emergency Department.”

**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Practice Management Manager

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 52(22)

SUBMITTED BY: Social Emergency Medicine Section

SUBJECT: Minimum Standards of Care for Health-Related Social Needs in the ED

PURPOSE: Appoint a task force or committee to identify minimum standards of care for health-related social complaints in the ED, acknowledging the standards are advisory in nature and must be reflective of standards that can be reasonably achieved in all ED, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

FISCAL IMPACT: Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

WHEREAS, The emergency department has, since its founding, been a critical element of the health care safety net; and

WHEREAS, The COVID-19 pandemic has highlighted the need to integrate care for health-related social needs in the emergency department; and

WHEREAS, There has recently been a growth in interest from hospitals and emergency departments in providing socially conscious care in the emergency department; and

WHEREAS, No standards of care addressing health-related social needs in the emergency department currently exist; therefore be it

RESOLVED, That ACEP appoint a task force or committee to identify minimum standards of care for health-related social complaints in the emergency department, acknowledging that these standards are only advisory in nature and must be reflective of standards that can be reasonably achieved in all emergency departments, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

Background

This resolution asks ACEP to appoint a task force or committee to identify minimum standards of care for health-related social complaints in the ED, acknowledging the standards are advisory in nature and must be reflective of standards that can be reasonably achieved in all ED, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings and submit a report to the 2023 Council.

The health of a population depends upon several factors, including disease, public health initiatives, and the social determinants of health (SDH). As the only place in the US health care system where patients cannot be turned away for inability to pay, the emergency departments (EDs) see a disproportionate share of low-income and uninsured patients. These factors often converge in the ED where the impact of social conditions such as homelessness, low-literacy, and poverty lead to recidivism and may contribute to moral injury for emergency physicians and others in the health care continuum. Further, we know that physician moral injury is directly correlated to a personal sense of disempowerment to effect change in the work environment. However, questions remain about population-level SDH measurement and payment implications and about how to assess and address SDOH during health service delivery. The Institute of Medicine and the Center for Medicare and Medicaid Services have focused on identifying social needs and recommend that clinical systems screen for food and housing insecurity, financial strain, transportation,
childcare, education, employment, mental health needs, exposure to violence, and social isolation. Screening tools that include questions about social needs have predicted emergency department revisits and inpatient admissions after an emergency department visit. However, there could be improved guidance for clinicians about how to best integrate social needs assessment into clinical care and access to resources.

ACEP’s policy statement “Emergency Department Planning and Resource Guidelines” states:

“Emergency departments (EDs) should possess the staff and resources necessary to evaluate all individuals presenting to the ED. The ED should have the capabilities to provide or arrange treatment necessary to stabilize patients who are found to have an emergency medical condition. Because of the unscheduled and episodic nature of health emergencies and acute illnesses, experienced and qualified physician, nursing, and ancillary personnel should be continuously available to meet those needs.”

EDs are beginning to take ownership of social determinants of health for their patients and there are examples of successful social emergency medicine interventions focusing on the development of coordinated care models providing ED patients in need with comprehensive medical and social services, however there are no current standards of care addressing health-related social needs in the emergency department currently exist. The first “standard” document for hospital standardization was adopted by the American College of Surgeons in 1919 and ultimately evolved into the Joint Commission on Accreditation of Hospitals in 1951, and the Joint Commission on Accreditation of Healthcare Organizations in 1987. In 2021, the WHO published the Classification and Minimum Standards for Emergency Medical Teams.

ACEP has not previously established minimum standards of care but there are multiple relevant policy statements that provide guidance on emergency department resource allocation, staffing, etc., such as:

- Emergency Department Planning and Resource Guidelines
- Freestanding Emergency Departments
- Geriatric Emergency Department Guidelines
- Pediatric Readiness in the Emergency Department
- Pediatric Readiness in Emergency Medical Services Systems

In June 2022, the Board of Directors approved moving forward with development of a business plan for an ED Accreditation program. The accreditation program will include tiers based on staffing levels and other criteria.

**ACEP Strategic Plan Reference**

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

**Fiscal Impact**

Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder meeting/task force depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

**Prior Council Action**

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and
Resolution 52(22) Minimum Standards of Care for Health-Related Social Needs in the ED
Page 3

push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

Resolution 35(21) Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals adopted. Directed ACEP to support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; and support rural health services research, including financial analyses of rural hospitals to better define the optimal funding model for rural critical access hospitals and rural emergency hospitals.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed ACEP to promote the inclusion of social workers and/or care coordinators within the ED team, educate hospitals on including social workers in team-based care, compile best practices on ED care models that included social workers or care coordinators, and advocate for payment for care coordination services in emergency medicine.

**Prior Board Action**

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Resolution 35(21) Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals adopted.

October 2020, approved the revised policy statement “Social Work and Case Management in the ED” with the current title; revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled “Patient Support Services.”


**Background Information Prepared by:** Sam Shahid, MBBS, MPH
Practice Management Manager

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 53(22)
SUBMITTED BY: Pennsylvania College of Emergency Physicians
SUBJECT: Law Enforcement and Intoxicated Patients in the ED

PURPOSE: Investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine the need for an in-person evaluation and encourage law enforcement to remain with any patients brought to the ED for evaluation who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP believes that workplace violence is a preventable and significant public health problem, and that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department; and

WHEREAS, Patients in police custody have been involved in 29% of shootings in emergency departments, with 11% occurring during escape attempts; and

WHEREAS, Half of emergency physicians report that >50% of assaults against healthcare workers in the ED are committed by patients intoxicated from drugs and/or alcohol; and

WHEREAS, Substance intoxication is a leading characteristic among perpetrators of workplace violence presenting with an altered mental state; and

WHEREAS, >75% of emergency physicians report that violence in the emergency department has impacted patient care, including loss of productivity of staff, emotional trauma to staff, increased wait times as staff are otherwise occupied, less focus of staff after an incident, and other mechanisms; and

WHEREAS, A large majority of emergency physicians report that violent patients have threatened to return and harm emergency department staff; and

WHEREAS, Emergency physicians believe the largest contributing factor to violence in the emergency department is lack of adequate consequence or response to attackers; and

WHEREAS, Patients in custody have rights to informed consent and refusal of medical interventions and rights to privacy and confidentiality that are similar to those of other patients; therefore be it

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

Background References
Background

This resolution asks ACEP to explore alternative methods to evaluate patients in police custody, such as telehealth, to determine the need for an in-person evaluation and encourage law enforcement to remain with any patients brought to the ED for evaluation who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed. The resolution authors ask that ACEP use available resources to investigate models currently being used around the country.

Violence in the ED is a serious and growing problem. According to surveys by ACEP and the Emergency Nurses Association (ENA), almost half of emergency physicians report being physically assaulted at work, while about 70 percent of emergency nurses report being hit and kicked while on the job.

ACEP’s policy statement “Protection from Violence and the Threat of Violence in the Emergency Department” states:

“The American College of Emergency Physicians (ACEP) believes that workplace violence is a preventable and significant public health problem, and that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department.”

Law enforcement officers (LEO) will frequently escort subjects under arrest to emergency departments. Emergency department encounters with patients-in-custody may be for “medical clearance” exams, for evidence collection (such as blood alcohol testing prior to booking) or for treatment of illness/injuries sustained before, during or after being taken into custody. Patients-in-custody are also potentially in any of the various stages of the criminal justice process. For example, they may be pre-booking, booked and pending a bond hearing, held pending trial, or convicted/sentenced. Some who are early in the process may ultimately be released on bond or found not guilty. The status of a patient in custody (i.e.: are they eligible for bond or serving a long sentence) can have significant impact on the evaluation, disposition, and follow-up of the ED patient.

The ED environment is not designed to maintain staff/LEO safety and prisoner security in the same way as a detention facility. Additionally, the movement of a patient-in-custody through a community into the ED environment can pose unique risks to the patient, law enforcement officers, bystanders, and the ED staff. These risks are potentially avoidable if the patient can be equally well cared for in an alternative care environment.

Alternative care models to care for intoxicated individuals have led to the creation of sobering centers in many cities and counties. These sobering centers provide a dedicated space for intoxicated adults to become sober while being monitored by trained staff. A study in Annals of Emergency Medicine by Smith-Bernardin, examined the 3-year experience at the San Francisco Sobering Center. There were 11,596 visits to the center. Less than 5% (506) were transferred to the ED.1

Telehealth and virtual care have emerged as alternative care models during the pandemic as both patients and health systems sought options in the location of health care services. The models were used for a wide variety of applications including screening patients with suspected COVID, urgent care, mental health, and follow up appointments after hospitalization or surgery. CMS approving payment for these types of models during the public health emergency.
Alternative care models such as telehealth have been utilized in detention facilities. A *JAMA* study by Khairat, outlined the use of telemedicine to provide specialty care for prisoners in North Carolina. Prisoners overall rating of satisfaction with the televisit was 4.29 on a 5-point scale. Physicians were slightly less satisfied with a 3.68 mean rating.²

Alternative care models for the evaluation of patients-in-custody have the potential of providing an equal level of care and may avoid some of the outlined safety risks if set up with careful consideration. All alternate care models for incarcerated patients must take into account that despite US Supreme Court and legislative precedents, incarcerated individuals may be at a greater risk of receiving a different level of treatment from the health care system due to the challenges unique to this population.

The second resolved clause addresses an additional safety factor. Law enforcement may initially accompany patients who are agitated, intoxicated, or are in an altered mental status to the emergency department. It is well documented that this category of patients (whether brought by LEO, EMS, or others) poses an increased risk of violence to ED staff. An article by Harada in *Annals of Emergency Medicine* in December 2021 stressed the importance of police presence in the ED for safety of staff.³ Despite this, LEOs may “release” patients-in-custody on arrival to the ED. Whether this is on their own accord or due to departmental policies it can create new safety risks for the patient, staff, and other patients in the ED.

There are no standard guidelines for these scenarios. Resources in the ED could theoretically be expanded, and personnel made safer by the original LEO remaining with the patient-in-custody until the encounter is completed or the officer is no longer needed by the staff. Concerns could also be raised that continued presence of a LEO with a patient-in-custody could possibly interfere with the full evaluation of the patient and is a potential violation of patient privacy. Further research across this spectrum is needed to determine the best way to provide high quality care to patients-in-custody while preserving the safety of all those that may encounter that patient.

**Background References**


**ACEP Strategic Plan Reference**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presented in the Emergency Department adopted. Directed ACEP to support research, development, and adoption of best practices for emergency physicians regarding law enforcement and security personnel presence in the hospital environment and the ED and collaborate with other interested organizations to create toolkits outlining state specific policies and laws related to law enforcement presence in the hospital environment, including EDs.
Amended Resolution 52(21) Standardization of Medical Screening Exams of Arrested Persons Brought to the ED” adopted. Directed ACEP to work with interested chapters and other stakeholders to develop guidelines for the medical screening examination of individuals in law enforcement custody when the arresting agency requests a medical evaluation of the individual prior to processing into a detention center; and develop best practice guidelines for the conveying of an arrested person’s pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

Resolution 51(21) Medical Bill of Rights for Detained and Incarcerated Persons While Receiving Emergency Medical Care referred to the Board. Called for ACEP to adopt a Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation and work with stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state, and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital’s emergency department.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action


Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presented in the Emergency Department adopted.

Amended Resolution 52(21) Standardization of Medical Screening Exams of Arrested Persons Brought to the ED” adopted.


Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

April 2006, reviewed the information paper “Recognizing the Needs of Incarcerated Patients in the Emergency Department.”

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.
Resolution 53(22) Law Enforcement and Intoxicated Patients in the ED
Page 5

**Background Information Prepared by:** Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 54(22)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Moral Injury Reporting and Tracking

PURPOSE: Assign a committee with developing a process to identify emergency medicine employers, quantify the degree of moral injury imposed by emergency medicine employers, and make the findings available to members.

FISCAL IMPACT: Budgeted committee, section, and staff resources for some tasks. Unbudgeted and unknown costs for conducting an environmental survey and analyzing results. The unbudgeted costs will vary based on the resources required and may include using consultants and other external resources.

WHEREAS, “Burnout” and moral injury are significant problems in emergency medicine; and

WHEREAS, Higher levels of “burnout” place patients and the healthcare system at risk; and

WHEREAS, The Surgeon General and National Academy of Medicine recently released reports with best practices and recommendations to promote wellness and reduce burnout; and

WHEREAS, Moral injury – a significant cause of “burnout” – is often perpetrated on employees by their employers; and

WHEREAS, Increasing consolidation and monopsony power leaves emergency physicians particularly vulnerable to moral injury; therefore, be it

RESOLVED, That, to safeguard the welfare of our membership and patients, ACEP task a committee with developing a process to identify employers of emergency physicians and quantify the degree of moral injury imposed by said employers on their emergency physician employees and further making these findings available to the general membership.

Background

This resolution asks ACEP to task a committee with developing a process to identify emergency medicine employers, quantify the degree of moral injury imposed upon emergency physicians by them, and make the findings available to the general membership.

The National Library of Medicine defines moral injury as an occurrence when one “perpetrates, bears witness to, or fails to prevent an act that transgresses our deeply held moral beliefs.” The term moral injury was first used to describe soldiers’ responses to their actions in war and application of the term in reference to physicians came soon thereafter. Although commonly regarded as burnout, it is important to distinguish the prevalence of physician distress as moral injury.

An ever-changing landscape in the administration of emergency departments, in addition to the expected stressors associated with being an emergency physician, have created what is akin to an epidemic of dysfunction in practice. Physicians navigate through overly regulated health care mandates, often compromising care to comply with seemingly detached administrative mandate.
Organizations and medical systems determine the bulk of physician well-being by the policies set at the executive ranks. Most physicians enter emergency medicine with a strong desire to help people with any concern, in any environment. The pressure of, and sometimes failure to, consistently meet patients’ needs has a profound impact on physician wellbeing – the crux of consequent moral injury.

In an increasingly business-oriented and privatized health care environment, physicians must often consider a multitude of factors in addition to their patients’ best interests when deciding on treatment. Financial considerations, whether hospitals, health care systems, insurers, patients, and sometimes of the physician himself or herself, lead to conflicts of interest. Electronic health record keeping distracts from patient connection and may serve as a centralized measure of productivity. Additionally, the threat of litigation may drive physicians to increase the number of testing and/or treatment modalities. Patient satisfaction scores and provider rating and review sites add additional complexities to the patient encounter. Business practices may alter referral patterns and can be an additional source of stress.

Finding balance among such intensely competing drivers is emotionally and morally exhausting. Routinely experiencing the loss of control in the different aspects of care can be frustrating and deeply painful. These are examples of “death by a thousand cuts.”

Unsurprisingly, the onset of the pandemic exacerbated existing stressors, further compounding any moral injury experienced by physicians. While some health systems pledged to improve internal and administrative conditions to mitigate burnout, it is apparent that there is little to no standardization of ensuring physician well-being. Efforts to recognize systems that strive to dismantle burnout and moral injury are prevalent, such as the American Medical Association’s “Joy in Medicine Health System Recognition Program.” The ACEP Board of Directors approved creating the “Emergency Medicine Wellness Center of Excellence Award” in April 2019 to recognize excellence in promotion and identification of wellness and resiliency best practices in emergency medicine.

As of this writing, there are no comprehensive databases or reports available to indicate systems or employers with high levels of burnout, moral injury, and overall dissatisfaction by employed physicians. Burnout and moral injury are intensely multifactorial and it would be difficult to appropriately attribute the weight of each factor for any specific individual. No algorithm or system to accomplish this currently exists.

ACEP’s policy statement “Physician Impairment” states:

“ACEP recognizes the need for mental and physical health and well-being among emergency physicians, while assuring patient safety.”

“...emergency physician groups, employers, and residency programs should support physician wellness, facilitate physician resiliency, assist with physician burnout prevention, promote early recognition of and nonpunitive mechanisms for reporting potential physician impairment, and offer early intervention and treatment or other forms of assistance to help prevent or resolve physician impairment.”

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee, section, and staff resources for some tasks. Unbudgeted and unknown costs for conducting an environmental survey and analyzing results. The unbudgeted costs will vary based on the resources required and may
include using consultants and other external resources.

**Prior Council Action**

None

**Prior Board Action**

February 2020, approved the revised policy statement “Physician Impairment;” revised and approved October 2013, October 2006, and April 1994; reaffirmed September 1999; originally approved September 1990.

April 2019, approved the “Emergency Medicine Wellness Center of Excellence Award” to recognize excellence in promotion and identification of wellness and resiliency best practices in emergency medicine.

**Background Information Prepared by:** Jonathan Fisher MD, MPH, FACEP  
Senior Director, Workforce and Emergency Medicine Practice

Alyssa Ceniza  
Wellness & Diversity Programs Manager

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker  
Melissa W. Costello, MD, FACEP, Vice Speaker  
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION:  55(22)

SUBMITTED BY:  Jennifer Conn, MD, FACEP
Kevin Conn, MD, FACEP
Rachel Levitan, MD
Anne Jennifer Richter, MD, FACEP

SUBJECT:  Patients Leaving the ED Prior to Completion of Care Against Medical Advice

PURPOSE:  Asks ACEP to affirm that patients leaving the ED against medical advice prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

FISCAL IMPACT:  Budgeted committee and staff resources.

WHEREAS, Patients initiate an episode of care by presenting to the emergency department for evaluation of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part; and

WHEREAS, Patients without intent to harm themselves or others have the right to choose to leave the emergency department and sign out against medical advice at any point during their evaluation, workup, and management ending their episode of care; and

WHEREAS, Emergency providers manage multiple emergent patients simultaneously and may be unable to immediately avail themselves to the patient desiring to leave; and

WHEREAS, Leaving the emergency department against medical advice prior to completion of care does not allow the emergency provider to completely evaluate the patient, order indicated tests and imaging, review and act on results, discuss all results with the patient including incidental findings that require follow up, obtain appropriate consults, admit or transfer the patient, nor prepare a complete list of discharge diagnoses, prescriptions, instructions and referrals; and

WHEREAS, Emergency providers do not usually practice in a setting where they may schedule a follow up appointment with a patient; and

WHEREAS, The expectation of patients who utilize emergency departments expect their episodes of care and discharge paperwork to be complete; therefore be it

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.
Background

This resolution asks ACEP to acknowledge that patients leaving the emergency department (ED) against medical advice (AMA) prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure. The CPT codes encompass these concepts but there are no ACEP documents that acknowledge these concepts or their potential impacts.

Patients who leave the ED do so for a variety of reasons including family obligations, pet care needs, financial responsibilities, being upset about the care provided, long waiting times, and ED crowding. The rates of AMA range from 0.1-2.7% of ED visits. Patients leaving AMA are at higher risk for bad outcomes and increased costs. Patients leaving AMA are 10 times more likely to initiate a litigation process against the emergency physician and the hospital than a typical ED patient with a rate of around 1 lawsuit per 300 AMA cases.1,2

Patients who leave AMA often leave with short notice or even walk out with no notice. They also may be leaving prior to completion of their evaluation and treatment. Given the lack of a complete ED work-up, these patients often leave without time for a complete discharge process. Patients who leave the ED AMA must have the decisional capacity, understand, and acknowledge the risks of leaving. By leaving prior to a complete ED evaluation, a patient will not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure. There is significant medical-legal risk associated with the failure of the patient to receive complete discharge information and follow-up because they left prior to completion of treatment. The concern is that emergency physicians may be held to an expectation to provide a complete discharge process including treatment plans and referrals for follow up for patients who have left AMA. This expectation could expose emergency physicians to increased liability for failure to provide this information.

ACEP’s policy statement “Interpretation of Diagnostic Imaging Tests” states:

“Organizations should create service standards and operating procedures that clarify testing availability, timeliness, interpretation responsibility (including the role of residents), communication methods for preliminary and final results, as well as quality assurance, discrepancy follow-up, and incidental finding communication.”

“Organizations should provide clear guidance and support for the management of patient communication as it pertains to changes in findings, diagnosis, or need for further intervention, including the communication of incidental findings that were not available when the patient was in the ED.”

Organizations should have policies and procedures in place delineating expectations and responsibilities for handling these communications for patients who leave AMA.

References


ACEP Strategic Plan Reference

Career Fulfillment – Goal: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

June 2018, approved the revised policy statement “Interpretation of Diagnostic Imaging Tests;” revised and approved February 2013, and June 2006 with current title; reaffirmed October 2000; originally approved March 1990 titled “Interpretation of Diagnostic Studies.”

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 56(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Policy Statement on the Corporate Practice of Medicine

PURPOSE: Adopt a policy statement on the corporate practice of medicine based on the California Medical Board’s guidance.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement. Unbudgeted costs of $25,000 – $30,000 for potentially obtaining a legal opinion.

WHEREAS, A significant number of the nation’s emergency departments (EDs) are controlled by a staffing company with private equity backing or ownership; and

WHEREAS, Optum, a subsidiary of the United Healthcare, an insurer, through Sound Physicians has significant ownership of emergency medicine practices; and

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states as a legal doctrine 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, ACEP has filed an amicus brief in support of the American Academy of Emergency Medicine – Physician Group (AAEM-PG) litigation against Envision that addresses the CPOM doctrine in California and the California Medical Board’s guidance on the CPOM; and

WHEREAS, ACEP, ACEP members, or other stakeholders may be called upon to be engaged in or offer amicus opinion in other CPOM matters in the future or to testify or opine in litigation, and having an existing policy statement will assist ACEP in those circumstances; and

WHEREAS, The membership of ACEP has a very negative view of the corporatization of emergency medicine based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the Department of Justice and the Federal Trade Commission by ACEP (letter to Lina Khan and Jonathan Kanter, April 20, 2022); therefore be it

RESOLVED, That ACEP adopt the following policy statement based on the California Medical Board’s guidance:

ACEP Policy Statement on the Corporate Practice of Medicine

ACEP strongly believes that the physician-patient relationship should be free of commercialization and undue influence by business interests. The corporate practice of medicine prohibition is intended to prevent unlicensed persons from interfering with or influencing the physician’s professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. The following health care decisions should be made by a licensed physician and would constitute the unlicensed practice of medicine if performed by an unlicensed person:
• Determining what diagnostic tests are appropriate for a particular condition.  
• Determining the need for referrals to, or consultation with, another physician/specialist.  
• Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.  
• Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

In addition, the following “business” or “management” decisions and activities, resulting in control over the physician’s practice of medicine, should be made by a licensed physician and not by an unlicensed person or entity:

• Ownership is an indicator of control of a patient’s medical records, including determining the contents thereof, and should be retained by a licensed physician.  
• Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.  
• Setting the parameters under which the physician will enter into contractual relationships with third-party payers.  
• Decisions regarding coding and billing procedures for patient care services.  
• Approving of the selection of medical equipment and medical supplies for the medical practice.

The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the “business” or “management” decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

The following types of medical practice ownership and operating structures also are prohibited:

• Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care, or treatment.  
• Management service organizations arranging for or providing medical services rather than only providing administrative staff and services for a physician’s medical practice (non-physician exercising controls over a physician’s medical practice, even where physicians own and operate the business).

In the examples above, non-physicians would be engaged in the unlicensed practice of medicine, and the physician may be aiding and abetting the unlicensed practice of medicine.

References
3. [https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/](https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/) (go to the section on Corporate Practice)

Background

This resolution requests the College to adopt a policy statement on the corporate practice of medicine based on the California Medical Board’s guidance.

Laws regarding the corporate practice of medicine vary from state-to-state. Governmental agencies have authority to prohibit certain behavior from companies licensed to do business in their jurisdictions. ACEP, however, does not have equivalent authority over separate legal entities and as such, some prohibitory language included in the resolution may not be enforceable by the College.

Although ACEP does not have a specific policy statement on the corporate practice of medicine, in April 2022, the ACEP Board of Directors approved the “ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine” reaffirming ACEPs core beliefs and emphasizing the physician-patient relationship as the moral center of medicine that can never be compromised. The statement includes:
“Medical decisions must be made by physicians and any practice structure that threatens physician autonomy, the patient physician relationship, or the ability of the physician to place the needs of patients over profits should be opposed.”

The Emergency Medicine Group Ownership Task Force was created in response to Amended Resolution 58(19) Role of Private Equity in Emergency Medicine. The task force is currently preparing a report of its findings to address the effects of different ownership structures on the practice of emergency medicine and the impact on individual physicians.

ACEPs policy statement “Emergency Physician Rights and Responsibilities” states:

“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.”

“Emergency physician autonomy should not be unduly restricted by value based or other cost-saving guidelines, contracts, rules, or protocols. The physicians must have the ability to do what they believe in good faith is in the patient’s best interest.”

ACEPs policy statement “Emergency Physician Contractual Relationships” states:

“The emergency physician is individually responsible for the ethical provision of medical care within the physician-patient relationship, regardless of financial or contractual relationships.”

“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.”

The College also has existing policies “Compensation Arrangements for Emergency Physicians,” “Definition of Democracy in Emergency Medicine Practice,” and “Emergency Physician Compensation Transparency.”

State law varies on the topic of corporate practice of medicine. Laws can be viewed by state at: https://silo.tips/download/corporate-practice-of-medicine-50-state-survey

Since this resolution is based on California law, a few excerpts from that law are:

“Section 2052---Any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter, or without having at some other provision of law, is guilty of a misdemeanor.”

“Section 2400---Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may, in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.”

“Section 2052 of the California Medical Practice Act declares it to be illegal for any person to practice, attempt to practice or to advertise himself/herself out as practicing medicine in California without a valid certificate of licensure. For the purposed of the act the term “person” is limited in meaning to “a natural person” and with limited exception it declares corporations and other artificial
entities to have “no professional rights, privileges or powers” thereunder. Accordingly, it has been stated as being settled that as a general rule a corporation may neither engage in the practice of medicine directly, nor may it do so indirectly by “engaging physicians to perform professional services for those with who the corporations contracts to furnish such services.”

In Pacific Employers Ins. Co. V. Carpenter, 10 Cal.App.2d 595, 594 (1935). California courts have held that state medical licensure laws prohibit corporations from practicing medicine through licensed employees or independent contractors, and from realizing profits through the distributions of a physician’s professional services. Whether or not an arrangement will be considered “unlawful practice of medicine” depends on the extent of control or influence a corporation has over the physician’s practice. Indicia of unlawful physician control include employment, mandatory fee schedules, minimum office hour requirements, the selection of office sites, personnel or equipment, and other controls which singly or in combination may interfere with the ability of a physician to independently exercise his or her medical judgment. See, e.g., Cal. Ass’n of Disp. Opticians v. Pearle Vision, 143 Cal.App.3d 419 (1983) Lack of patient freedom of choice in the selection of his/her treating physician is also a factor that implies the existence of corporate practice of medicine. The corporate practice of medicine prohibition remains a significant factor in the structure of health care provider relationships. It is a criminal offense for any person or entity to practice or attempt to practice, or to advertise or hold itself out as practicing medicine, without having at that time a valid license, therefore. Penalties for the unlawful practice of medicine are significant and include: (1) criminal prosecution ‘(2) injunctive relief’ (3) ouster in a quo warranto proceeding’ and (4) exposure to civil lawsuits.

The general rule against the corporate practice of medicine is not absolute as exceptions to the California law permit the following types of corporations to practice medicine: (1) professional medical corporations, partnerships and group practices‘ (2) Knox-Keene Health Care Service Plans (i.e., HMOs)‘ (3) nonprofit corporations‘ (4) fraternal, religious, hospital, labor, education, and similar organizations may contract with physicians on an independent contractor basis in certain situations‘ (5) corporations having an interest in the health of its employees may contract with physicians to provide medical services for the corporation’s employees at a reduced cost, and (6) certain licensed health care institutions may contract with physicians to provide medical services for the institution’s employees at a reduced cost.

It is consistently recognized by the American Medical Association (AMA) and legal professionals that the adoption and enforcement of corporate practice of medicine doctrine is not just a matter of statutory law but as well a complex and living web of case law and attorneys general and regulatory agency opinions. An internet search yields several different types of state-level comprehensive reviews, albeit each limited in some way and nearly all cautioning about the complexities of this issue residing in of notoriously porous statutes and in a constant state of change.

ACEP currently works with our chapters to summarize or curate resources via our Legislative Information Clearinghouse. This is currently being used to monitor such issues as crowding, liability reform, reimbursement, and many more. Matters of CPOM are not one of the issues currently tracked as a state legislative issue. ACEP is working with state chapters to help create and track references on selected existing legal and regulatory resources related to the corporate practice of medicine in states.

In July 2021, ACEP’s executive director discussed ACEP’s concerns with the AMA’s CEO regarding matters related to the corporate practice of medicine and interest in potentially collaborating with the AMA on an educational or needs assessment meeting. There was mutual interest in exploring this further, possibly through a virtual summit that could convene professional and state medical societies, as well as research organizations. Like ACEP has experienced, many of these research efforts are limited by a lack of transparency around ownership models and/or the inability to link ownership data to claims-based or other government database research, as well as published literature to study the CPOM landscape. At this time, ACEP and AMA staff continue working to develop the needs assessment.

ACEP began a campaign in March 2022 to collect stories that would help inform the Federal Trade Commission’s (FTC) efforts to update its health care merger guidelines by expanding its evaluations on the impact of mergers and acquisitions to assess labor conditions rather than just competition. Stories were submitted through the ACEP website and other communications promoting the campaign were launched. The stories were reviewed to identify common themes and statistics and were used to create ACEP’s response to a recent FTC/DOJ request for information. ACEP President Dr. Gillian Schmitz and ACEP Executive Director, Sue Sedory, provided public comments in a listening
session hosted by the FTC and DOJ on April 14, 2022, on the effects of mergers and acquisitions in the healthcare industry. In their comments, Dr. Schmitz and Ms. Sedory shared results from ACEP's story collection that showed numerous anti-competitive labor-related effects associated with mergers and acquisitions in emergency medicine including: reduced wages and/or non-cash benefits; infringement of due process rights; interference with physician autonomy to make independent medical decisions benefiting patients; inability to find a job or undue imposed restrictions on ability to switch jobs; and a shift to use of a less-skilled health care workforce jeopardizing patient care.

ACEP filed an amicus brief in the AAEMPG v. Envision case on March 25, 2022, upholding the sanctity of a physician’s duty to patients and the importance of allowing them to practice medicine without undue pressure from outside forces. Through this filing, ACEP is applying its might on behalf of our nearly 40,000 members in legal efforts to assert the physician’s right to autonomy in medical decision-making. EMRA also filed a Declaration of Interest in support of the ACEP position.

Additionally, ACEP has been in communication with the Physicians Advocacy Institute to help inform a report they are developing that would address trends in emergency medicine regarding physician employment and acquisitions of medical practices.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources for development of a policy statement. Unbudgeted costs of $25,000 – $30,000 for potentially obtaining a legal opinion.

Prior Council Action

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) 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; 2) adopt as policy: “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.”; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, 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 to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

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.

Prior Board Action

August 2022, reviewed the draft final report from the Emergency Medicine Group Ownership Task Force and referred the report back to the task force for additional information to be included in the report.

April 2022, the ACEP Board of Directors approved the ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine.

January 2022, approved filing a brief in the AAEM-PG vs. Envision lawsuit.


April 2021, approved the revised policy statement “Emergency Physician Rights and Responsibilities;” revised October 2015, April 20018, July 200; originally approved September 2000.

September 2021, approved actions regarding Referred Amended Resolution 52(20) The Corporate Practice of Medicine.

January 2021, approved the revised policy statement “Definition of Democracy in Emergency Medicine Practice;” reaffirmed April 2014; originally approved June 2008.

October 2020, approved the policy statement “Emergency Physician Compensation Transparency.”

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 57(22)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Recognized Bodies for Emergency Physician Board Certification

PURPOSE: Amend the policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine” by adding additional language regarding alternate certifying boards affirm that board certification through the ABMS, AOA, or ABP are the only ACEP-recognized means for emergency physician board certification in the U.S.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), and the American Board of Pediatrics (ABP) have historically provided board certification for emergency physicians; and

WHEREAS, Organizations such as the National Board of Physicians and Surgeons (NBPAS) hold themselves out as a “board” that provides a “board certification” credential to the lay public, physicians, hospitals, insurers, and legislators; and

WHEREAS, Organizations such as NBPAS provide verification of continuing medical education (CME) and verification of training but no ongoing assessment of competency and thus do not meet the definition of a certifying body as defined by the National Commission for Certifying Agencies (NCCA); and

WHEREAS, ACEP has previous policy recognizing certifying bodies for emergency physicians that limited the recognition of emergency medicine board certification through the American Board of Medical Specialties (ABMS) or through the American Osteopathic Association (AOA), with no restriction to certification by alternate organizations; and

WHEREAS, NBPAS offers “board certification” in emergency medicine in addition to other specialties; and

WHEREAS, Some physicians are advocating on a hospital, insurer, or state level to have organizations such as NBPAS recognized as “equivalent” to ABEM and AOBEM certification, including but not limited to medical staff privileges, hospital bylaws, and insurance reimbursement; and

WHEREAS, ACEP has previously opposed regulatory and legislative efforts to have NBPAS status as equivalent to ABEM and AOBEM certification; and

WHEREAS, Organizations that do not establish continuing competency through ongoing independent assessment are not equivalent to specialty-specific board certification as provided by ABEM, AOBEM, ABP, and recognized international medical organizations; and

WHEREAS, Multiple ACEP policies reference emergency board certification by ABEM and ABP under the ABMS or AOBEM under the AOA, but no ACEP policy addresses organizations that claim to provide “equivalent” board certification outside of the ABMS or the AOA; therefore, be it

RESOLVED, That ACEP amend its policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine” to reflect that alternate organizations that claim to provide “board certification” but that do not provide ongoing assessment of their diplomates, do not provide transparency about their certification process, do not provide transparency about the specialties and numbers of certified physicians, or merely verify continuing medical education...
and training, are not recognized by ACEP as equivalent to board certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or the American Board of Pediatrics for any purpose; and

RESOLVED, That ACEP affirm that board certification through the American Board of Medical Specialties or the American Osteopathic Association are currently the only ACEP-recognized means for emergency physician board certification in the United States.

Background

This resolution calls for the College to amend its current policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine” by adding additional language to clarify that alternate organizations may provide “board certification” but fail to meet certain standards provided by the American Board of Medical Specialties (ABMS), the American Board of Emergency Medicine (ABEM) and/or the American Osteopathic Board of emergency Medicine (AOBEM). Included in that statement should be information that these organizations may lack ongoing assessment of their diplomates, transparency about their certification process, transparency about the specialties and numbers of certified physicians, or may merely verify continuing medical education and training. Also to be included is a statement that these organizations are not recognized by ACEP as equivalent to board certification by ABEM, AOBEM, or the American Board of Pediatrics (ABP) for any purpose. The resolution also calls for ACEP to affirm that board certification through the ABMS or the American Osteopathic Association (AOA) is currently the only ACEP-recognized means for emergency physician board certification in the United States.

ACEP’s policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine” recognizes and supports ABEM as the sole ABMS certifying body for emergency medicine, recognizes AOBEM as a certifying body in emergency medicine under the jurisdiction of the AOA, and recognizes ABP as an ABMS certifying body in pediatrics providing subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine.

ACEP’s policy statement “Definition of an Emergency Physician” states:

“An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.

It should be noted that residents in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency in Emergency Medicine are “Emergency Medicine Resident Physicians.”

ACEPs recently revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” affirms that the gold standard for care in the ED is the emergency physician as defined by ACEP:

“Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.”
In July 2022, The Joint Commission added the National Board of Physicians and Surgeons (NBPAS) as a credentialing body, deemed as a “Designated Equivalent Source Agency” and can now be used by hospitals and health systems for physician credentialing and privileging requirements. However, the ABMS has stated their objection to this interpretation. [https://www.abms.org/news-events/abms-response-to-nbpas-assertion-of-certifying-body-equivalency/](https://www.abms.org/news-events/abms-response-to-nbpas-assertion-of-certifying-body-equivalency/)

Currently, only a small list of hospitals accept NBPAS. According to the NBPAS website, candidates must be previously certified by an ABMS or AOA member board in the specialty being applied for through NBPAS.

**Background Reference**


**ACEP Strategic Plan**

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy Action Plan – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

**Fiscal Impact**

Budgeted committee and staff resources.

**Prior Council Action**

Resolution 68(21) Patient’s Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Called for ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physicians referred to the Board of Directors. Called for ACEP to approve and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician; that ACEP support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. Directed ACEP to define an “emergency physician” as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Resolution 38(98) Recognition of Certifying Bodies adopted. It directed the Board of Directors to review prior actions on recognition of certifying bodies in emergency medicine.

Resolution 37(94) Criteria for Certifying Bodies and Recognition of the BCEM not adopted. It called for ACEP to meet with leaders of BCEM to obtain the necessary information to consider recognition of the BCEM and for ACEP to adopt the “Criteria for Recognition of Certifying Bodies” with amendments that would allow ACEP to grant similar recognition and/or acknowledgement of BCEM.

Resolution 35(94) Certifying Boards not adopted. It called for rescinding current ACEP policies regarding certifying boards and that the College reaffirm its ongoing support for ABEM by continuing its role as a parent organization, while acknowledging that other certifying boards exist.
Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted. It directed ACEP to study the implications and possible criteria for College recognition of certifying bodies in emergency medicine.

Amended Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians.

Resolution 39(87) American Osteopathic Board of Emergency Medicine adopted. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians. The resolution was not adopted by the Board in November 1987

Substitute Resolution 47(79) Recognize the American Board of Emergency Medicine adopted. It recognized and supported ABEM as the sole certifying body for emergency medicine.

Prior Board Action

March 2022, approved the revised policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;” revised and approved June 2020 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;” originally approved January 2007 titled “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” replacing two policy statements “Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”


September 2000, rescinded the policy statement “ACEP Criteria for Recognizing Certifying Bodies in Emergency Medicine” and supported development of a new policy acknowledging that ACEP has no criteria for recognizing certifying bodies and will only recognize certifying bodies approved by ABMS or AOA.

Resolution 38(98) Recognition of Certifying Bodies adopted.

Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted.


Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 58(22)

SUBMITTED BY: Emergency Medicine Residents’ Association

SUBJECT: Removing Unnecessary and Invasive Medical Exams and Questionnaires from Employment Contracts

PURPOSE: Support cessation of invasive medical evaluation exams and questionnaires that may invade the privacy of emergency physicians seeking employment beyond what is necessary to confirm the ability to perform duties associated with the individual’s role as hired.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, In the course of employment many physicians discover that their employment is contingent upon completion of a post-offer/pre-employment medical evaluation, including physical examinations and questionnaires; and

WHEREAS, Some of the information requested may be considered sensitive by the physician in question seeking employment, for example, questions related to surgical history may incidentally disclose biopsies to rule out neoplasia, abortion care, procedures to assist with family planning, gender affirmation, and the like, as well as questions regarding medications, for example, may unnecessarily reveal chronic, auto-immune, or psychiatric complaints, among others including those related to hormone use or for cosmetic concerns; and

WHEREAS, Physician employees may wish to exert their right to privacy regarding conditions that do not cause impairment and have reasonable concern may color their professional or personal reputation; and

WHEREAS, Determining what information to provide to a medical screener (often a non-physician provider or nurse) places the physician in an ethical conundrum – whether to be honest or whether to obfuscate to protect one’s professional and personal identity; falsification by omission to one’s employer through mandated health exams may be cause for dissolution of contract, but revealing private health information may be deemed too invasive by the physician in question who is simply seeking to provide their skills in exchange for wages; and

WHEREAS, It is unclear why invasive medical screening exams are necessary to complete the hiring process for physicians who are not requesting or anticipating employer accommodations; therefore be it

RESOLVED, That ACEP support the cessation of invasive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking employment beyond that which is necessary to confirm ability to perform duties associated with the individual’s role as hired.

References

Background

This resolution calls for ACEP to support the cessation of invasive medical evaluation exams and questionnaires that may invade the privacy of emergency physicians seeking employment beyond what is necessary to confirm the ability to perform duties associated with the individual’s role as hired.
After the passage of the Americans with Disabilities Act (ADA) in 1990, professional organizations, such as the American Psychiatric Association (APA), proposed guidelines for state licensing boards when asking about a physician’s health. Title II of the ADA prohibits discrimination by public entities on the basis of disability, including psychiatric disabilities. Since the ADA’s passage, medical board screening of applicants of prior history of physical illness, mental illness, or substance use disorders (SUD) using broad or hypothetical questions has been increasingly seen as discriminatory. Arguments have been raised about the necessity and legitimacy of broad-based inquiries into a physician’s history with physical health, mental illness, or SUD and their use as a proxy for a physician’s ability to currently practice competently and without impairment. The American Medical Association (AMA), Federation of State Medical Boards (FSMB), and ACEP stress the importance to distinguish between illness and impairment. The ADA also focuses on this important distinction. However, state boards often find challenges complying with the recommendations as they attempt to identify the line between an applicant’s right to privacy with the sense of duty to protect the public.

ACEP’s policy statement “physician impairment” states:

“The existence of a health problem in a physician is NOT synonymous with occupational impairment. Because of their training and dedication, most physicians with appropriately managed personal health problems and other stressors are able to function safely and effectively in the workplace.”

In addition, the policy recommends that licensing and credentialing bodies use the FSMB language for questions about the physical or mental health of applicants. It further states that “licensing and credentialing bodies should not ask applicants and licensees about their past history of diagnosis or treatment for mental disorders, substance use disorders, physical disorders, and/or disabilities, focusing instead of current impairment.”

The FSMB policy on “Policy on Physician Illness and Impairment” also support the distinction between illness and impairment.

“It is important to distinguish illness from impairment. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of impairment may be prevented or resolved while the diagnosis of illness may remain.”

State board licensing application questions about physician health vary. Recently, there has been renewed attention on destigmatizing mental health issues and removing questions about mental health. There has been less focus on removing questions about physical health. In June 2018, the AMA amended its policy on Access to Confidential Health Services for Medical Students and Physicians mostly addresses issues around mental health. 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 re-licensure 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.” The FSMB, in its policy Physician Wellness and Burnout adopted in April 2018, recommends that state medical boards consider whether it is necessary to include “probing questions about a physician applicant’s mental health, addiction, or substance use on applications for medical licensure,” noting also that these questions are likely to discourage treatment-seeking among applicants. It goes on to state that “Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.” The FSMB recommends language such as: “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?” AMA Policy “Licensure Confidentiality” endorse this approach by the FSMB. An analysis of medical licensure application questions from 2018 found that a majority of states had questions that were unlikely to meet ADA standards. The table in the article shows the wide range in questions and approaches taken by states.
Amended Resolution 82(21) Defining the Job Description of an Emergency Physician directed ACEP to develop a job description that applies to all emergency physicians reflecting the true physical and cognitive demands of the specialty that can be used in relation to disability claims. ACEP developed a letter with a description of emergency medicine work and describing the job requirements of an emergency physician. The letter can be used on behalf of a member’s disability claim and can serve as the foundation for a future document. The Emergency Medicine Practice Committee is working on a policy statement and supporting documentation.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources

Prior Council Action

Amended Resolution 82 (21) Defining the Job Description of an Emergency Physician adopted. Directed ACEP work with appropriate stakeholders and the insurance industry to develop ACEP policy defining an accurate job description that can apply to all emergency physicians and consider developing an accurate job description for emergency physicians that can be used to support appeals of long term disability claim denials, until an acceptable ACEP policy is created.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. Directed ACEP to: 1) 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; 2) work with the American Medical Association, the Federation of State Medical Boards, 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 3) 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.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about physician’s mental health.

Resolution 16(18) No More Emergency Physician Suicides adopted. Directed ACEP to study the unique specialty-specific factors leading to depression and suicide in emergency physician and develop an action plan to address them.

Amended Resolution 32(04) Disability in Emergency Physicians adopted. Directed ACEP to evaluate and communicate issues related to disability and impairment in the practice of emergency medicine to members and address barriers to participation for members with disabilities. Also directed ACEP to request that ABEM include information on disability in their Longitudinal Study of Emergency Physicians.

Substitute Resolution 9(99) Federation of State Medical Board Recommendations adopted. Directed ACEP to consider establishing a formal relationship with the FSMB and to develop strategies and tools for members to respond to the FSMB’s recommendations in “Maintaining State-Based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession.”

Substitute Resolution 43(88) Emergency Physician Wellness adopted. Directed ACEP to endorse the concept of promoting emergency physician wellness and for the Board to report back to the Council Steering Committee on their
actions related to the Wellness Working Group report.

Amended Resolution 29(82) Physician Impairment adopted. Directed ACEP to establish a committee to develop a program on addiction education for members and a program to encourage colleagues with substance use disorders to seek help and provide a report to the 1983 Council about the progress on these efforts.

**Prior Board Action**

Amended Resolution 82 (21) Defining the Job Description of an Emergency Physician adopted.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.


February 2020, approved the revised policy statement “Physician Impairment;” revised and approved October 2013, October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

Amended Resolution 32(04) Disability in Emergency Physicians adopted.

Substitute Resolution 9(99) Federation of State Medical Boards adopted.


Amended Resolution 29(82) Physician Impairment adopted.

**Background Information Prepared by:** Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director
RESOLUTION: 59(22)

SUBMITTED BY: Missouri College of Emergency Physicians

SUBJECT: In Memory of Brian Robb, DO, MBA, FACEP

WHEREAS, Brian Robb, DO, MBA, FACEP, was a long standing member of the Missouri College of Emergency Physicians (MOCEP); and
WHEREAS, Dr. Robb provided expert and compassionate emergency care to the people of western Missouri in a practice that spanned 38 years; and
WHEREAS, Dr. Robb served 28 years as President and Medical Director of Liberty Emergency Physicians Inc; and
WHEREAS, Dr. Robb served on the MOCEP Board of Directors for more than a decade; and
WHEREAS, Dr. Robb served MOCEP as Vice-President, President, and Past-President between 2008 and 2014; therefore be it
RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO, MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.
Late Resolution

RESOLUTION: 60(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of James R. Roberts, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a distinguished leader and pioneer when James R. Roberts, MD, FACMT, FAAEM, FACEP, passed away Friday, July 22, 2022, at the age of 76; and

WHEREAS, Dr. Roberts graduated Lafayette College and obtained his medical degree from Thomas Jefferson University in 1972. He completed his internship in 1973 at Highland General Hospital in Oakland, California, and his emergency medicine residency at the Medical College of Pennsylvania in 1975. Subsequently, he was a McNeil Scholar at Bellevue Hospital in New York City where he completed medical toxicology training; and

WHEREAS, Dr. Roberts was a trailblazer in the field of emergency medicine, and was one of the first board-certified emergency physicians and was a board-certified medical toxicologist; and

WHEREAS, Dr. Roberts served as Professor of Emergency Medicine, Vice Chair, Department of Emergency Medicine, and Senior Consultant, Division of Toxicology, at the Drexel University College of Medicine; and

WHEREAS, Dr. Roberts served as Chair of the Department of Emergency Medicine, Director, Division of Medical Toxicology, Mercy Catholic Medical Center, Philadelphia, Pennsylvania; and

WHEREAS, Dr. Roberts served as Chair of the editorial board for Emergency Medicine News magazine (Wolters Kluwer) for almost 40 years; and

WHEREAS, Dr. Roberts co-authored the book “Clinical Procedures in Emergency Medicine and Acute Care” (Elsevier) first published in 1983, now in its 7th edition, which defined the procedural scope of the practice of emergency medicine; and

WHEREAS, Dr. Roberts was named as one of the 30 most influential physicians in the history and development of American academic emergency medicine by the Emergency Medicine Residents’ Association (EMRA); and

WHEREAS, Dr. Roberts was a founding member of EMRA and was the first resident representative to the American College of Emergency Physicians; and

WHEREAS, Dr. Roberts received ACEP’s Judith Tintinalli Award for Outstanding Contribution in Education in 2016; and

WHEREAS, We owe a tremendous amount of gratitude to him for his commitment to the education of the next generation of emergency physicians and to the specialty as a whole; and

WHEREAS, Dr. Roberts was a loving and proud husband, father, and grandfather; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, FACEP, who was a pioneer in the specialty and 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 extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.
RESOLUTION: 61(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Douglas D. Rockacy, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a valued teacher and iconic emergency physician when Douglas D. Rockacy MD, FACEP, passed away tragically on July 16, 2022, at the age of 47; and

WHEREAS, Dr. Rockacy completed medical school at the University of North Carolina in 2000 and his residency in emergency medicine at the University of Pittsburgh in 2003; and

WHEREAS, Dr. Rockacy has been a key faculty member within the University of Pittsburgh Emergency Medicine Residency for the past 19 years; and

WHEREAS, Dr. Rockacy has been a mentor for countless medical students and residents reflected in his receiving the Faculty Teaching Award from the University of Pittsburgh Emergency Medicine Residency multiple times; and

WHEREAS, Dr. Rockacy has been a long standing nocturnist at the UPMC-Mercy ED for more than 15 years, averaging greater than 200 overnight shifts per year; and

WHEREAS, Dr. Rockacy embodied and exemplified the mission and values of the American College of Emergency Physicians, and

WHEREAS, Dr. Rockacy has been emphatically admired by patients, families, EMS partners, and staff; and

WHEREAS, Dr. Rockacy was a universally loved proud father, husband, uncle, and friend; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, 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 extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.
Resolutions are not official until adopted by the Council and the Board of Directors (as applicable).
RESOLUTION: 63(22)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Jason M. White, MD, FACEP

WHEREAS, Emergency medicine lost a beloved physician leader of our specialty in the passing of Jason M White MD, FACEP, who died July 10, 2022; and

WHEREAS, Dr. White earned his medical degree from the University of Michigan in Ann Arbor, MI and completed his residency training in emergency medicine at Henry Ford Hospital in Detroit, Michigan; and

WHEREAS, Dr. White established and served as the president of Timberline Emergency Physicians, P.C. for almost 20 years; and

WHEREAS Dr. White was a recognized leader in the field of emergency medicine on a regional level, having served as president of the Michigan College of Emergency Physicians and received the MCEP Ronald L. Krome Meritorious Service Award in 1998; and

WHEREAS, During his 38 years at Ascension St. Mary’s of Michigan in Saginaw, MI, he served many patients in an underserved population and served as medical director of the emergency department, chair of many committees, and chief of staff of the hospital and was a generous supporter of the Ascension St. Mary's Foundation; and

WHEREAS, Dr. White helped establish the emergency medicine residency program in Saginaw, and with his exceptional dedication to physician education, leadership, and professional development, he changed the trajectory of many physicians; and

WHEREAS Dr. White’s commitment and dedication to professional and personal development while providing high quality care was a priority and he demonstrated this by seeking his Master’s in Medical Management at the University of Southern California and though his work serving as chief medical officer; and

WHEREAS Dr. White’s passion for teaching had no limit and he was known not only for his bedside clinical teaching of residents and students, but also for his ability to give lectures while bringing in history, everyday experiences, and humor to his presentations; and

WHEREAS, Dr. White received stellar evaluations from the students, and he was not only an advocate for education, but a role model demonstrating professionalism and compassion for his learners; and

WHEREAS Dr. White created a sense of family for the emergency medicine community and made it a priority to get to know people, not only his patients but also his colleagues and the relationships, both professional and personal, that developed out of these activities lasted many years; and

WHEREAS Dr. White’s legacy as an innovative leader and mentor of our specialty who integrated education into his culture and personal commitments will be most remembered because of his willingness to serve and his supportive mentorship which he combined with his wonderful, witty sense of humor; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College’s condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.
Memorandum

To: 2022 Council

From: Sonja Montgomery, CAE
Governance Operations Director

Date: September 2, 2022

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2022-23. The committee will hold a conference call soon to discuss their recommendations. The committee’s recommendations will be discussed by the Board at their meeting on September 28, 2022. 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 $148,329
- President-Elect $107,865
- Chair $35,736
- Vice President $35,736
- Secretary-Treasurer $35,736
- Immediate Past President $35,736
- Speaker $35,736
- Vice Speaker $18,413
- Non-Officer Board Members $11,054
Memorandum

To: 2022 Council

From: Susan E. Sedory, MA, CAE
Executive Director and Council Secretary

Date: July 1, 2022

Subj: Emergency Department Accreditation Task Force Report

The ED Accreditation Task Force was appointed in July 2021 to determine the feasibility of establishing an ED accreditation program. The task force was also assigned to include Substitute Resolution 28(21) Consumer Awareness Through Classification of EDs in their work:

RESOLVED, That the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

The task force was comprised of 15 members. Emergency physicians with payer experience, as well as members from other ACEP committees, were added to an Advisory Board to aid the task force with consideration of how to align incentives to promote the uptake of accreditation by hospitals. The list of task force members and Advisory Board members is included at the end of this memo.

The Board of Directors discussed the task force report on June 24, 2022, and approved distributing it to the Council. As a next step, the Board approved funding up to $50,000 to develop a business plan for an Emergency Department Accreditation Program. While the proposed initial criteria are merely that and do not establish the final standards that will be ultimately be included, the Board approved that the future Emergency Department Accreditation Program will include tiers based on staffing levels; that further delineation of these tiers in various settings may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; that Emergency Department Accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and that all tiers for the Emergency Department Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

The task force report is provided in Appendix A. The proposed “Initial Criteria for Accreditation” is provided in Appendix B. Since there is little hard evidence regarding appropriate standards staffing, the task force derived these initial standards from existing ACEP policies and group consensus. The proposed initial standards do not address the tiers based on staffing. Appendix C includes the citation of existing ACEP policy for the proposed “Initial Criteria for Accreditation.” Appendix D is ACEP’s policy statement “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department.” Appendix E is excerpts from prior task force reports.
ED Accreditation Task Force Members
Adrian Tyndall, MD, FACEP – Chair
Alison Haddock, MD, FACEP – Board Liaison
Sandra Schneider, MD, FACEP – Staff Liaison
Kevin Biese, MD, MAT, FACEP
Kathleen Clem, MD, FACEP
Nicholas Cozzi, MD
Marianne Gausche-Hill, MD, FACEP
Maria Guyette, MD, MPPM, FACEP
Leon Haley, MD, MHSA, CPE, FACEP, FACHE (deceased)
Steve Jameson, MD, FACEP
Aditi Joshi, MD, MSc, FACEP
Alexis LaPietra, DO, FACEP
Lisa Maurer, MD, FACEP
Susan Stern, MD
Johnny Sy, DO, FACEP
Vivek Tayal, MD, FACEP
Mike Turturro, MD, FACEP

Advisory Board Members
Stephen Knight, MD, FACEP
James McClay, MD, FACEP
Jaewon Ryn, MD, JD
Tracy Sanson, MD, FACEP

The task force also acknowledges the participation of L. Anthony Cirillo, MD, FACEP, and Arvind Venkat, MD, FACEP, who served as the initial Board Liaison to the task force.
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Emergency Department Accreditation Task Force Report

Background

ACEP is the leader for emergency care and therefore should be the organization to establish the criteria for such care, based on evidence and established policies. ACEP has long standing policies on recommended resources and staffing of EDs. However, these policies often appear to our members and to external institutions as “aspirational suggestions.” Hospital boards may not be familiar with ACEP policies, and they may not be versed in the difference in education/training of EPs (as defined by ACEP), and non-Board-certified/Board-eligible (BC/BE) physicians, NPs, and PAs. EPs who staff some hospitals have limited options to use these policies to improve care within a hospital system.

Historically, accreditation programs have provided non-dues revenue for the College. But more importantly, accreditation programs establish and recognize “best practices.” They are a powerful tool to create change. As was done with residency programs through the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee-Emergency Medicine (RRC-EM), criteria can be raised over time. Institutions, once accredited, will strive to meet the new standards rather than to lose accreditation.

There are approximately 5,000 hospitals in the US, of which 962 are government owned, and 625 are non-federal psychiatric hospitals. Approximately 50% of hospital EDs see less than 30,000 visits per year, with many seeing less than 10,000 visits. From recent literature and our workforce study, we know that many of these smaller and lower-volume EDs are currently staffed by non-EPs. In others, NPs and, less commonly, PAs work independently. It appears that the number of non-EPs who work in EDs continues to decrease with time, and that they often are being replaced by NPs and PAs.

Process

The task force first evaluated ACEPs existing accreditation programs, hoping to learn best practices and build upon the work done to date. Representatives of those four accreditation programs were on the task force and reported on their programs during the first few meetings of the group.

ACEP has established several accreditation programs which vary in their success.

The Clinical Ultrasound Accreditation Program (CUAP) launched in June 2015 and was designed as a member benefit. The program was based on the “Ultrasound Guidelines” previously adopted by the Board. Originally it was hoped that such a program would facilitate reimbursement for the procedure from insurers. Today, it adds value to members who participate by improving and demonstrating the quality of care provided. Fees are intentionally kept low, as these are drawn directly out of the member’s funds and not paid by the hospitals. At this time, 48 programs are accredited, and another 11 are in the review process. The program currently involves over 2,000 EPs. There has been increased interest in the program following the pandemic and with increased marketing efforts. Recent changes to the program will allow for expansion into international and emergency ultrasound in locations other than the ED.

In 2016, the ACEP Council adopted Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers calling for ACEP to explore the possibility of setting ACEP endorsed minimum accreditation standards for freestanding emergency centers and to explore the feasibility of ACEP serving as an accreditation, not licensing, entity for freestanding emergency centers where they are allowed by state law. A task force was appointed, which created a series of standards applicable to freestanding emergency centers. Those standards were adopted by the Board in April 2018.
A business plan demonstrated that it was not financially feasible to move forward based on anticipated projections. ACEP then partnered with the Centers for Improvement in Health Care quality (CIHQ), who agreed to pay a royalty of $10,000 a year for the use of a ACEP freestanding accreditation standards. That royalty covered all the costs of creating the standards, but it is unclear how long that relationship will last because very few freestanding emergency centers have sought accreditation. The number of these has not been disclosed by CIHQ. The royalty is a flat fee, paid in May 2021, and currently is being invoiced for May 2022. Significant contraction of the independent freestanding industry has likely altered the viability of maintaining the program going forward. Under the royalty contract, “CIHQ exclusively owns the intellectual property rights to the program with the exception that ACEP shall retain ownership of any preexisting intellectual property incorporated into the program. Specifically, ACEP shall retain ownership of its standards for accreditation of freestanding and hospital-based emergency centers (“standards”) and hereby grants CIHQ an exclusive license to incorporate the standards into the program for the term of this agreement.”

The **Geriatric Emergency Department Accreditation Program (GEDA)** was approved by the Board in January 2017 and built upon the recommendations of the “Geriatric Emergency Department Guidelines.” Prior to the start of ACEPs program, it was noted that approximately 130 institutions called themselves a “geriatric ED,” suggesting a significant potential market. The program also received generous funding from the John A. Hartford Foundation and the West Health Institute, supporting the startup costs and staff salaries. The program has been very successful, with 305 hospitals accredited, including a few international institutions, with revenue projections of nearly $500K for 2022-23. This program shows great potential for future growth.

The **Pain and Addiction Care in the Emergency Department Accreditation Program (PACED)** is the newest of the ACEP accreditation programs, having launched in early April 2020. The program was put on a temporary hold during COVID and only recently have marketing efforts begun in earnest. As of early April 2022, there are six accredited sites with 22 applications in the pipeline and 220 on the interest list. We have been successful in securing grant dollars to pay the initial fees for some of these sites.

**Lessons learned:** Hospitals are interested in third party attestations of their ability to provide quality care. Some hospitals may seek to improve their market share, others to provide verification of interest and involvement in the community, while others may seek to keep local suburban or rural patients from being drawn to urban facilities. Regardless of the intent, the end result is a hospital that is providing the best care based on scientific evidence and the policies and established standards. Hospitals and EDs that provide such care should be recognized for their efforts. The GEDA program also has shown the power of losing accreditation. While achieving accreditation is well received by a hospital Board of Trustees, losing accreditation is seen as a significant event.

ACEP is the leading organization in the US (and arguably in the world) for EPs. We believe it is our duty to provide our members with the best environment to practice and care for their patients, and to provide the public assurance that the ED they visit will provide quality care, regardless of the size of the institution.

**Past Models / Historical Context**

There are many current accreditation programs for hospitals, though none specifically for the ED. The original accreditation of hospitals was created in 1919 by the American College of Surgeons (ACS). This program led to development of The Joint Commission (TJC), which accredits hospitals and healthcare organizations today, and develops Joint Commission standards. TJC standards for emergency care are a combination of historical standards (developed by other specialties), quality metrics, and facility standards. TJC and its competitor Det Norske Veritas (DNV) from the National Integrated Accreditation for Healthcare Organizations (NIAHO) are both recognized by the Centers for Medicare & Medicaid Services (CMS) as deeming organizations, meaning that accreditation is required for full participation in Medicare and Medicaid payment programs. This is the only program with direct financial incentives.

In the 1970s and 80s, TJC created a self-designated tiered classification of EDs, with a level 1 hospital having 24-hour physician coverage and available consultation to lower levels of hospitals which did not have physician coverage. Those classification were discontinued decades ago and, in conversations with TJC, there appears to be no interest in revising that system.
The issue of categorization of emergency services was addressed in 1971 by the American Medical Association’s (AMA) Commission on Emergency Medical Services which published its “Guidelines for the Categorization of Hospital Emergency Capabilities.” These guidelines provided the basis for state and local regionalization programs and were endorsed by the American Hospital Association (AHA) and TJC. The purpose of emergency services classification was to identify the capability of a hospital and its staff, and to provide advance knowledge of hospital emergency capabilities for EMS and patients so they could make better informed choices regarding hospital destination. Initially, the AMA Commission developed a horizontal categorization, which delineated overall capability of an ED to respond to a wide variety of emergency conditions rather than to provide definitive treatment for specific types of medical emergencies. The horizontal categories were comprised of comprehensive, major, general, and basic levels of service capabilities. By 1975, the AMA Commission had recognized the need for vertical categorization extending beyond the ED, which defined the capability of an emergency care facility to care for specific groups of critically ill patients. Vertical categorization was viewed as more cost effective since hospitals could choose to maintain or upgrade a given level of service in one or several critical areas without committing additional resources across the spectrum of emergency services. In 1981, the AMA’s Commission published the “Provisional Guidelines for the Optimal Categorization of Hospital Emergency Capabilities,” which described criteria for vertical categorization of nine critical areas: acute medical, behavioral, burn, cardiac, neonatal/prenatal/pediatric, obstetrical/gynecological, poisoning/drug, spinal, and trauma emergencies. This categorization is no longer in use.

ACS through its Trauma Center Verification Program sets the national standards for hospitals for trauma care. As trauma care within a hospital is initiated in the ED, their standards include the ED. Those standards include education and training of staff, including the EP, requirements for continuing education, equipment, and participation in a registry. As part of regional trauma systems, EDs have been categorized by their level of trauma care capabilities by organizations such as the American College of Surgeons in its “Resources for Optimal Care of the Injured Patient” or, in some cases, state health departments. This categorization provides information that could potentially be used by the EMS system to transport the patient to the most appropriate ED. While there are 5 levels of ACS recognized trauma centers, levels 1 and 2 are represent the vast majority of accredited facilities, with some level 3 centers, primarily in rural areas, and virtually no designated level 4 or level 5 facilities. Facilities with a publicly stated level 3, 4 or 5 are often designated or certified as such at a state or regional level, rather than by the ACS. (https://jamanetwork.com/journals/jama/fullarticle/196242#:~:text=The%20results%20of%20this%20national,IV%2E
V%2C%2021 – table one).

Accreditation of stroke centers and cardiac centers followed, as did the more recent accreditation programs for chest pain, atrial fibrillation, and heart failure centers by the American College of Cardiology (ACC) Society for Cardiovascular Patient Care. The ACC recently developed an agreement with TJC that permits TJC to accredit hospitals initially using ACC standards with royalties paid to ACC.

Today, TJC and other accrediting bodies use quality metrics along with physical plant requirements and internal policies to establish standards for EDs in the US. While these standards may be used to measure quality and promote the use of quality improvement in a department, they do not address some of the critical issues that affect the care received by patients, particularly in the emergency department. In addition, they permit local practices that do not lead to a national level of care. Currently, TJC has no standards specific to ED physician qualifications, and permits institutions to establish their own standards. TJC standards on consultation resources are weak, dealing only with consultants on the hospital staff with response times determined by the institution. Their standards on hallway beds and board/crowding were not enforced and have now been eliminated.

Accreditation Council for Graduate Medical Education (ACGME)

The task force discussed the accreditation of residencies through the ACGME. The RRC-EM convened shortly after the American Board of Medical Specialties voted to recognize the specialty of EM. At that time there were several existing, non-accredited residency programs in EM. The initial criteria for residencies bear little resemblance to today’s criteria. For example, early on, attending staff were not required to be in the department 24/7, and later permitted to sleep through the night – in essence “on call.” Over time, criteria for supervision, education, and other facets of residency programs have been changed, effectively raising the bar. Yet even with this slow increase in expectations on the part of the hospital and faculty, few programs have closed, and most closures occurred for financial reasons rather than inability to meet more stringent ACGME standards.
Lessons Learned from Other Accreditation Programs

The task force reviewed the lessons learned from these other accreditation programs. The most effective accreditation programs are those with financial incentives/penalties (such as TJC/DNV). Finding these financial incentives for an Emergency Department Accreditation Program (EDAP) proved difficult. We had several individuals familiar with the insurance industry involved with the task force in the hopes we could find a financial incentive for hospitals that were accredited. While this may be an option in the future, our experts did not feel that insurance-based incentives would be possible in the early stages of the EDAP.

Accreditation programs appeal to the C-suite. This is particularly true of smaller and more rural hospitals that often cannot compete for many existing accreditation programs. However, the C-suite is getting tired of all of the accreditation programs, especially the ones that require on-site visits. One administrator from a large facility told the task force that it felt like every day there was another group doing an on-site visit. Accreditation programs that do not require on-site visits appear to have more appeal.

Accreditation can be meaningful for an institution; however, loss of accreditation can be “front page news.” GEDA has been very successful in using this to drive change and enhance programs. GEDA, like the ACGME RRC-EM, has used “conditional approval,” requiring changes within a set period of years. In general, large institutions are interested in accreditation if other large institutions are accredited or if accreditation drives desired market share. Smaller institutions are more interested in retaining community trust.

Criteria, once established, can be increased, and the “bar raised.” However, it is more difficult to lower the bar with time. Using the ACGME RCC-EM as an example, initially it required only a few faculty, then faculty had to be “in house” 24/7, then the faculty needed to be involved in all patients (in part this was billing but also had an ACGME component), then the majority of the faculty needed to be board certified, and finally the faculty that supervise residents must all be board certified.

ACEPs Prior Work on Accreditation/Certification (1984-2008)

ACEP has had several policies relating to categorization of EDs. These policies include “Categorization of Emergency Services,” approved by the Board of Directors in April 1984, reaffirmed in June 1992, and allowed to sunset in September 1997. The policy supported the integration of both horizontal and vertical categorization and stated that ACEP "supports the categorization of in-hospital EMS as a means of identifying in advance the ability of an institution to respond to patient needs. The matching of a patient's illness or injury to the proper level of care capability should promote both quality of care and cost effectiveness." This policy was allowed to sunset because categorization of EDs was considered an issue in which ACEP should not be involved.

A second ACEP policy relating to categorization, “Military Emergency Medical Systems,” was approved by the BOD in June 1988, with "volume and patient acuity being the primary determinants of categorization; volume and acuity should then determine the numbers and credentials of physicians and other providers." The revised policies “Military Emergency Medical Services Systems” and “Military Emergency Medicine,” which were approved by the BOD in June 1997, do not address the issue of categorization.

A third policy “Health Care Facility Definitions” was approved by the BOD in June 1985 and rescinded in April 1994. This policy defined emergency facilities and ambulatory care facilities in general terms of treatment of life-threatening conditions and non-life-threatening conditions.

ACEP's 1996 “Emergency Care Guidelines” states that "hospital based EDs must possess the staff and resources necessary to evaluate all persons presenting to the ED." The policy states that “a qualified EP... possesses the training and experience in emergency medicine sufficient to evaluate and initially manage and treat all patients who seek emergency care."

A fifth policy “Poison Information and Treatment Systems,” was approved by the BOD in September 1995. This policy states that "high quality toxicological treatment and poison information... will be enhanced by... continued development of regional toxicology treatment centers ... whose goal is excellence in clinical care, education, and research... and by the use of the resources of regional toxicology treatment centers for serious or unusual poisonings."
The 1994 Council Policy Forum held during ACEPs *Scientific Assembly* debated the question, "should ACEP be involved in certifying EDs?" The consensus was that ACEP should be involved in certifying EDs. Suggestions included categories based on volume, credentials of ED staff, resources, outcomes, and systems. Results of the Forum indicate Council approval for including physician credentials as part of the certification process, and rejection of physician credentials being based solely on the American Board of Emergency Medicine (ABEM) Board certification. Based on the discussions during the Forum, the Council requested ACEP investigate the feasibility of certification of EDs. During its January 1996 meeting, the Board decided not to pursue a College administrative accreditation program at that time. Board members recommended that staff efforts should be focused on influencing organizations such as the JCAHO (now TJC) and the National Committee on Quality Assurance (NCQA) in this area.

In 1998, the Council adopted resolution 15(98) Certifying Emergency Departments on ED categorization, regionalization, and certification/ accreditation. A task force, chaired by Dr. Brian Hancock (other members included Drs. Gail Anderson, Ken Frumkin, Tony Gerard, and Ron Hellstern) reported in 2000. They rejected the concept of regionalization or categorization, stating that “the emergency physician is trained to manage any patient presenting with an emergent condition.” Further, they advocated for “participation of emergency physicians in any policy group discussion that may have the effect of re-distributing emergency patients.” The task force also rejected the concept of ACEP creating an alternative or replacement to JCAHO and NCQA. They did suggest continued monitoring of the environment as it relates to certification and accreditation.

In 2008, another Council resolution, Amended Resolution 20(08) Emergency Department Categorization Task Force, again raised the issue of ED categorization. That task force (chaired by Dr. Abhi Mehrotra) created a matrix of levels – comprehensive, advanced, basic, and limited. The task force presented a list of 14 service subsections with the four levels for each. The task force presented to the Board in 2010 and at that time, the Board was concerned over the complexity of the data required. After debate, there was not Board support for this program to continue. (Article re: initial task force report https://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2010.00931.x – Appendix E is selected portions from the initial and the second task force reports – full report available from staff upon request at sschneider@acep.org).

**SAEM Effort**

In the 1990’s, the Society for Academic Emergency Medicine (SAEM) attempted certification for academic institutions. The bar was set remarkably high, designed to force institutions to make significant changes in their facilities and practices. Few institutions applied and only one attained certification. Because there was little interest on the part of academic institutions and because few applied, there were no market share incentives, and the program was discontinued.

**Proposed Emergency Department Accreditation Program**

**Criteria**

After some initial deliberation, the task force decided that it was necessary to create some draft criteria for an accreditation program before it could assess feasibility.

Initial draft criteria were created based upon ACEPs existing policies and are attached in Appendix B. All ACEP policies were reviewed, and statements related to the operation of an ED including staffing, patient care, etc. were collated. These were then turned into the initial criteria. Using a modified Delphi system, these criteria were voted on using a 1-5 scale. Criteria falling below the level of 4 were discussed, and a few criteria were eliminated. The task force then received additional direction from the Board and the ACEP president. This led to the inclusion of criteria extracted from existing policy that dealt with contracting arrangements. The task force voted and agreed on these new criteria.

The task force recognized that smaller, rural hospitals would find these initial criteria impossible to meet. A small subcommittee of the task force headed by Steven Jameson met several times and made recommendation to the task force based on prior Rural EM Task Force reports. Their recommendations relied heavily on the use of telehealth. They suggested following the model used by Mayo and other facilities which utilize NPs or PAs practicing in several geographically distant rural areas connected electronically to a centralized EP. The tracking board of those institutions...
is visible to the EP, allowing the physician to ask about any patient being evaluated. In the Mayo model, the treating NP or PA can present a patient to the EP via telemedicine connection but is not obligated to do so.

The task force recommends that only very rural and low volume hospitals be permitted to have a telehealth “accommodation” to a staffing requirement. While the task force voted that “rural” would be based on volume (less than 20K visits per year) and geography, their vote was superseded later by the Board that passed new policy identifying such hospitals as those that are designated “critical access” or “rural emergency hospitals.”

The criteria in Appendix B should be considered preliminary. If the project is approved by the Board, the criteria will be more thoroughly reviewed and presented separately to the Board for approval. Again, these initial criteria were used primarily for the purpose of assessing feasibility and the current Board vote will not be addressing these specific criteria.

The task force recommended additional criteria derived from the recent telehealth report. The Advisory Board representative from the Telehealth Committee produced additional criteria after consultation with leadership within the committee. These are noted in Appendix B.

The task force spent a lot of time discussing the options of a tiered system. Those opposing a tiered system were concerned that it would be more confusing to the public and that most criteria created in EDAP should be attainable by all hospitals, with the exception of staffing requirements. Those who supported a tiered system argued that tiering would make the program financially more feasible, and over time, allow for a “raising of the bar” which would improve quality. Ultimately, the task force voted via email, and a majority of task force members supported a tiered EDAP.

The Board recently passed an updated policy on the supervision of NPs and PAs attached as Appendix D. The other policies used for this document can be found linked to the standards in Appendix B and C.

Education of staff was a specific concern of the task force. The requirement for Board certification consistent with ACEPs policy defining an EP was felt to be sufficient evidence for on-going education of the physician staff. Current board certification by ABEM, the American Osteopathic Board of Emergency Medicine, and for Academic Pediatric Association’s Pediatric Emergency Medicine, attests to the knowledge and skill of its diplomates. Education standards need to be established for non-boarded physicians, NPs, and PAs. For the latter two groups, we suggest working with the American Academy of Emergency Nurse Practitioners and the Society of Emergency Medicine Physician Assistants to evaluate their current certification process and incorporate these certifications where appropriate.

The task force acknowledges that some EDs utilize non-boarded physicians, some of whom are ACEP members and have practiced EM for decades. In addition, there are some non-boarded physicians who completed residency training. ACEP has no policy that specifically deals with non-ABEM physicians practicing in EDs. Further consideration regarding the involvement of physicians who do not meet the ACEP definition of an EP will be needed as EDAP is developed, including whether or not such physicians would need to be supervised by ABEM-certified physicians or other physicians who meet the ACEP definition of an EP. The task force received guidance from our Board liaison and other Board members that supervision would be required for all physicians who do not meet the ACEP definition of an EP (copied below):

“An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.

It should be noted that residents in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency in emergency medicine are "emergency medicine resident physicians."

GEDA has taught us that there is value in monitoring the effect of an accreditation program over time. The task force suggests that one or more quality or patient outcomes metrics be required that will be reported by all participants. The
exact nature of this reporting, and the development of the common metric(s) will be established after Board initial approval and will be voted on by the Board in the next phase.

**Competition**

There are multiple accreditation programs initiated each year, so it is likely that other organizations will be interested in accrediting EDs certainly in the future. Accreditation can provide significant non-dues revenue while supporting physicians and providing improved care to patients. Though no accreditation service exists today, institutions and other specialties may be interested in developing such programs if ACEP does not.

TJC and other hospital accrediting bodies will see this as competitive. However, we hope that our program will be complementary to TJC and fill the gaps that currently exist in their standards. It is possible that TJC will approach ACEP about collaboration, however any such arrangement must provide that ACEP remains in control of the criteria for accreditation.

**Conclusion**

Ultimately, the ED Accreditation Task Force submits this report to the Board of Directors and recommends that the Board utilize external consultants to develop a business plan for a tiered ED Accreditation Program (EDAP). They request that the Board provide clarity around whether all accreditation tiers will require direct oversight of all nurse practitioners (NPs) and physician assistants (PAs) as well as non-EM Boarded physicians, as this core issue was discussed, but not resolved at the Task Force level.
Proposed Initial Criteria for Accreditation
Note: EP stands for an emergency physician as defined by existing ACEP policy.

STAFFING

Medical Director
• Emergency department (ED) medical director is ABEM/AOBEM certified.
• The ED medical director is responsible for assessment of clinical privileges.
• ED medical director is involved in decisions regarding equipment purchases for hospital that would involve ED (EHR).

Physician Staffing
• There is an EP physically on duty 24/7/365.
• An EP is aware and able to see every patient seen by an NP or PA.
• EPs are not required to sign charts of patients they did not see.
• Emergency physicians can perform procedural sedation in accordance with ACEPs guidelines (include propofol/ketamine, non-fasting, single provider with nurse).
• The term "doctor" during clinical care in the ED is limited to physicians or, if used by a non-physician, is clarified.
• The emergency physician is a member of the trauma team if one exists.
• Physician contracting and credentialing.
• The emergency physicians, regardless of employment status, have the same rights and privileges as other members of the medical staff.
• The hospital provides due process for emergency physicians regardless of employment/contractual arrangements.
• The hospital's contract for emergency physician coverage includes due process by the contracting vendor.
• The emergency physician has the right to view itemized reports of what is billed and collected for their service at least semi-annually.
• Contracts with the emergency physician, including both hospital and contracting vendor, do not include a restrictive covenant.
• Medical staff credentialing and privileging forms do not include questions regarding prior psychiatric care.
• Hospital contracts, and those contracts provided by staffing companies, shall include policies that support family leaves of absence.
• Hospitals that require current ACLS, PALS and ATLS certification will provide their rationale for these required courses.

Nurse Practitioners (NPs) and Physician Assistants (PAs)
• NPs and PAs do not practice independently in the ED. The emergency physician on duty is aware of all patients.
• The emergency physician is responsible for the ongoing practice evaluation of each NP and PA.
• All NPs and PAs must complete ED specific training prior to starting in the ED and attain certification through AAENP or SEMPA in the first five years of employment.
• Nursing staffing.
• There is adequate staff to evaluate all individuals presenting to the ED.
• The institution supports emergency nurses to attain certified emergency nurse certification.
• Other staff.
• There is access 24/7 to social work in person or via telehealth.
• There is a formal onboarding process for all ED staff members.

POLICIES

• There is a disaster plan and a surge plan in place.
• The following written policies exist and are followed:
  o Response time for consultants including expectation and monitoring.
  o There is a hospital policy that states the admitting physician is responsible for all care of the patient once the admitting physician accepts the patient.
Responsibility for patient notification regarding incidental findings on X-ray or imaging, including those reported after the patient has departed the ED

Responsibility for patient notification of critical abnormal laboratory values including fecal occult blood results found during the patient encounter and those reported after the patient has left the ED

Responsibility for the care of inpatients boarded in the ED (nursing and physician)

Responsibility for the care of critical care patients boarded in the ED (nursing and physician)

Disposition of patients who do not meet criteria for inpatient admission but cannot be safely discharged home including how long such patients can remain in the ED before they are admitted and the service/physician responsible for their care

Responsibility for the care of patients with primary psychiatric disease who are boarded in the ED (physician responsible, protocols for care).

Expected response time for consultants called to the ED

Acceptance of the responsibility of care by the admitting physician (writing of orders, etc.).

Referral method for patients with non-emergent dental complaints.


All staff are permitted to eat and drink at the workstation while on duty.

QUALITY

- There is a quality assurance program in place.
- Quality metrics are monitored and reported.
- Peer review of an emergency physician is conducted by another licensed EP.
- Issues of physician disciplinary, quality of care or credentialing pertaining to medical care are reviewed and affirmed by a licensed emergency physician.
- ED leadership tracks utilization of imaging studies and includes quality assurance feedback to ED clinicians on evidence-based utilization (EQUAL).
- ED leadership tracks re-admission rates and works with hospitals on interventions to reduce 72-hour re-admissions in a patient-centered, safe manner.
- Sites must report their quality data to a QCRD or provide an explanation of how their quality performance is measured and assessed against regional or national data.
- Sites should provide a list of quality measures currently monitored in the ED.
- Sites should have physician review of quality measurements that are reported on physician and show that physicians are involved in the selection and the assessment of measures.
- Individual physicians shall receive reports on their quality performance on quality measures at least quarterly and their performance compared to others (anonymous) in the group and, if available, national, or regional data.
- Patient experience data should be used to improve performance, viewed in aggregate as well as individually, and should not be used to calculate a financial reward or penalty.

EQUIPMENT/ PHYSICAL PLANT

- ED ultrasound is available 24/7.
- There is a sanitary, private, non-bathroom area proximal to the ED for ED employees who are breastfeeding.
- There is an information system with ED-specific functionality for triage, documentation, CPOE, results-reporting, decision support, order sets, medication prescribing, patient tracking, and ED operations support (an Emergency Department Information System - EDIS).
- There is health information exchange capability, whether through a regional HIE or through other HIE networks, to enable integrated access to patient records from other institutions.
- There is an adequate end-to-end internet bandwidth to support telehealth and tele-imaging.
- EP has dedicated access to a workstation for patient management which is reasonably accessible near the patient care area(s).
- There is a sufficient institutional support for EDIS configuration, data collection and reporting is required to meet quality reporting, operational reporting, and outcomes measurement needs.
- There is a policy and process for regular updates to the EDIS system in alignment with Vendor procedures.
- There is a policy for rapid response to health information technology (HIT) issues.
- There is a well-developed and tested downtime procedure.
- There is participation in a QCDR with ED specific measures.
There is reporting of HIT environment parameters including EDIS vendor, module, and version; the presence of clinical IT liaison dedicated to the ED. [please recommend other items to report back to the credentialing committee.]

There is remote access to the EDIS.

PATIENT CARE

- The ED has resources for victims of domestic/family violence.
- Translation services in person or via telehealth.
- Computerized physician order entry system available for all medication orders.
- Food and drink are available to patients (age appropriate).
- The site shall review their pediatric readiness status at least every two years and develop remediation plans to correct deficiencies.
- The ED is included in infection control measures followed by the rest of the hospital.
- The hospital and ED meet “peds-readiness” criteria.
- Pediatric weights are recorded in kilograms.
- Time from presentation to discharge for treat and release patients is monitored and recorrect.
- Time from presentation to the decision to admit and time from decision to admit till the patient leaves the ED is monitored and recorded.

SAFETY

- The safety of staff, visitors and patients is ensured.
- Reporting of verbal and physical assault is mandatory.
Proposed Initial Criteria with Citation of Existing ACEP Policy
Note: EP stands for an emergency physician as defined by existing ACEP policy

STAFFING

Medical Director

Physician Staffing
- The term "doctor" during clinical care in the ED is limited to physicians or, if used by a non-physician, is clarified. [https://www.acep.org/patient-care/policy-statements/use-of-the-title-doctor-in-the-clinical-setting/](https://www.acep.org/patient-care/policy-statements/use-of-the-title-doctor-in-the-clinical-setting/)

Physician Contracting and Credentialing
- The emergency physicians, regardless of employment status, have the same rights and privileges as other members of the medical staff. [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf](https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf)
- The emergency physician has the right to view itemized reports of what is billed and collected for their service at least semi-annually. [https://www.acep.org/globalassets/new-pdfs/policy-statements/compensation-arrangements-for-emergency-physicians.pdf](https://www.acep.org/globalassets/new-pdfs/policy-statements/compensation-arrangements-for-emergency-physicians.pdf)
• Contracts with the emergency physician, including both hospital and contracting vendor, do not include a restrictive covenant. https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-physician-rights-and-responsibilities.pdf
• Hospital contracts, and those contracts provided by staffing companies, shall include policies that support family leaves of absence. https://www.acep.org/globalassets/new-pdfs/policy-statements/family-and-medical-leave.pdf
• Hospitals that require current ACLS, PALS and ATLS certification will provide their rationale for these required courses. https://www.acep.org/patient-care/policy-statements/use-of-short-courses-in-emergency-medicine-as-criteria-for-privileging-or-employment/

Nurse Practitioners (NPs) and Physician Assistants (PAs)
• https://www.acep.org/patient-care/policy-statements/providers-of-unsupervised-emergency-department-care/
• https://www.acep.org/patient-care/policy-statements/providers-of-unsupervised-emergency-department-care/
• All NPs and PAs must complete ED specific training prior to starting in the ED and attain certification through AAENP or SEMPA in the first five years of employment https://www.acep.org/globalassets/new-pdfs/policy-statements/guidelines-reg-the-role-of-physician-assistants-and-nurse-practitioners-in-the-ed.pdf
• https://www.acep.org/patient-care/policy-statements/providers-of-unsupervised-emergency-department-care/

Nursing Staffing
• There is adequate staff to evaluate all individuals presenting to the ED. https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf

Other Staff
• There is access 24/7 to social work in person or via telehealth. https://www.acep.org/globalassets/new-pdfs/policy-statements/social-work-and-case-management-in-the-emergency-department.pdf
• There is a formal onboarding process for all ED staff members. https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf

POLICIES
• There is a disaster plan and a surge plan in place. https://www.acep.org/globalassets/new-pdfs/policy-statements/disaster-planning-and-response
• The following written policies exist and are followed:
  o Response time for consultants including expectation and monitoring
  o There is a hospital policy that states the admitting physician is responsible for all care of the patient once the admitting physician accepts the patient https://www.acep.org/patient-care/policy-statements/responsibility-for-admitted-patients/
  o Responsibility for patient notification regarding incidental findings on Xray or imaging, including those reported after the patient has departed the ED
  o Responsibility for patient notification of critical abnormal laboratory values including fecal occult blood results found during the patient encounter and those reported after the patient has left the ED
Responsibility for the care of inpatients boarded in the ED (nursing and physician)
Responsibility for the care of critical care patients boarded in the ED (nursing and physician)
Disposition of patients who do not meet criteria for inpatient admission but cannot be safely discharged home including how long such patients can remain in the ED before they are admitted and the service/physician responsible for their care
Responsibility for the care of patients with primary psychiatric disease who are boarded in the ED (physician responsible, protocols for care).
Expected response time for consultants called to the ED
Acceptance of the responsibility of care by the admitting physician (writing of orders, etc.).
Referral method for patients with non-emergent dental complaints.
All staff are permitted to eat and drink at the workstation while on duty. https://www.acep.org/patient-care/policy-statements/food-and-drink-for-staff-in-the-emergency-department/

QUALITY

- Quality metrics are monitored and reported.
- Issues of physician disciplinary, quality of care or credentialing pertaining to medical care are reviewed and affirmed by a licensed emergency physician.
- ED leadership tracks utilization of imaging studies and include quality assurance feedback to ED clinicians on evidence-based utilization (EQUAL)
- ED leadership tracks re-admission rates and works with hospitals on interventions to reduce 72-hour readmissions in a patient-centered, safe manner.
- Sites must report their quality data to a QCRD or provide an explanation of how their quality performance is measured and assessed against regional or national data.
- Sites should provide a list of quality measures currently monitored in the ED.
- Sites should have physician review of quality measurements that are reported on physician and show that physicians are involved in the selection and the assessment of measures.
- Individual physicians shall receive reports on their quality performance on quality measures at least quarterly and their performance compared to others (anonymous) in the group and, if available, national, or regional data.
- Patient experience data should be used to improve performance, viewed in aggregate as well as individually, and should not be used to calculate a financial reward or penalty.

EQUIPMENT/ PHYSICAL PLANT

- There is a sanitary, private, non-bathroom area proximal to the ED for ED employees who are breastfeeding. https://www.acep.org/globalassets/new-pdfs/policy-statements/support-for-nursing-mothers.pdf
- There is an information system with ED-specific functionality for triage, documentation, CPOE, results-reporting, decision support, order sets, medication prescribing, patient tracking, and ED operations support (an Emergency Department Information System - EDIS). https://www.acep.org/globalassets/new-pdfs/policy-statements/health-information-technology-for-emergency-care.pdf
- There is health information exchange capability, whether through a regional HIE or through other HIE networks, to enable integrated access to patient records from other institutions. https://www.acep.org/globalassets/new-pdfs/policy-statements/health-information-technology-for-emergency-care.pdf
- There is an adequate end-to-end internet bandwidth to support telehealth and tele-imaging
- EP has dedicated access to a workstation for patient management which is reasonably accessible near the patient care area(s)
• There is a sufficient institutional support for EDIS configuration, data collection and reporting is required to meet quality reporting, operational reporting, and outcomes measurement needs. [https://www.acep.org/globalassets/new-pdfs/policy-statements/health-information-technology-for-emergency-care.pdf]

• There is a policy and process for regular updates to the EDIS system in alignment with Vendor procedures.
• There is a policy for rapid response to HIT issues
• There is a well-developed and tested downtime procedure
• There is participation in a QCDR with ED specific measures
• There is reporting of HIT environment parameters including EDIS vendor, module, and version; the presence of clinical IT liaison dedicated to the ED. [please recommend other items to report back to the credentialing committee.]
• There is remote access to the EDIS

PATIENT CARE

• The ED has resources for victims of domestic/family violence. [https://www.acep.org/patient-care/policy-statements/domestic-family-violence/]
• Translation services in person or via telehealth. [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf]
• Food and drink are available to patients (age appropriate)
• The site shall review their pediatric readiness status at least every two years and develop remediation plans to correct deficiencies.
• The ED is included in infection control measures followed by the rest of the hospital. [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department.utilization.during.outbreaks.of.influenza.pdf]
• The hospital and ED meet "peds-readiness" criteria. [https://www.acep.org/globalassets/new-pdfs/policy-statements/pediatric-readiness-in-emergency-medical-services-systems.pdf]
• Time from presentation to discharge for treat and release patients is monitored and recorded [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf]
• [https://www.acep.org/globalassets/new-pdfs/policy-statements/crowding.pdf]
• Time from presentation to the decision to admit and time from decision to admit till the patient leaves the ED is monitored and recorded. [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf]
• [https://www.acep.org/globalassets/new-pdfs/policy-statements/crowding.pdf]

SAFETY

• The safety of staff, visitors and patients is ensured. [https://www.acep.org/globalassets/new-pdfs/policy-statements/emergency-department-planning-and-resource-guidelines.pdf]
• Reporting of verbal and physical assault is mandatory. [https://www.acep.org/patient-care/policy-statements/protection-from-violence-in-the-emergency-department/]
• [https://www.acep.org/globalassets/new-pdfs/policy-statements/safer-working-conditions-for-emergency-department-staff.pdf]
Physician assistants (PAs) and nurse practitioners (NPs) serve as integral and valued members of the physician-led emergency department care team. They do not possess the training and expertise in emergency medicine that may only be acquired through successful completion of an ACGME-accredited emergency medicine residency training program - there are no exceptions. The American College of Emergency Physicians (ACEP) believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams. Accordingly, ACEP endorses the following principles for EDs that utilize PAs and/or NPs in the delivery of emergency department care.

Emergency Department Physician-Led Care Teams

- Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.

- EDs should have a Medical Director who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.
• The ED Medical Director should be responsible for the orientation and ongoing professional practice evaluation of PAs and NPs working in the ED. The individual evaluative process should be transparent and should provide PAs and NPs with constructive feedback including recommendations for clinical care delivery improvement and professional development.

• As PAs and NPs have variable training and experience, the ED Medical Director should have the authority to approve both departmental credentialing and for the granting of clinical privileges for PAs and NPs working in the ED.

• ACEP supports the ongoing educational efforts of PAs and NPs in order to improve their clinical and professional knowledge and skills. These ongoing educational efforts may include formal postgraduate emergency medicine training programs. However, these postgraduate training programs for PAs and NPs do not provide training comparable to that provided in an ACGME-accredited emergency medicine residency training program and will never substitute for this comprehensive, specialized, and standardized training.

• ACGME-accredited emergency medicine residency training of physicians should include training in the value and importance of the emergency physician-led care team. This training should include instruction on how to effectively supervise PAs and NPs.

Emergency Physician Supervision of PAs and NPs

• ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.

• The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided “Onsite” or “Offsite” as defined below.

• While there are ongoing efforts to achieve the gold standard of all ED care being provided by an emergency physician, ACEP believes that there are, at the present time, workforce limitations to specific types of CMS-designated facilities located in rural or frontier areas where emergency physicians may provide supervision of an PA/NP in an ED through telehealth means.

• The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided “Offsite” by telehealth means are as follows:
  ○ Critical Access Hospitals (CAHs)
  ○ Rural Emergency Hospitals (REHs)

Supervision of PAs and NPs

For all patients being cared for by a PA or NP within the ED, the on-duty emergency physician should solely determine which level of supervision is appropriate. This determination should be made based upon the clinical patient information available and an individual assessment of the PA or NP caring for the patient. Emergency physicians should always have the authority and opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP while they are on duty. Emergency physicians must be allowed to determine their level of interaction, care, and involvement for patients seen by a PA or NP under their supervision.

The following concepts of supervision are defined as follows:
• “Direct” versus “Indirect” Supervision - defines the **degree of involvement** of the emergency physician in the care of a patient being seen by a PA or NP.
  
  o **Direct Supervision**: When the supervising physician personally examines/evaluates the patients for which she/he is the supervisor. This is the gold standard of supervision.
  
  o **Indirect Supervision**: When the supervising physician contemporaneously discusses or reviews the management of patients for which she/he is the supervising physician but does not personally examine/evaluate the patient.

• “Onsite” versus “Offsite” Supervision – delineates the **location** of the supervising emergency physician for patients being cared for by a PA or NP.
  
  o **Onsite**: When the supervising physician is **physically** present in the ED and is available to examine/evaluate the patient.
  
  o **Offsite**: When the supervising physician is **not physically** present in the ED but is available 24/7/365 for real-time consultation such as by telehealth means. As stated above, “Offsite Supervision” is only appropriate for ED patients being cared for by a PA or NP in the following CMS-designated facility types:
    
    - Critical Access Hospitals (CAHs)
    - Rural Emergency Hospitals (REHs)

  - Since the supervising emergency physician is not physically present when providing “Offsite Supervision,” the PA or NP caring for the patient MUST discuss ALL patients with the supervising physician.

• The following levels of emergency physician involvement in the care of patients seen by a PA or NP are **NOT adequate** for optimal patient care and are **NOT considered** appropriate supervision of an PA or NP in the ED.
  
  o **Oversight**: When an emergency physician is available for supervision, but the PA or NP does not discuss or review the management of the patient, and the physician is not involved in real-time patient care or does not examine/evaluate the patient directly.
  
  o **Asynchronous Chart Review**: Review of charts in a non-contemporaneous manner for care provided by an PA or NP. While chart review is an important quality assurance activity, it does not constitute direct or indirect supervision.

**Additional Concepts**

- Multiple staffing models utilizing PAs and NPs exist. The use of PAs and NPs in the ED should be determined at the site level by local ED physician leadership, who are responsible for PA/NP hiring, supervision and credentialing of clinical privileges. These emergency physician leaders should be responsible for establishing processes and practice standards that ensure both sufficient physician availability for PA and NP supervision as well as adequate physician opportunity to supervise.

- Emergency physicians should not be required to sign the chart of a patient unless they have a real-time opportunity to be involved in the patient’s care. Though state and hospital policies may require
a physician signature on all patient charts regardless of physician involvement or supervision, it should be clearly noted in these cases that the physician was not actively involved in the patient’s care.

- All clinical documentation should clearly reflect the role and involvement of the emergency physician and any PAs or NPs who have actively participated in the care of a patient. In particular, the physician should carefully document their independent findings and medical decision making.
In order to develop a comprehensive and organized list of data elements for the registry, the task force used the framework of the Categorization of Hospital Emergency Services (CHES) system developed in the 1980s. Due to the scope and complexity of the process, it was agreed that a categorization system would provide context for the hospital emergency care registry data development process and determining the data elements that should be included in ACEP's emergency medicine registry. The CHES process is defined as a method to catalogue services, equipment, and medical staff coverage routinely provided to patients with emergency medical conditions at a facility and makes distinctions between levels of service that are available. The levels that the task force designated are:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td><strong>Comprehensive</strong> hospital emergency services for specific disease silos - comprehensive ED and specialized in-patient intensive care services and specialized diagnostic, operative, and therapeutic services and equipment, and with in-house and/or promptly available physician specialists related to the disease silo.</td>
</tr>
<tr>
<td>A</td>
<td><strong>Advanced</strong> hospital emergency services for specific disease silos - advanced ED and in-patient intensive care services and most specialized diagnostic, operative, and therapeutic services and equipment, and with promptly available physician specialists related to the disease silo.</td>
</tr>
<tr>
<td>B</td>
<td><strong>Basic</strong> hospital emergency services for specific disease silos - basic ED and in-patient care services and diagnostic, operative, and therapeutic services and equipment, and with selected physician specialists available for consultation.</td>
</tr>
<tr>
<td>L</td>
<td><strong>Limited</strong> hospital emergency services for specific disease silos - limited ED and in-patient care and diagnostic services and equipment, and with limited physician specialists available for consultation.</td>
</tr>
</tbody>
</table>

The task force considered the levels of service available in emergency departments for a broad spectrum of emergency medical conditions (horizontal categorization) and the specific levels of emergency care services available for a variety of time-sensitive clinically related conditions or clinical silos (vertical categorization). The task force expanded the CHES model to systematically identify the services and resources needed to provide limited emergency services through comprehensive specialized emergency care. The emergency service silos (Attachment A) identified for criteria development were:

- Emergency Department Services
- Amputation/Replantation Injury
- Burns
- Cardiovascular/Respiratory
- Neonatal
- Neurovascular
- Obstetrical-Gynecological
- Pediatric
- Poisoning Care
- Psychiatric/Behavioral Health
- Radiation/Toxic Material Exposure
- Sexual Assault
- Spinal Cord Injury
- Trauma

Criteria for the silos were established which define the services, facilities, equipment and medical staff coverage needed for each of the four levels of service (Comprehensive,
<table>
<thead>
<tr>
<th>CHES Level of Emergency Department Services</th>
<th>L</th>
<th>B</th>
<th>A</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Licensed Basic Hospital Services - Medical, Surgical, Nursing, Anesthesia,</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Laboratory, Radiological, Pharmaceutical and Dietary</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2a Emergency Department Physician Staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABEM or ABOEM Certified EP on duty 24/7/365</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ABEM or ABOEM Certified EP serving as ED Medical Dir</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emergency Physician on duty 24/7/365</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physician on-call and available within 15 minutes</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine Residency Training Program</td>
<td></td>
<td></td>
<td></td>
<td>optnl</td>
</tr>
<tr>
<td>Emergency Physician Participation in Hosp Exec Cmte</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2b ED Nursing Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN licensed CEN Certified Nurse Manager / patient care coordinator w/ masters</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>degree in nursing, health care admin or business admin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN licensed CEN Certified Nurse Manager &gt; 3 yrs ED experience</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN licensed Nurse Manager</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN licensed CEN certif staff nurse(s) on duty 24/7/365</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>RN licensed staff nurse(s) on duty 24/7/365</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>RN or LVN licensed staff nurse on duty 24/7/365</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ED nurse education program</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2c ED Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanism to limit unauthorized entry into treatment areas</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multiple &gt;200 sq ft areas for critical care resuscitations</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Separate 150 sq ft treatment area(s) for resuscitations</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Separate negative pressure area(s) for care of patients requiring</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiberoptic laryngoscope /available to ED ?</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy instrument and supplies</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cricothyrotomy equipment and supplies</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BiPAP ventilation system</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ENT emergency tray</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Slit-lamp</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonometer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Difficult airway box or tray</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Suprapubic catheters, urethral sounds</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

4 Inpatient Care Services
<table>
<thead>
<tr>
<th>Service</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Care Unit</td>
<td>X</td>
</tr>
<tr>
<td>Intensive/critical Care Unit</td>
<td>X</td>
</tr>
<tr>
<td>Surgical Intensive Care Unit</td>
<td>X</td>
</tr>
<tr>
<td>Neurologic Intensive Care Unit</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient nursing service</td>
<td>X</td>
</tr>
<tr>
<td>Operating Suite Services 24/7/365 on 30 min notice</td>
<td>X</td>
</tr>
<tr>
<td>Operating Suite Services - multiple simultaneous suites and staffing capability within 30 min.</td>
<td>X</td>
</tr>
<tr>
<td>Operating Suite Services - 24/7/365 in-house staffing</td>
<td>X</td>
</tr>
<tr>
<td>Hemodialysis services</td>
<td>Access to hemodialysis services __ days / wk</td>
</tr>
<tr>
<td>Access to hemodialysis services 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>Nuclear Medicine Service</td>
<td>coronary perfusion scanning capability within 8 hrs</td>
</tr>
<tr>
<td>VQ lung scanning within 8 hours</td>
<td>X</td>
</tr>
<tr>
<td>Lab / Transfusion Services</td>
<td>access to T+CM blood for transfusion within 1 hr.</td>
</tr>
<tr>
<td>access to 5 units blood for transfusion within 30 min.</td>
<td>X</td>
</tr>
<tr>
<td>Comprehensive diagnostic and pathology lab services</td>
<td>X</td>
</tr>
<tr>
<td>Limited lab services, CBC, Chem 12, LFTs, routing cultures, etc</td>
<td>X</td>
</tr>
<tr>
<td>Blood gass analysis</td>
<td>X</td>
</tr>
<tr>
<td>Radiology Service - access to:</td>
<td>X</td>
</tr>
<tr>
<td>interventional radiology services 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>interventional radiology services - within 1 hr.</td>
<td>X</td>
</tr>
<tr>
<td>angiography, peripheral vascular - 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>CT angiography 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>CT scanner 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>CT angiography - elective</td>
<td>X</td>
</tr>
<tr>
<td>MRI within 8 hrs</td>
<td>X</td>
</tr>
<tr>
<td>MR Angiography</td>
<td>X</td>
</tr>
<tr>
<td>Bedside ultrasound in ED</td>
<td>X</td>
</tr>
<tr>
<td>Ultrasound diagnostic services within 1 hr. 24/7/365</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Medicine Research and Training Program including residency training in emergency medicine</td>
<td>optnl</td>
</tr>
<tr>
<td>Specialty Availability</td>
<td>In-house 24/7/365</td>
</tr>
<tr>
<td>General surgeon or general surgery resident</td>
<td>X</td>
</tr>
<tr>
<td>Internist or internal medicine resident</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Department Services</td>
<td>DRAFT</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Anesthesiologist or anesthesiology resident</td>
<td>X</td>
</tr>
<tr>
<td>In-house or on-call and available w/i 15 min.</td>
<td></td>
</tr>
<tr>
<td>General surgeon or general surgery resident</td>
<td>X</td>
</tr>
<tr>
<td>Anesthesiologist or anesthesiology resident</td>
<td>X</td>
</tr>
<tr>
<td>On-call and available within 30 min.</td>
<td></td>
</tr>
<tr>
<td>General surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>X</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>X</td>
</tr>
<tr>
<td>Gastroenterologist</td>
<td>X</td>
</tr>
<tr>
<td>Internist / family practitioner</td>
<td>X</td>
</tr>
<tr>
<td>Nephrologist</td>
<td>X</td>
</tr>
<tr>
<td>Neurosurgeon</td>
<td>X</td>
</tr>
<tr>
<td>Obstetrics-gynecologic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Ophthalmologic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Orthopedic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Otorhinolaryngologic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>X</td>
</tr>
<tr>
<td>Plastic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>X</td>
</tr>
<tr>
<td>Pulmonologist</td>
<td>X</td>
</tr>
<tr>
<td>Thoracic - vascular surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Urologic surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Neuroradiologist</td>
<td>X</td>
</tr>
<tr>
<td>On the Medical Staff</td>
<td></td>
</tr>
<tr>
<td>Hand surgeon</td>
<td>X</td>
</tr>
<tr>
<td>Oral medicine / dental surgeon</td>
<td>X</td>
</tr>
</tbody>
</table>
President-Elect Candidates
2022 President-Elect Candidates

Aisha T. Terry, MD, MPH, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV
### Question #1: What can ACEP do to proactively respond to current trends in physician reimbursement?

ACEP does an excellent job of ensuring that the voice of emergency physicians (EPs) is heard during the many processes that determine our reimbursement each year. From influential quarterly meetings with the Centers for Medicare and Medicaid Services (CMS) to stellar representation on the American Medical Association (AMA) RVS Update Committee (RUC), emergency medicine (EM) consistently has a highly regarded voice at the table during reimbursement decision-making. As the new year swiftly approaches, we must now focus efforts on targeted EP education and advocacy efforts in order to prepare for many major reimbursement changes that will dramatically impact our practice as of January 1, 2023.

Below are my top 3 reimbursement changes, listed in increasing importance, with #1 being the most critical reimbursement challenge we will face in 2023:


For the first time since 1995, the mapping of medical documentation in EM to determine the associated code level is changing as of January 1, 2023. The impetus for these changes was based on the AMAs response to members wanting a more streamlined approach to documentation. Previously, code level was determined based on history, physical examination, and medical decision making (MDM), but will now be based upon time or MDM. The anticipated changes are robust, and if not well understood, could result in major reimbursement deficits for EPs.

**What can ACEP do?** Work now to education EPs about the upcoming changes in the guidelines and lobby to have emergency services determined by MDM, rather than time which is not a descriptive element of evaluation and management (E/M) codes in EM.

#### #2: Telehealth

Increased telehealth reimbursement is a silver lining of the pandemic. All 5 ED E/M codes, critical care codes, and some observation codes are now billable via telehealth provision through December 31, 2023. Other flexibilities related to telehealth have also been implemented based on the public health emergency (PHE), such as allowing telehealth reimbursement for care provided outside of traditional geographic limitations, which has improved access to care especially in rural areas. It is unclear as to when such flexibilities will end.

**What can ACEP do?** Intensify efforts to influence CMS to make permanent the reimbursement of telehealth services. Encourage members to collect data which demonstrates quality provision of care via telehealth.

#### #1: Merit-based Incentive Payment System (MIPS)

MIPS is the major value-based performance program for Medicare. It evaluates physician performance based on the weighted categories of quality, cost, improvement activities, and promoting interoperability which determines an upward, neutral, or downward payment adjustment. EPs could face up to a 9% penalty in Medicare reimbursement. MIPS has been phased in since its inception in 2017 and has allowed for hardship waivers during the pandemic, such that most physicians have avoided penalties thus far. In 2022, however, the threshold for avoiding a penalty was set higher than the year before making it more challenging. It is anticipated that in 2023 CMS will again raise the bar in terms of eligibility for avoiding a penalty. Further, pandemic hardship waivers will likely be a thing of the past in the new year.

**What can ACEP do?** ACEP must continue to educate EPs about the MIPS thresholds, weighted categories, and new MIPS Value Pathways (MVP) options. ACEP can also continue to encourage greater participation with the College’s Qualified Clinical Data Registry (CEDR) which provides the vehicle by which MIPS reporting can be done seamlessly.
**Question #2:** What would you choose as your main focus if you were allowed only one accomplishment while serving as president?

As President of ACEP, I will exemplify phenomenal leadership by doing more than just delivering messages and ideas, but by also embodying them in a way that fosters inspiration and trust. I will lead by example in order that others will be compelled to follow and emulate. My hope is that future leaders of the College will one day feel that they are “standing on my shoulders,” affording them a broadened vantage point and ability to “see” further than I. A President’s legacy is only as good as their ability to advance the progress made by their predecessor and to inspire younger generations to carry the torch in perpetuity. While I am elated and energized by the opportunity to lead our College at this most pivotal time in our history, I wisely realize that my efforts alone will not adequately bring about the far-reaching renewal and reform that we need. Thus, if only allowed a single accomplishment as President, I would choose to focus on leaving a lasting impression on current and future generations through my leadership and leadership development.

The unprecedented challenges and unchartered territory faced by our specialty would be best tackled by intentionally using a collaborative, multi-year approach, led by a diversity of leadership who play essential roles on the team. The key to addressing tough topics like physician autonomy, scope of practice, a resource-constrained environment, and moral injury, is to empower an appointed leadership team, equipped with the skillset and passion necessary to bring about meaningful change. Leadership development is about providing promising individuals with exposure, mentorship, and apprenticeship, in a way that amplifies their unique talents. Given the challenges caused by the pandemic over the past few years - now more than ever - we need to be inspired, uplifted, and valued.

**Question #3:** What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?

“The world is getting too small for both an Us and a Them. Us and Them have become co-dependent, intertwined, fixed to one another. We have no separate fates, but are bound together in one.” - Sam Killermann

Divisive issues – those that tend to foster disagreement and even hostility – create the illusion of there being an “us” and a “them.” This illusion creates a sense of competition wherein there must be a winner and a loser, allowing little to no space for listening and compromise. Time and time again, divisiveness has resulted in stress, anxiety, and damaged relationships. As we continue to weather the far-reaching impacts of the pandemic and find ourselves coping with unprecedented amounts of burnout, it is especially important that divisiveness be stamped out as it only further depletes our energy and hope for a brighter future.

Most acknowledge that divisiveness is a problem and would appreciate a path forward. In fact, the Public Agenda/USA Today Hidden Common Ground survey from February 2021, found powerful consensus across political affiliations that our country needs to move beyond the destructive nature of political divisiveness. It also found that most think that there is more common ground amongst the public than is typically acknowledged, but that disagreements tend to be handled destructively rather than constructively.

Whether the issue is firearm violence or the role of private equity in health care, we know that our specialty will continue to grapple with really tough topics. Divisive issues are typically related to ethics and personal choice which fosters strong opinions as well as proposed solutions that tend to be polarized and inflexible. Rather than focus on the issue, we must determine how to minimize the destructive potential of the divisiveness. An issue does not in and of itself create division; rather, our approach and accompanying emotions involved with resolving the issue determines the degree of vitriol felt. In the words of Eckhart Tolle, “rather than being [our] thoughts and emotions, [we must] be the awareness behind them.”

As a two-term ACEP Board of Directors member, I marvel at how well my fellow Board colleagues struggle with and come to important decisions on challenging issues. We are diverse, having representation from various geographic locations, political ideologies, and demographic backgrounds, yet we spend hours having cordial and honest discussions about a myriad of complex and controversial topics; we listen to each other and respect each others’ perspectives. Perhaps most importantly, we are influenceable. We realize that there are several ways to reach an end goal, and that one must be open to exploring them all, while factoring in key elements like unintended consequences, justice, timing, and practicality.

Having led health policy efforts as an associate professor and advocate in our nation’s capital for over a decade, I understand the necessity, yet challenge of achieving bipartisan wins. The divisive issues in Washington, DC are many, but the skilled policymaker and advocate focuses on discovering and exposing commonalities on both sides of the aisle. The best bills are those that are bipartisan and have a Senate and House version; this approach tends to be most efficient relative to energy and often successful.

As we seek to mitigate the effects of divisiveness, being mindful of our emotions, listening, being influenceable, and intently seeking to discover and expose commonality are examples of strategies to employ.
Aisha T. Terry 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)**

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

**Education (include internships and residency information)**

1999  
Duke University  
Durham, North Carolina  
Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor

**POST GRADUATE EDUCATION AND MEDICAL TRAINING:**

2003-2006  
University of Maryland Medical System, Department of Emergency Medicine  
Emergency Medicine Residency Program

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

**Specialty Board Certifications (e.g., ABEM, AOEBEM, AAP, etc.) and dates certified and recertified**

2008  
Board Certified (ABEM) in Emergency Medicine; re-certified 2018

2011  
Washington, DC, medical license (active)
Professional 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)

National ACEP Activities – List your most significant accomplishments

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
2017-2019  ACEP 2nd Journal Editor-in-Chief Search Committee Task Force, member
2020-2023  Board of Directors, elected member (2nd term)
  • ACEP Secretary/Treasurer
  • ACEP Quality and Patient Safety Committee, Board liaison
  • ACEP CEDR Committee, Board liaison
  • ACEP Quality Improvement and Patient Safety Section, Board liaison

American College of Emergency Physicians
2008  Hero in Emergency Medicine Award
2009  ACEP Council Teamwork Award
2018  ACEP Council Diversity Champion Award
2021  ACEP John G. Wiegenstein Leadership Award (nominee)

ACEP Chapter Activities – List your most significant accomplishments

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

**Practice Profile**

*Total hours devoted to emergency medicine practice per year:* 1200 Total Hours/Year

**Individual % breakdown the following areas of practice. Total = 100%.*

- Direct Patient Care 60%
- Research 5%
- Teaching 25%
- Administration 10%

Other: __________

**Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)**

Academics, 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

**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.

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<th>Defense Expert</th>
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CANDIDATE DISCLOSURE STATEMENT

Aisha Terry MD, MPH, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: Medical Faculty Associates
   Address: 2120 L Street, NW
   Washington, DC 20018
   Position Held: Associate Professor of Emergency Medicine and Health Policy, Attending Physician
   Type of Organization: Multi-specialty physician 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
   Address: 4950 W. Royal Lane
   Irving, TX 75063-2524
   Type of Organization: 501c6
   Duration on the Board: 5 years

   Organization: Emergency Medicine Foundation (EMF)
   Address: 4950 W. Royal Lane
   Irving, TX 75063-2524
   Type of Organization: Non-profit
   Duration on the Board: 2 years

   Organization: National Emergency Medicine Political Action Committee (NEMPAC)
   Address: 4950 W. Royal Lane
   Irving, TX 75063-2524
   Type of Organization: Non-profit
   Duration on the Board: 2 years
3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑️ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☑️ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☑️ NO
☐ If YES, Please Describe:
7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.
   ☐ NO
   ☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.
    ☐ NO
    ☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Aisha Terry                  Date                  06.28.2022
Tuesday, August 9, 2022

Kelly Gray-Eurom, MD, MMM, FACEP
Chair
Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

RE: Aisha T. Terry, MD, MPH, FACEP - Endorsement Letter

Dear Dr. Gray-Eurom,

As President of the District of Columbia Chapter of the American College of Emergency Physicians (DCACEP), it is my pleasure to write to you on behalf of our three hundred and thirty emergency medicine physician members, to proudly endorse Aisha T. Terry, MD, MPH, FACEP for President-Elect of the American College of Emergency Physicians.

Dr. Terry's aptitude for planning, organization, and management has played an integral part in the Chapter's innovation and success. She has served in varying capacities in the Chapter, including as President, Councillor and BOD member. From 2013-2016, during her term as the Chapter President for the District of Columbia, the Chapter’s activity flourished, membership increased by 50%, and revenue doubled.

In 2004, Dr. Terry started as a member of the College’s Emergency Medicine Practice Management and Health Policy Section and the Public Health and Injury Prevention Committee. She was elected President of the Emergency Medicine Residents’ Association (EMRA) and served on its Board of Directors from 2005-2008.

Dr. Terry continued her dedication and contributions to the College as a member of the Board of Trustees of the Emergency Medicine Foundation (EMF), while continuing her service on the Public Health and Injury Prevention Committee. She chaired the subcommittee on Disparities in Health Care as well as the subcommittee on Sobering Centers. In 2008, Dr. Terry was appointed chair of the College’s Associate Membership Task Force. As a Board member, Dr. Terry has served or is currently serving as Board liaison to eight of the College’s committees/sections. Her management and decision-making skills are evident by her election as the College’s Secretary/Treasurer in 2020 and as Vice President in 2021.
In 2016, Dr. Terry was appointed chair of the College’s first Diversity and Inclusion Task Force. As chair Dr. Terry was innovative and created an Unconscious Bias Online Course, “Unconscious Bias: Protect Yourself and Your Patients”. This course is available for CME to any member of the American College of Emergency Physicians and continues to serve as resource for many.

Many are inspired by Dr. Terry’s contribution in the advancement of diversity in the College. She implemented several recommendations made by the College’s Diversity and Inclusion Task Force by spearheading the creation of the Diversity, Inclusion and Health Equity (DIHE) Section. While serving as Board liaison to the DIHE section, several resolutions were proposed and adopted by the College’s Council. Her leadership and expertise in policy making ensured the success of the DIHE section’s resolutions. Her outstanding leadership was recognized by the Council in 2018 as she was named the inaugural recipient of the ACEP Council Diversity Champion Award.

Dr. Terry’s leadership and expertise in the practice of emergency medicine is further demonstrated by her significant contributions (13 chapters as first or second author) to the College’s COVID-19 Field guide online textbook.

Dr. Terry is well known for her expertise on quality measurement in emergency medicine. She has been a champion for ACEP’s clinical data registry, CEDR (Clinical Emergency Data Registry). Dr. Terry serves as the Board liaison to ACEP’s robust quality portfolio, which encompasses a significant percentage of ACEP’s budget and requires the work of 12% of the College’s staff. She serves as Board liaison to ACEP’s national committees and Board liaison to Annals of EM, JACEP Open journal, the Young Physicians Section, and EMRA.

The DCACEP Chapter is fortunate to have such a dedicated advocate within our Chapter to represent emergency medicine. We are proud to support Dr. Terry’s candidacy for President-Elect of the American College of Emergency Physicians.

Sincerely,

Marisa K. Dowling, MD, MPP
President
District of Columbia ACEP Chapter
Aisha T. Terry MD, MPH, FACEP

Dear friends and fellow colleagues,

First, thank you for your steadfast and exemplary service to the College, Council, and our specialty. It remains an utmost honor and privilege to serve alongside you for the past nearly two decades. As emergency physicians, we bravely take the helm and navigate the complex waters of serving our nation’s health care safety net every single day. Of late, the seas have been particularly stormy, making our unified coordination of steering the boat absolutely critical. Thus, as we continue to grapple with ongoing existential challenges ranging from threats to our workforce to unprecedented levels of divisiveness, embrace these moments as opportunities to amplify our ability to model extraordinary physician leadership and our value. We each bring something important to the endeavor of surviving and succeeding together.

As your president-elect, every action taken and every initiative pursued will be influenced by the recognition that we are all in the same boat and that our fates are intertwined. While we each may sail different paths, we’re all sailing the same sea and are vulnerable to the same crashing waves. It therefore behooves us to embrace our many commonalities, respect our differences, and choose harmony over strife.

Last year, I had the esteemed honor of being elected Vice President of ACEP by my fellow Board member peers. This role afforded me the new opportunity to work closely with two of the College’s key vehicles of communication – Annals of Emergency Medicine and JACEP Open – and to serve as liaison to the Emergency Medicine Residents’ Association (EMRA) and the Young Physicians Section (YPS) – impressive groups which are literally our future. These experiences have influenced my approach for achieving a visionary, yet practical agenda. In this vein, the use of effective communication and a focus on our future will serve as central tenets as we:

- Re-affirm the value of the emergency physician and re-define the specialty to secure the future of our practice.
- Optimize the College’s communications platforms.
- Ensure the longevity of our livelihoods and the financial security of the College.

In addition to using my most recent experiences as Vice President of ACEP to inform the role of President-elect, I look forward to building upon my prior track record of leading the execution of strategy that leads to meaningful change.

- As EMRA President from 2005 to 2008, revenue surpassed the $1M mark in part due to my leadership in broadening the reach of the publication, EM Resident, and the EMRA Job Fair, both of which continue to thrive today.
- As President of the District of Columbia Chapter of ACEP in 2012, I led the Board in revitalizing the organization by focusing on enhanced member value and fiscal stewardship. Membership increased by 50% and revenue doubled.
- From 2018 to 2021, I served as lead Board liaison to ACEP’s Quality Portfolio which fosters member value (e.g. $300M in avoided penalties) and College sustainability (~15% of revenue). My Washington, DC location has afforded me easy access to related meetings with federal agencies, to ensure that our voice is heard as decisions about our practice are made.
- As ACEP Treasurer, I led during the year of COVID-19 – arguably the most challenging financial period in the history of the College. We passed, however, a 2021/2022 budget with greatly mitigated deficit.

I am uniquely equipped to serve as an experienced spokesperson, while leading in a measured yet innovative way, that represents and motivates all emergency physicians around action that creates real change. With optimism and gratitude, I ask for your support and vote for ACEP President-elect.

Sincerely yours in service,

Aisha Terry MD, MPH, FACEP
THE VISION and ACTION PLAN

- Re-affirm the value of the Emergency Physician and re-define our specialty to prepare us for a bright future

- Optimize ACEP’s communications platform to promote relevance to members and improve Chapter connection

- Ensure the longevity of our healthy livelihoods & the financial stability of the College

THE RIGHT LEADER FOR THESE CHALLENGING TIMES

- Track record of vision coupled with execution and action
- Health policy and public health leader; skilled at finding commonality, bridging gaps, and building consensus
- Current Vice President of ACEP, elected by peers
- ACEP Treasurer during unprecedented financial uncertainty of Covid era
- As DC ACEP President, membership increased by 50% and revenue doubled
- As EMRA President, revenue hit $1 Million mark, EM Resident publication was revolutionized, Job Fair reached new heights

AISHA TERRY MD, MPH, FACEP

2022 PRESIDENT-ELECT CANDIDATE
AISHA TERRY
MD, MPH, FACEP

2022 PRESIDENT-ELECT CANDIDATE

THE DIFFERENCE

• Associate Professor of EM & Health Policy
• Health Policy Fellowship Senior Advisor
• Full-time clinician; 15+ years of experience in academics, military ED's, & rural practice
• Nearly two decades of a service to ACEP
• NEMPAC Board of Trustees
• EMF Board of Trustees

“Dr. Terry’s measured statements [were] refreshing, insightful, and balanced. The issues that Dr. Terry covered can be emotional and political tinderboxes, and [she] handled them with professionalism and aplomb. For me, [her] participation and contributions alone were worth the trip.”
- 2021 LAC participant comment

“Dr. Terry dedicates a significant part of her career to the innovation and growth of medical education and is recognized as an accomplished educator and researcher. Dr. Terry’s contribution to the specialty of emergency medicine extends to many areas of medicine and the world. [A prolific] author and grant awardee, Dr. Terry boldly advocates for and promotes the role of research within emergency medicine and the College.”
- Excerpt from 2021 John G. Wiegenstein Leadership Award nomination letter

“Dr. Terry’s measured statements [were] refreshing, insightful, and balanced. The issues that Dr. Terry covered can be emotional and political tinderboxes, and [she] handled them with professionalism and aplomb. For me, [her] participation and contributions alone were worth the trip.”
- 2021 LAC participant comment

“Dr. Terry dedicates a significant part of her career to the innovation and growth of medical education and is recognized as an accomplished educator and researcher. Dr. Terry’s contribution to the specialty of emergency medicine extends to many areas of medicine and the world. [A prolific] author and grant awardee, Dr. Terry boldly advocates for and promotes the role of research within emergency medicine and the College.”
- Excerpt from 2021 John G. Wiegenstein Leadership Award nomination letter

THE DIFFERENCE

• Applauded spokesperson; 25+ invited ACEP media contributions in 2020 alone
• 15+ years of mentoring and inspiring future health policy physician leaders
• Based out of Washington, DC - the epicenter of advocacy and headquarters for ACEP legislative and regulatory affairs
• Uniquely equipped with extensive ACEP quality portfolio knowledge
• Diversity and inclusion champion
Curriculum Vitae
Aisha T. Terry (formerly Liferidge), MD, MPH, FACEP
Associate Professor of Emergency Medicine and Health Policy
Health Policy Fellowship, Senior Advisor
Attending Physician
George Washington University School of Medicine and Health Sciences
American College of Emergency Physicians, Board Member and Vice President

DATE: October 2022

PERSONAL DATA:

3001 26th Street, NE
Washington, DC 20018
443-801-8459
aisha.t.terry@gmail.com

EDUCATION:

08/1995 - 05/1999 Duke University
Durham, North Carolina
Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor

08/1999 - 05/2003 University of North Carolina School of Medicine
Chapel Hill, North Carolina
Doctor of Medicine (MD)

08/2009 - 05/2011 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:

06/2003-06/2006 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.

2015-2017 **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.

Medical Education, George Washington University, Department of Emergency Medicine (Principal Investigator), Description: A virtual focus group of medical students was conducted on April 30, 2020. Each student was asked to broadly and candidly reflect on their personal experiences relative to the COVID-19 pandemic, and to specifically expound upon how their personal growth and medical education has been impacted. Conclusion: Key concepts to consider include prioritizing routine virtual delivery of content through innovative technology, encouraging increased student autonomy and self-directed learning through less prescriptive schedules, and emphasizing reflection training and sharing to improve self-awareness and professional development.

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:
07/2018-present  Associate Professor, Department of Emergency Medicine
Senior Advisor, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

07/2018-present  Associate Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

01/2012-06/2018  Assistant Professor, Department of Emergency Medicine
Director, Emergency Medicine Health Policy Fellowship
George Washington University School of Medicine

07/2013-06/2018  Assistant Professor, Department of Health Policy
Milken Institute of Public Health, George Washington University

07/2007-12/2011  Assistant Professor, Department of Emergency Medicine
University of Maryland School of Medicine

Other Employment:
07/1998-06/1999  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.

07/2006-06/2007  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
2021  ACEP John G. Wiegenstein Leadership Award (nominee)
2022  ACEP Colin Rorrie Award for Excellence in Health Policy (nominee)

**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  
2017-2019  ACEP 2nd Journal Editor-in-Chief Search Committee Task Force, member  
2020-2023  Board of Directors, elected member (2nd term)  
  ■ ACEP Secretary/Treasurer (2020-2021)  
  ■ ACEP Quality and Patient Safety Committee, Board liaison  
  ■ ACEP CEDR Committee, Board liaison  
  ■ ACEP Quality Improvement and Patient Safety Section, Board liaison  
  ■ ACEP Vice President (2021-2022)  
    o Emergency Medicine Residents’ Association, Board liaison  
    o Young Physicians Section, Board liaison  
    o *Annals of Emergency Medicine* journal, Board liaison  
    o *JACEP Open* journal, Board liaison  
2022-2023  *Annals of Emergency Medicine* Editor in Chief Search Task Force, member  
2022  Interdisciplinary multi-organization Sepsis 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  
2020-present  Board of Trustees member

**National Emergency Medicine Political Action Committee (NEMPAC)**  
2020-present  Board of Directors, member
American Academy of Neurology
2009-2015 Practice Parameters Guidelines on the Treatment of First Seizure, subcommittee member

Stop the Spread empowered by Impact Assets – non-profit that seeks to harness the power of the private sector and philanthropic resources to impact the health of the nation.
2020-present Advisory Board member, appointed


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, Co-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.

2019-present Health Policy Fellowship, Senior Advisor, provide mentorship, networking opportunities, and professional development to health policy fellows; participate in didactic teaching; facilitate office placement with Congressional office, government agency, and/or think tanks.
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 and Health Sciences
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; taught professional development; serve as coach in Coaching Program.
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; Patients, Populations, and Systems (PPS) Instructor; develop and teach curriculum which exposes first and second year medical students to systems-based learning.
2020-2021 Practice of Medicine Coaching Task Force, Co-chair; Appointed by Deans to lead school wide effort to design, implement, and create evaluation around professional development coaching program for the school of medicine.
2021-present Practice of Medicine Coaching Program Coach; longitudinal, required course that teaches self-directed learning utilizing the Master Adaptive Learner (MAL) process, to enhance competency in academic, clinical, and personal skills.

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.
2021-present Coaching Program, coach; longitudinally coach medical students as related to academic and personal competencies; teach EPA’s.

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:

Emergency Medicine Foundation sponsored
Proposed award amount: $50,000
Hours devoted: 60+

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:


Abstracts and/or Proceedings:


2. **Liferidge AT**. “Cost Effectiveness Analysis of Triage of Non-emergent Emergency Department Patients a Medical Home,” 2012 International Forum on Quality and Safety in Health Care; Paris, France. April 2012. *(International)*


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 2014.

5. **Terry, A.** Developed Professional Development Coaching Program for the George Washington University School of Medicine and Health Sciences. 2020-2021.

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:


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.
12. Terry AT, et al. The Medical Student Experience in the Era of Covid-19: Reflections on the Transformation of Medical Education, George Washington University, Department of Emergency Medicine (Principal Investigator), Description: A virtual focus group of medical students was conducted on April 30, 2020. Each student was asked to broadly and candidly reflect on their personal experiences relative to the COVID-19 pandemic, and to specifically expound upon how their personal growth and medical education has been impacted.
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.

WEBINARS/PODCASTS:


INVITED MEDIA CONTRIBUTIONS:

Radio:

Print:


**SERVICE TO THE COMMUNITY:**

2006-present 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.
- Granted 4-year academic scholarship to new Beneficiary 2022 to 2026 attending the College of William and Mary
Board of Directors Candidates
2022 Board of Directors Candidates

**William B. Felegi, DO, FACEP**
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

**Jeffrey M. Goodloe, MD, FACEP**
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

**Gabor (Gabe) D. Kelen, MD, FACEP**
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV
2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

William B. Felegi, DO, FACEP

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<th>Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?</th>
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<td><strong>Workforce.</strong> Last year, ACEP reported a surplus of residency trained emergency physicians based on the available information. The messaging that went out was clear - reduce the number of graduating residents, extended the years in a training program, look for alternative career pathways, encourage residents to practice in rural areas, etc. Many graduating residents became alarmed when they heard this and some interpreted the message, “Let’s punish current and future residents for the shortage by increasing the length of training and further place us in deeper debt without a guaranteed job.” Where I know that this was not the intent, it was the message that future and new residents heard and disseminated on social media to create further concern and panic. I now believe that our college has softened the messaging and understands the importance of the report and needs to be more transparent with membership. Various stakeholders have met to discuss viable options. It is important for the continued success of our college to place workforce as a top priority. I have concerns about the interpretation and messaging since I’m not certain that career emergency physicians who have practiced for many years with integrity and strong core values are willing to seek alternative career pathways. From speaking with many of you, I question the long term stamina and resilience for physicians who work in hospitals with little support and no opportunity for protected time as those in the academic arena. Since the workforce report was disseminated after COVID-19, we have seen a fair number of physicians either retire, reduce their clinical hours, or look for alternatives to increase their incomes. With some of these changes, the projected surplus of residency trained emergency physicians may not be as crucial as originally predicted. One thing however is certain. <strong>There will always be a mismatch in the number of the residency trained emergency physicians in suburban and urban areas as compared to rural areas</strong> for many legitimate reasons.</td>
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<td><strong>Scope of Practice.</strong> Our leadership and members must maintain the college’s integrity and we have the responsibility and right to question the training of AP’s (physician assistants and advanced nurse practitioners) who have replaced many emergency physicians. It is very apparent that some hospitals and contract groups have decreased professional expenses as part of a shrewd and calculated business model. In my current role as a medical director in a small rural and critical access hospital, I am astonished at the lack of training from AP’s who apply for jobs. The majority of these professionals are recent graduates with absolutely no emergency experience and lack proper training for core procedures performed in the emergency setting. This is a set-up for disaster and poor patient care. We need to question and further publicize the hours of training that we have as compared to AP’s. The publicity campaign initiated by the college needs to continue and expand its scope. <strong>More attention and resources will need to be given to states since this will have to be fought on the state level and some states may not have adequate resources.</strong></td>
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<td><strong>College Sustainability.</strong> Action plans have a cost whether financial (salaries, legal fees, etc.), physical resources, staff and members’ time, etc. The landscape for the practice of emergency medicine has evolved over the last 30+ years where the priority was to have properly trained emergency physicians replace “rent a doc” and establish a foothold in emergency departments. Practices changed and many “democratic” EM groups where successfully organized. For many reasons, the corporatization of medicine emerged and many of us now work as employees of hospitals, publicly traded national companies, or contract management groups owned by private equity. <strong>Our college is no longer our grandfathers’ College.</strong> The employee model has evolved and has changed the needs of many of our members. Physicians continue to be economically strapped. With some transitioned to the employed model, funds for dues and CME’s have been reduced and physicians are looking to reduce professional expenses. The college still has the resources to be able to address changes and ensure that our members’ sustainability is just as important as our patients. <strong>We always do the right thing for our patients and we need to have the courage to do the right things for members and focus on emergency physicians and their immediate needs.</strong> Physician wellness is not just about going to the gym for a workout. For some, wellness does not mean how much time he or she has at home but rather what the work environment is like. Do our colleagues even have enough energy left after their shift to enjoy so little free time, or are they sucked dry of all their vital juices every day because of difficult working conditions? Physician burnout is a reflection of physicians’ job satisfaction—a vital exhaustion, characterized by loss of enthusiasm from work, depersonalization, lack of purpose, and low sense of accomplishment. We are all entitled to decent working conditions and to have the necessary resources to perform our jobs well to optimize patient care. We will lose members unless we continue to focus on physician burnout as a reflection of physician job satisfaction. Some residencies have had their members join unions. Unions clearly have advantages and disadvantages and historically have been organized to protect employees’ rights and</td>
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improve the work environment. Unless our college continues to focus on the individual physicians working conditions, we will lose members to other organizations or lead to the unionization for some of our members.

**Question #2: Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?**

Career Fulfillment: Tackling tough issues head-on and working with you to tackle frustrations that get in the way of career satisfaction. Unless we have satisfied members, our membership will dwindle or other organizations may be more appealing to our membership including possible unionization. It is imperative that the college continue to recognize that in order to fulfill our important responsibilities in caring for this nation’s emergency needs, we must ensure that every emergency physician has a safe and secure working environment, adequate resources to perform our vital role, and fair compensation. ACEP needs to maintain its integrity with our membership. A long time ago, I learned at an ACEP leadership event that integrity was doing the right thing at the right time for the right reasons. We need to base our priorities, interest, and messaging on strengthening our integrity for our members. Our college needs satisfied members and physician satisfaction starts in the workplace regardless of location – urban, suburban, rural, and regardless of the physician model – independent contractor, locums, hospital – community or academic, contract management group owned by a democratic group, publically traded company, or private equity firm. No one else in America has been given the privilege with dealing and caring for the sickest and most critically injured. Yet, we work in a dangerous and complex environment. The college needs to have the courage in addressing inequities and advocate for an emergency physician “Bill of Rights?”

Practice & Innovation: Revolutionizing acute, unscheduled care, developing new career opportunities and taking the lead in reshaping the emergency medicine workforce landscape. The latter is a clear top issue. It is important to demonstrate that residency trained physicians are the most preferred provider based on education, training, and procedural skills. We need to continue to work with like-minded individuals to promote residency trained physicians. We need to demonstrate that the quality of care and outcomes are the highest when patients are treated by an emergency physician.

**Question #3: What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?**

There are so many issues we face in our everyday practice of emergency medicine. Some are very common to all of us – fair balanced billing, maintaining integrity of prudent layperson, fair Medicaid and Medicare reimbursement, protecting EMTALA, etc.

The disparity of emergency health care in our nation is a complex issue with no one solution and no easy answers. It’s the single most divisive issue in emergency medicine at this time. On one hand, the college aspires to have board certified emergency physicians working in every emergency department in this country. On the other hand, some want to ensure that all freestanding emergency department are staff similarly on site 24/7. Many critical access in rural hospitals have tried to increase the quality of care delivered to patients by hiring AP’s that have additional training in emergency medicine, but some training programs have been ostracized for calling them “residency programs.” If our goal is to have an EM physician lead team in every ED, then we need to work on ways to make this happen. Do we really know why residents do not want to practice in critical and rural hospitals? Do we need to readjust training for residents to practice in rural areas? We have made many assumptions in the past, but are they correct? Estimates of 42% of the population get its care in rural ED yet the ED’s only made up 17% of all ED visits. Do we abandon our efforts? We need to figure this out quickly or this goal will never be realized and we will need to readjust our priorities.

There has been a dichotomy of emergency care in this nation as long as we have been a specialty. Most of our emergency medicine residencies programs are based in urban or suburban areas. Rightfully so since an excellent training program needs a large number of patients to allow the opportunity to be exposed to patients with significant pathology and opportunity for core training in emergency procedures. The majority of graduates seeking career choices in academic settings are located in larger urban and suburban facilities that are conveniently located where lifestyle is perceived as better. Rural areas, especially those at critical access and frontier hospitals, face challenges in resources. Most physicians would rather practice in a resource rich environment than a resource scarce one. We need to advocate, working with our partners, to encourage changes in emergency medicine programs to incorporate changes in the didactic and clinical curriculums for rural medicine. One big issue is the stringent requirement placed on programs that disallow rotations in many critical access hospitals due to the lack of board certified emergency physicians and low volumes. We need to advocate for change since we end up being a part of the problem and not the solution. How can we expect to have residents exposed to rural medicine when residents cannot rotate at these very small hospitals to gain exposure to practicing emergency care with austere resources? We believe that patients should have access to quality emergency care but not uncommonly do I hear that patients have made a conscious decision to live in resource limited areas – WTF, really? For almost 25 years I was a faculty member and understand how demanding the volumes can be in a busy urban and suburban ED where the majority of EM trained physicians work, but I don’t think the majority of EM physicians understand what it’s like to work in a hospital that has very limited resources and no consultants available.
CANDIDATE DATA SHEET

William B. Felegi, DO, FACEP

Contact Information
731 Red Lion Way
Bridgewater, New Jersey 08807-1668
Phone: 908-227-3484 (cell)
E-Mail: William.felegi@ahsys.org

Current and Past Professional Position(s)
- Medical Director Van Buren County Hospital Emergency Department
- Medical Director Van Buren County Hospital Ambulance
- EMS Medical Director Farmington Ambulance
- Medical Director, Atlantic Health, Morristown Medical Center, Travel MD, Corporate Health
- Life Member Bound Brook Rescue Squad, Inc.
- American Board of Emergency Medicine Senior Board Examiner (Approximately 27 exams)
- Iowa Osteopathic Medical Association Board of Directors
- State of New Jersey Gubernatorial Commission Appointments
  o Rationalizing Health Care Resources, Subcommittee Hospital/Physician Relations & Practice Efficiency Commission (Gubernatorial Appointment), 2007-2008
  o Health Care Access Commission (Gubernatorial Appointment), 2006-2008
  o Advisory Council for Basic & Intermediate Life Support (EMTFF), (Gubernatorial Appointment), 2002-present
  o State of New Jersey Influenza Pandemic Action Committee, 1999-2006
- Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College - Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018
- Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York 2008-2015
- Department of Emergency Medicine, Hackettstown Medical Center, Hackettstown, NJ, 2016-2017
- Morristown Medical Center Advisory Board, 2014-2016
- Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ
  o Chairman, 2015-2016
  o Interim Chairman, 2014-2015
  o Vice Chairman, 2001-2013
  o Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
  o Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
  o Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-1996
  o Clinical Medical Director Fast Care & Work Med, 1995-2016
  o Medical Review Officer, Work Med, 1995-2016
  o Associate Director Emergency Department 1995-2014
  o Chairman, Trauma Quality Improvement Committee, 2002-2003, 2004-2005
  o Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
  o Member, Quality & Patient Safety Committee, 1998-2016
  o Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
  o Member, Radiology Task Force, 2005-2006
  o Member, ED Peer Review Committee, 2005-2016
  o Member, Clinical Resource Management Committee, 2001-2005
  o Member, CPR Committee 1994-1998
  o Chairman, ED/Radiology Performance Improvement Team, 1998-2003
  o Chairman, ED Performance Improvement Committee, 1996-1998
  o Member, Hospital Wide Performance Improvement Committee, 1995-2008
  o Member, MI Critical Pathway Committee, 1995-2003
  o Chairman, CPR Committee, 1994-1998
ACLS Course Medical Director, 1994-1997
- Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2004
- Trauma Liaison, Dept. EM to Dept. Surgery, Section of Trauma for Level I Designation, 1994-2016
- Member, Trauma/Radiology CQI committee, 1994

**Education (include internships and residency information)**

- Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, 1979
- Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90 (AOA approved rotational/transitional type)
- PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91
- PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94
- Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94
- American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic Medicine, Athens, Ohio, September 2012-2013

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

**Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified**

- American Board of Emergency Medicine (ABEM) - Continuously certified since initial certification 1995
- American Board of Osteopathic Emergency Medicine (AOBEM) 2020

**Professional Societies**

- American College of Emergency Physicians (ACEP)
  - New Jersey Chapter of ACEP
  - Iowa Chapter ACEP
- American College of Osteopathic Emergency Physicians (ACOEP)
- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- Iowa Osteopathic Medical Association (IOMA)
- International Society of Travel Medicine (ISTM)
- American Association for Physician Leadership (AAPL) formerly ACPE

**National ACEP Activities – List your most significant accomplishments**

- Member, Council Reference Committee B 2016 Council Meeting
- Board of Governors, Emergency Medicine Action Committee (EMAF), 2011-13
- Chairperson, Federal Governmental Affairs Committee (FGA), 2011-14
- Team Captain, 911 Legislative Network, 2007-present
- Member, Federal Governmental Affairs Committee (FGA), 2003-present
- 911 Legislative Network, 2003-present.
- Board of Directors National Emergency Medicine Political Action Committee (NEMPAC), 2003-2008
- Member, State Legislative/Regulatory Committee, 2006-present
- ACEP National Awards – During the last 16 years serving with national ACEP, my time has been devoted to becoming well versed in national and state political agendas and the art of political advocacy working with numerous groups and our members. Were we have achieved many wins and assisted other chapters, I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine are a team effort. No one person can be credited with our success stories. That’s why when your peers honor you with a prestigious award one does feel that in some way, they have made a significant accomplishment on behalf of the group.
  - ACEP 2009 911 Legislative Network Member of the Year
  - ACEP 2008 911 Legislative Network Member of the Year

**ACEP Chapter Activities – List your most significant accomplishments**
• Immediate Past Present, 2006
• President, 2005-2006
• President-Elect, 2004-2005
• Secretary/Treasurer, 2003-2004
• Councilor or Alternate Councilor, 2003-present
• Treasurer, 2002-2003
• Board of Directors, 1999-2006
• Chairman, Political Action Committee, STATPAC, 2002-2013
• Government Affairs/STATPAC, 2001-2003
• Co-Chair, Government Affairs STATPAC, 2000-2001
• NJ ACEP State Awards - During the last 22 years serving with NJACEP, my time has been devoted to becoming well versed in the state political agendas and the art of political advocacy working with numerous groups and members including our state Political Action Committee - STATPAC. Whether it was collecting record breaking PAC donations or achieving exemption from ACLS for board certified emergency medicine physicians to perform procedural sedation, we have achieved many wins. I have always felt that just because one is a leader, the credit goes to the group of individuals that you work with in the committees and subgroups since leadership and emergency medicine is a team effort. No one person can be credited with our success stories. That’s why when your peers honor you with prestigious awards one does feel that in some way, they have made a significant accomplishment on behalf of the group.
  o NJ ACEP Distinguished Service Award, 2009
  o NJ ACEP Good Government Award, 2003

**Practice Profile**

**Total hours devoted to emergency medicine practice per year:** 2496* Total Hours/Year*

**includes paid on-call time**

**Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 80%  Research 0%  Teaching 5%  Administration 15%

Other: ______________________________  %**

**Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)**

I practice full time rural emergency medicine for the last three years at a small independent 25 bed licensed critical access hospital in Southeast Iowa. The nearest tertiary care facility is 90 minutes away and the ED has four beds. I am a full-time salaried employee working for the hospital and the only residency trained, board certified emergency medicine physician who works in the Emergency Department in a 50 square mile county of 7,150 residents. The remainder of the time, the ED is staffed with either an AP or PA and either myself or another family medicine trained physician who is on call for back-up as needed. We also have the 24/7 availability of a telemedicine service staffed by board certified emergency physicians 24/7 provided by an independent third party paid for by the hospital.

The remainder of my career was spent at a level one trauma center, regional pediatric hospital, cardiac center, and emergency medicine residency training program with 25 years’ experience as a faculty member, attending, and various administrative roles including the Chairperson of the Department of Emergency Medicine. Originally a physician shareholder in an emergency medicine owned group at multiple hospitals in the tristate area in the Northeast, our company was sold to a large national contract management group which was then purchased by a multi-specialty private equity firm.

**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.)**

Van Buren County Hospital, Keosauqua, Iowa
Emergency Department Medical Director
Medical Staff Secretary, 2019-2020
Quality & Patient Safety Committee, 2018-present
Pharmacy & Therapeutics Committee, 2018-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.

<table>
<thead>
<tr>
<th>Defense Expert</th>
<th>Plaintiff Expert</th>
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<td>0 Cases</td>
<td>0 Cases</td>
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</table>
CANDIDATE DISCLOSURE STATEMENT

William B. Felegi, DO, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Van Buren County Hospital
   Address: 304 Franklin Street
   Keosauqua, Iowa 52565
   Position Held: Emergency Department and Ambulance Medical Director
   Type of Organization: Critical Access Hospital

   Employer: Atlantic Health (as an independent contractor)
   Address: 101 Madison Avenue, Suite 202
   Morristown, New Jersey 07960
   Position Held: Medical Director, Travel MD®, Corporate Health
   Type of Organization: Non-Profit Hospital System

   Employer: Envision Physician Services formerly EmCare’s Partners Group, formerly Emergency Medical Associates
   Address: 3 Century Drive
   Parsippany, New Jersey 07054
   Per diem contract employee with privileges at Hackettstown & Morristown Medical Centers, NJ. No income generated for the last 3 years
   Type of Organization: Private equity owned physician management organization

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

   Organization: Iowa Osteopathic Medical Association
   Address: 6919 Vista Drive
   West Des Moines, Iowa 50266
   Type of Organization: State organized medical society
   Duration on the Board: 2011-current
Organization: New Jersey Association of Physicians & Surgeons (NJAOPS)
Address: 666 Plainsboro Road, Suite 356
Plainsboro, New Jersey 08536
Type of Organization: State organized medical society
Duration on the Board: 2014-2017

Organization: Morristown Medical Center Advisory Board
Address: 100 Madison Avenue
Morristown, New Jersey 07960
Type of Organization: Non-Profit Hospital
Duration on the Board: 2014-2016

Organization: Board of Governors Emergency Medicine Action Committee (EMAF)
Address: 1125 Executive Circle
Irving, Texas 75038-2522
Type of Organization: Nationally organized group to financially support advocacy efforts for ACEP
Duration on the Board: 2011-2013

Organization: Board of Directors National Emergency Medical Political Action Committee (NEMPAC)
Address: 2121 K Street, Suite 325
Washington, DC 20037
Type of Organization: Physician National Political Action Committee
Duration on the Board: 2003-2008

Organization: NJACEP Board of Directors
Address: c/o 201 East Main Street
Lexington, Kentucky 40507
Type of Organization: State organized medical society
Duration on the Board: 1999-2006
Organization: Office of the New Jersey Governor
Address: 125 West State Street
Trenton, New Jersey 08608
Type of Organization: State of New Jersey Rationalizing Health Care Resources, Subcommittee
Duration on the Board: 2007-2008

3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☐ If YES, Please Describe:
6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

William B. Felegi, DO, FACEP       Date 06/28/2022
Dear Councillor:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) again supports William B. Felegi, D.O., FACEP for the national ACEP Board of Directors. Our chapter enthusiastically endorses Bill’s candidacy. His presence on the Board will immensely benefit our college for years to come.

Bill’s career spans over 30 years ranging from attending the first state run EMT class as a volunteer rescue squad member at the age of 16, to Chairman and Assistant Clinical Professor of Emergency Medicine at a tertiary care center and trauma center with the oldest emergency medicine residency in NJ.

Bill began his relationship with the NJ Chapter as a resident when he attended our board meetings. He participated in the chapter as an elected board member for two terms and then in the leadership tract holding all leadership offices including Chapter President. He decided not to re-run for the board to allow younger physicians the opportunity to participate in the chapter mentoring future leaders. He has served either as Councilor or Alternate for 18 years.

He has been an ACEP member since 1991 and has embraced service to ACEP with passion and determination over the last 3 decades. For over 15 years he has served on two important national committees - State Regulatory & Legislative Affairs and the Federal Government Affairs Committee where he served as the Chair for 3 years. He has helped guide not only ACEP’s positions on critical issues but also many members with similar interests.

Bill has been a fixture at ACEP’s annual Leadership & Legislative Conference for over 25 years mentoring young or inexperienced physicians when lobbying with our annual hill visits. For his continued national efforts, he was twice awarded ACEP’s prestigious 911 Member of the Year.

In NJ, Bill is credited with protecting emergency physicians when he championed a campaign to lobby against regulations that mandated all physicians who provided procedural sedation to have ACLS training well before ABEM publicly supported the “no merit badges” for board certified emergency physicians. In NJ, even anesthesiologist must take ACLS. Due to his perseverance, emergency physicians are the only specialty exempt from the regulation.

Another accomplishment was his championship to lobby for the contemporaneous reading of CTs for suspected stroke patients with a radiology attending and radiology resident. Prior readings were only offered by residents at hospitals with a radiology residency and often lead to re-reads the following day when an attending was available. Stroke care was compromised.
He engaged in a successful grass roots letter writing campaign to the Commissioner of Health to accomplish the change in the regulations.

Bill served as the Chair of our PAC, NJ STATPAC, and under his leadership, was able to collect a record amount donated per election cycle. Our chapter also has recognized his accomplishments with our **NJ-ACEP “Distinguished Service” Award** and our **“Good Government” Award**.

Bill’s strongest qualities are his highly collaborate management style, a desire and willingness to engage physicians and to improve working environment, and a passion for our specialty. Perhaps one of his greatest attributes are his **humor, honesty and integrity**. His greatest asset is his ability to participate in a discussion of a critical issue with a group, synthesize the discussion, summarize the important elements, and then offer a broad review of the pros and cons. It is not uncommon for a group to change their decision based on his synopsis of **unintended consequences** which are often overlooked.

Our proud chapter stands behind Dr. Felegi as he seeks to advance emergency medicine through our vital organization.

Sincerely,

*Pat Hinfey*

Patrick Hinfey, MD, FACEP
NJ-ACEP President
My Fellow Councilors:

We are creative not only in the practice of our specialty but in addressing serious issues that our society and government have neglected or ignored. ED’s have always acted as the “canary in the coal mine.” We have witnessed the plight of the homeless, opiate misuse, poverty, inequities in medical care, uninsured, hospital and ED overcrowding, psychiatric holds, scope of practice creep, COVID-19, nursing shortages, drug shortages, increased violence against health care professionals, eroding of women's rights of choice in their healthcare, proposed cuts in Medicare, out of network building, and now Monkeypox!

The list goes on and on...

We persevere for now...to “continue in a course of action even in the face of difficulty or with little or no prospect of success” - something we face at work every day.

I am tired and frustrated ... My colleagues are the same... and I am sure you have similar feelings...

**Physician satisfaction starts in the workplace** regardless of location - urban, suburban, rural; regardless of the physician model - independent contractor, locums, hospital – critical access, community or academic; or contract management group owned by a democratic group, publicly traded company, or private equity firm. No one else has been given the privilege to care for the sickest and most critically injured. Our work environment is dangerous and complex. Many have not been treated fairly by our employers. Democratic physician run companies are becoming sparse.

**ACEP must focus on the individual physician.** We need to have a “Physician Bill of Rights” for adequate and safe working conditions. If hospitals and managed contract groups cannot treat physicians fairly despite our dedication to our patients, then we need a better organized approach to focus on these inequities. Decades ago, unions were established because employees were mistreated. Should a viable alternative be available, members may leave the College unless ACEP does more in fighting for physician rights and a safe workplace

We can no longer try to do the right thing because of political consequences. **By choosing the easy way out, we avoid conflicts with others but create conflicts within.** We need to maintain our integrity - doing the right thing at the right time for the right reason. The foundation of our College is only strengthened with satisfied members. It’s time we pay attention and heal the healers, we cannot continue to neglect ourselves.

Huge health care disparities exist in rural America. Where it is ideal to have a residency trained emergency physician in every ED, it may not be practical. ACEP needs to continue to advocate for EM physician lead teams and to **aggressively question the training of any advanced practitioner who works in any ED.** Many rural hospitals are not accredited by the Joint Commission and CMS has no desire to police the care in rural America. We need to advocate for our profession and **all** our patients.

Paramount is ACEP’s solutions for workforce issues. We know that the majority of residents attend a program where they want to practice or choose to practice in bigger cities or suburban areas. **We will continue to have a mismatch in the concentration of EM physicians regardless of any surplus of physicians.** We need to explore the reasons behind residents’ choices to practice and work on viable solutions.

We always do the right thing for patients and we need to have the courage to do the right thing for members and focus on emergency physician’s needs. **Foremost are our actions in responding to our members’ issues.**

I look forward to further discussion with you. **Stay Safe!**
William B. Felegi, D.O, FACEP
Board of Directors Candidate

**Clinical Practice**
- Residency trained Board Certified Attending & Faculty Member EM Residency 25 years in NJ
- Past Chairman, EM tertiary care hospital, trauma center & pediatric hospital in NJ
- Currently at Rural Critical Access Hospital in Iowa as ED & Ambulance Service Medical Director
- Travel MD® Medical Director

**State Leadership**
- NJ ACEP Past Board Member
- Past President NJ ACEP
- Councilor or Alternate 19 years
- Past Chairman NJ ACEP STATPAC
- Past Chairman NJ ACEP Government Affairs
- Board Member Iowa Osteopathic Medical Society
- Past Board Member NJ Osteopathic Assoc. Physicians & Surgeons

**National Activities & Leadership**
- Past Chairman FGA
- Member FGA & State Legislative/Regulatory Committees
- Past Board of Governors EMAF
- Past Board of Directors member NEMPAC
- ABEM Board Examiner – 26 Exams

**Awards**
- 911 ACEP 911 Legislative Network Member of the Year 2008 & 2009
- NJ ACEP Distinguished Service Award
- NJ ACEP Good Government Award
- 5 Faculty Teaching awards

**Work Experience**
- Morristown Medical Center, NJ – Envision Physician Services formerly EmCare’s Partners group formerly Emergency Medicine Associates of NJ (Prior 24 years)
- Van Buren County Hospital, Iowa – current for the last 4 years

**About Me**
- Extensive experience with regulatory and federal issues germane to EM
- Health Care Policy Fellowship
- No longer on the payroll of a CMG
- Exclusive fulltime rural ED work
Strengths

- Integrity – doing the right thing at the right time for the right reason
- Collaboration
- Consensus building
- Examining unintended consequences

Reasons for Seeking Election

- I have watched emergency medicine grow over the last 27 years. Our specialty has had its growing pains and has fought many battles on behalf of the profession and our patients. But we have not adequately protected our members. We always do what’s right for our patients. We devise ingenious workarounds so that we continue to provide excellent emergency care in environments that are not always supportive of what we do. However, you are the most important patient and we cannot neglect the fact the physicians who are employed providers are entitled to basic employment rights and safe working conditions just like any other employee.

- With so many physicians employed by either a hospital or managed contract group the membership of ACEP has changed to the employed physician model in the majority and we need to recognize that this has changed the landscape of our membership and priorities.

- There has been a dichotomy of emergency care in this nation as long as we have been a specialty. Disparity exists in rural America and care models in emergency medicine must adapt to the rural environment. Once size does not fit all. Where I spent the majority of my career in an academic program, I now practice full time in a small rural critical access hospital and the only board-certified emergency physician in a county of 9,000.

Significant Issues & ACEP Mission

- ACEP needs to develop an EM physician’s “Bill of Rights” that encompasses a fair and safe employment environment. We have rights spelled out for contracts and billing practices but not basic rights for fair working benefits and safety like many other employees. Unions were developed to protect workers who were being abused. ACEP needs to advocate for our physicians.

- We need to focus on physician satisfaction with the work environment just like we have focused on patient satisfaction. We too need to be satisfied with our jobs and workplace.

- Disparities in rural America need to be addressed. Many ED’s are staffed by AP’s and we need to question their training and advocate for physician lead teams with emergency physician oversight. AP training programs must be held accountable and a rural ED program of ACEP sponsored ED accreditation needs to be implemented.

- Work force issues are paramount and need viable and reasonable solutions. Regardless, we will continue to experience a mismatch in the concentration of EM physicians regardless of a predicted surplus of physicians. We need to explore the reasons behind residents’ choices to practice and work on viable solutions.
Curriculum Vitae

William B. Felegi, D.O., FACEP
731 Red Lion Way
Bridgewater, New Jersey 08807
908.227.3484 (Cell)
william.felegi@ahsys.org

RESIDENCIES

Chief Resident, Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1993-94

PGY 1-3 - Morristown Memorial Hospital Residency in Emergency Medicine Morristown, New Jersey, July, 1991-94

PGY 1 - Somerset Medical Center Residency in Family Practice Somerville, New Jersey, July, 1990-91

Internship, St. Michael's Medical Center Seton Hall University School of Graduate Medical Education Newark, New Jersey, July, 1989-90
(A.O.A. approved rotational/transitional type)

EDUCATION

American Osteopathic Association (AOA) Health Policy Fellowship, Ohio University College of Osteopathic Medicine, Athens, Ohio, September 2012-13

Emergency Medicine Foundation (EMF) & American College of Emergency Physicians (ACEP) Teaching Fellowship Program, Dallas, Texas, 2002

Doctor of Osteopathic Medicine, University of New England College of Osteopathic Medicine Biddeford, Maine, May, 1989

University of New England College of Osteopathic Medicine Dean's Summer Research Fellowship, 1986, "Gastric Laceration and Rupture As a Complication of Cardiopulmonary Resuscitation."

Bachelor of Arts, Major: Psychology, Rutgers College of Rutgers University New Brunswick, New Jersey, May, 1979

LICENSE & CERTIFICATION

State of New Jersey 10/26/90, No. 25MB05562100, Expiration: 6/30/2021

State of Iowa 2/13/2018, No. DO-05145, Expiration: 1/01/2022

NJ DEA Registration, No. FF7427188, Expiration: 9/30/2023

IA DEA Registration, No. BF2583690, Expiration: 9/30/2023

NJ CDS Registration, No. DO53599, Expiration: 10/31/2021
**LICENSE & CERTIFICATION**

(con't.)

- **IA CSA Registration**, No. 1307596. Expiration 9/30/2021
- **Diplomate** National Board of Osteo. Medical Examiners, No. 18031, 7/1/1990
- **Diplomate** American Board of Emergency Medicine, No. 23557, 12/31/2025
- **Diplomate** Amer. Osteo. Board of Emergency Medicine, No. 4448, 12/31/2022
- **Fellow**, American College of Emergency Physicians, 1997
- **Certificate in Travel Health™**, International Society of Travel Medicine, 20011-present
- **Fundamental Critical Care Support Instructor**, Society of Critical Care, 9/04
- **Civil Defense Radiological Monitor**, United States Department of Defense

**PROFESSIONAL ORGANIZATIONS**

- American College of Emergency Physicians (ACEP), No. 360717, 1991-present
  - New Jersey Chapter (NJACEP), 1991-present
  - Iowa Chapter (Iowa ACEP), 2018-present
- American Medical Association, (AMA), 2011-present
- American Association for Physician Leadership (AAPL) formerly ACPE, 2011-present
- International Society of Travel Medicine (ISTM), 2003-present
- American Osteopathic Association (AOA), No. 52018, 1989-present
- American College of Osteopathic Family Practitioners (ACOFP), No. 52018, 1989-2016
- Iowa Osteopathic Medical Association (IOMA), 2017-present
- New Jersey Association of Osteopathic Physicians and Surgeons (NJAOPS), 1989-2017
- Medical Society of New Jersey (MSNJ), 1990-2017
- Morris County Medical Society, 2004-2017
- Somerset County Medical Society, 1990-2004
- Morris & Sussex County Society of Osteopathic Physicians, 2002-2017
- Member Emergency Medical Associates Research Foundation, 1997-2017
- Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society), 1989-present
PROFESSIONAL ORGANIZATIONS
(con't.)
Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity), 1989-present
Life Member, University of New England College of Osteopathic Medicine Alumni Association, 1989-present

AWARDS
Morristown Memorial Hospital Residency in Emergency Medicine, Most Valuable Contributor, 2009-10
American College of Emergency Physicians – 2009 911 Legislative Network Member of the Year
NJ ACEP Distinguished Service Award, 2009
American College of Emergency Physicians – 2008 911 Legislative Network Member of the Year
Morristown Memorial Hospital Residency in Emergency Medicine, Clinical Instructor of the Year, 2005-06
Morristown Memorial Hospital Residency in Emergency Medicine, Most Valued Contributor to the Residency Program, 2004-05
NJ ACEP Good Government Award, 2003
Morristown Memorial Hospital Residency in Emergency Medicine, Most Valued Contributor to the Residency Program, 2001-02
Morristown Memorial Hospital Residency in Emergency Medicine, Teacher of the Year, 2000-01
Morristown Memorial Hospital Residency in Emergency Medicine, Most Valuable Contributor, 1997-98
Psi Sigma Alpha Society (National Osteopathic Scholastic Honorary Society)
Sigma Sigma Phi, Grand Chapter (National Honorary Osteopathic Fraternity)
Student Osteopathic Medical Association (SOMA) Scholarship, 1987
Howard G. Lapsley Memorial Scholarship, Muhlenberg Hospital, Plainfield, New Jersey, 1987
New Jersey State First Aid Council State Championship - First Aid Competition, Youth Group, 1976
Commendation from N. J. State First Aid Council 5th District - 5/19/91 for service to first aid & rescue squads
NATIONAL ACTIVITIES

American Board of Emergency Medicine (ABEM):
  Oral Board Examiner, 2002-2013 (4 Terms)
  Senior Oral Board Examiner, 2014–present (23 Exams)

American College of Emergency Physicians (ACEP):
  Board of Governors, Emergency Medicine Action Fund (EMAF), 2011-2013
  Chairman, Federal Governmental Affairs Committee (FGA), 2011-2014
  Team Captain, 911 Legislative Network, 2007-present
  Federal Governmental Affairs Committee (FGA), 2005-present
  911 Legislative Network, 2003-present
  Board of Directors National Emergency Medicine Political Action Committee (NEMPAC), 2003-08.
  State Legislative/Regulatory Committee, 2006-present

STATE ACTIVITIES

American College of Emergency Physicians, New Jersey Chapter (NJACEP):
  Immediate Past President, 2006
  President, 2005-06
  President-Elect, 2004-05
  Secretary/Treasurer, 2003-04
  Councilor or Alternate Council, 2003-present
  Treasurer, 2002-03
  Board of Directors, 1999-2006
  Chairman, Political Action Committee, STATPAC, 2002-2013
  Government Affairs/STATPAC, 2001-2003
  Co-Chair, Government Affairs/STATPAC, 2000-01

New Jersey Association of Osteopathic Physicians and Surgeons (NJAOPS):
  Board of Directors, 2014-2018
  Government Affairs Committee, 2014-2018
  Grassroots Committee, 2014-2018

State of New Jersey Commission on Rationalizing Health Care Resources,
  Subcommittee Hospital/Physician Relations & Practice Efficiency Commission (Gubernatorial Appointment), 2007-08

State of New Jersey Health Care Access Commission (Gubernatorial Appointment), 2006-08

State of New Jersey Advisory Council for Basic & Intermediate Life Support (EMTTF), (Gubernatorial Appointment), 2002-present

State of New Jersey, Influenza Pandemic Action Committee, 1999-2006

EMPLOYMENT EXPERIENCE

Van Buren County Hospital, Keosauqua, Iowa, 2016-present

Envision Physician Services, formerly EmCare (EmCare’s Partners Group-EPG), formerly Emergency Medical Associates (EMA), Parsippany, NJ – Employed Physician, 1994-present
EMPLOYMENT
EXPERIENCE
(con’t.)
Current Base Hospital – Hackettstown Medical Center, Hackettstown NJ, 2016-present

Prior Base Hospital - Morristown Medical Center, Morristown, NJ, 1994-2016

Atlantic Health, Morristown Medical Center, Travel MD™, Corporate Health - Clinical Medical Director, 1995-present (Independent Contractor Status)

PROFESSIONAL
EXPERIENCE
Emergency Department, Van Buren County Hospital (VBCH), Keosauqua, IA
Emergency Department Director
Medical Director VBCH Ambulance

Department of Emergency Medicine, Morristown Medical Center, Morristown, NJ:
  Chairman, Department of Emergency Medicine 2015-2016
  Interim Chairman, Department of Emergency Medicine 2014-2015
  Vice Chairman, Department of Emergency Medicine 2001-2013
  Attending & Faculty Member, Residency in Emergency Medicine, 2001-2016
  Associate Attending & Faculty Member, Residency in Emergency Medicine, 1996-2001
  Assistant Attending & Faculty Member, Residency in Emergency Medicine, 1994-96
  Clinical Medical Director Fast Care & Work Med, 1995-2016
  Medical Review Officer, Work Med, 1995-2016
  Associate Director Emergency Department, 1995-2014

Staff Physician - Your Doctor's Care, Somerville, NJ, 1994

Team Physician Sports Coverage Parsippany-Troy Hills High School, Parsippany, NJ 1993

Morristown Memorial Hospital Mt. Kimball Division Work Med - Occupational Medicine Clinic Morristown, NJ, 1993-94

HOSPITAL
ACTIVITIES
Van Buren County Hospital, Keosauqua, IA
  Medical Staff Secretary, 2019-2020
  Member, Quality and Patient Safety Committee, 2018-present
  Member, P&T Committee, 2018-present
  Member, Trauma Committee, 2018-present

Morristown Medical Center, Morristown, NJ:
  Morristown Medical Center Advisory Board Member, 2014-2016
  Member, Atlantic Health Sepsis Initiative Committee, 2011-2016
  Member, Quality and Patient Safety Committee, 2008-2016
  Member, Department of Cardiovascular Medicine, STEMI Team Committee, 2007-2016
  Member, Radiology Task Force, 2005-06
  Member, ED Peer Review Committee, 2005-2016
  Member, Clinical Resource Management Committee, 2001-05
  Co-Chairman, Trauma Quality Improvement Committee, 2005-2016
HOSPITAL ACTIVITIES
(con’t.)
Chairman, Trauma Quality Improvement Committee, 2002-03, 04-05
Member, CPR Committee, 1999-2013
Chairman, ED/Radiology Performance Improvement Team, 1998-2003
Chairman, ED Performance Improvement Committee, 1996-98
Member, Hospital Wide Performance Improvement Committee, 1995-2008
Member, MI Critical Care Pathway Committee, 1995-2003
Chairman, CPR Committee, 1994-98
ACLS Course Medical Director, Advanced Cardiac Life Support American Heart Association, 1994-97
Member, Trauma Quality Improvement Committee, 1994-2002, 2003-2004
Trauma Liaison, Department of Emergency Medicine to Department of Surgery, Section of Trauma for Level I Trauma Center designation, 1994-2016
Member, Trauma/Radiology CQI Committee, 1994

ACADEMIC APPOINTMENTS
Assistant Clinical Professor Emergency Medicine, Sidney Kimmel Medical College – Thomas Jefferson University, Philadelphia, Pennsylvania, 2015-2018
Assistant Clinical Professor Emergency Medicine, Mount Sinai School of Medicine, New York, New York, 2008-2015

FUNDED RESEARCH
Program Title: Expanded Access IND Program to Provide Stamaril® Vaccine to Persons in the United States for Vaccination Against Yellow Fever
Program #: STA00011
Sponsor: Sanofi Pasteur
Sponsor’s Primary Investigator: Dr. Riyadh Muhammad
Sub-Investigator: William B. Felegi, D.O.

PUBLICATIONS


PRESENTATIONS
(con’t.)


Arizona College of Osteopathic Medicine, Phoenix, AZ, “Escape Fire” – Panel Discussion with Questions and Answers by the 2012-13 AOA Health Policy Fellows, March 14, 2013


St. Joseph’s Regional Medical Center Emergency Medicine Residency Governmental Affairs Conference Day, “State Liability Issues and Update” with Panel Discussion, August 11, 2004

2004 Bridgewater Township Middle School Career Day, “Emergency Medicine & Osteopathic Medical Education.”


2003 7th Annual New England Regional Society for Academic Emergency Medicine, Shrewsbury, Massachusetts, abstract poster presentation entitled: “Does the Distribution of Written Guidelines with Accompanying Educational Information for Appropriate Use of Meperidine Change ED Physicians’ Prescribing Habits?” W.B. Felegi, M.E. Silverman, J.R. Allegra Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey, April, 2003


1999 Institute for Health Care Improvement 11th Annual National Forum on Quality Improvement & Health Care storyboard entitled "Decreasing X-Ray Turnaround Time in the Emergency Department": W.B. Felegi, Department of Emergency Medicine, Morristown Memorial Hospital, December, 1999

### Presentations

<table>
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<tr>
<th>Year</th>
<th>Event</th>
<th>Presentation Title</th>
<th>Authors</th>
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<tr>
<td></td>
<td>Emergency Medicine Clinical Pathological Conference (CPC) Region D</td>
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<td>(Central Region) Competition, Society of Academic Emergency Medicine, Chicago, Illinois, May 1998</td>
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<tr>
<td>1997</td>
<td>1st Annual New England Regional Society for Academic Emergency Medicine Conference &amp; Brown University School of Medicine, Providence, Rhode Island, abstract poster presentation entitled</td>
<td>&quot;Does Point-of-Care Testing in the Out-of-Hospital Setting Influence Patient Care?&quot;</td>
<td>R. Lavery, W.B. Felegi, D. Oh, B. Tortella</td>
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<td>1996</td>
<td>Special Guest Speaker for Emergency Medical Services Paramedics</td>
<td>&quot;Gynecological, Obstetrical &amp; Neonatal Emergencies&quot;</td>
<td>J.R. Allegra, J. Brennan, B. Felegi, L. Fields, F. Grubiner, G. Kiss, B. Lavery, T. Pruzik; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown</td>
<td>New Jersey State First Aid Council 68th Annual Convention, Educational Symposium &amp; Trade Show, Lake Kiamesa, New York, October 1996</td>
</tr>
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<td>1996</td>
<td>American College of Emergency Physicians Research Forum, Cincinnati Ohio, abstract presentation entitled</td>
<td>&quot;Use of Time - Temperature Indicators to Monitor the Storage Temperature of Medications in the Prehospital Setting&quot;</td>
<td>J.R. Allegra, J. Brennan, B. Felegi, L. Fields, F. Grubiner, G. Kiss, B. Lavery, T. Pruzik; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown</td>
<td>Lifeline Technologies, Inc.; and, University &amp; Dentistry of New Jersey, February 1996</td>
</tr>
<tr>
<td>1996</td>
<td>Annual Meeting Society for Academic Emergency Medicine, Denver, CO, abstract poster presentation entitled</td>
<td>&quot;Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation&quot;</td>
<td>W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency</td>
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PRESENTATIONS (con’t.)

*Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, May 1996*

1996 New Jersey Chapter of the American College of Emergency Physicians Scientific Assembly, Atlantic City, NJ, abstract poster presentation entitled, *"Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation"*: W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, June 1996

1996 National Association of Emergency Medical Services Physicians Mid-Year Meeting and Scientific Assembly, San Diego, CA, abstract oral presentation entitled, *"Gastric Trauma and Pulmonary Aspiration at Autopsy After Cardiopulmonary Resuscitation"*: W. B. Felegi, R.L. Doolittle, A.S. Conston, S.V. Chandler; Department of Emergency Medicine, Morristown Memorial Hospital, Morristown, New Jersey; Department of Pathology, Somerset Medical Center, Somerville, New Jersey, July 1996

Special Guest Speaker for Emergency Medical Services Paramedics Gynecological, Obstetrical & Neonatal Emergencies" 1995 - New Jersey State First Aid Council 67th Annual Convention, Somerset, New Jersey

Special Guest Speaker for Emergency Medical Services Paramedic Personnel: Morris County Fire & Police Academy Emergency Medical Technician Core Lecturer EMT Basic & Refresher Courses, 1991-1994

Introduction to Emergency Nursing Lecture Series of Morristown Memorial Hospital Guest Speaker, 1992

13th Annual Maine Biological and Medical Services Symposium poster presentation entitled *"Gastric Ruptures, Gastric Mucosal Lacerations, and Gastric Dilation Following Cardiopulmonary Resuscitation in the Prehospital Environment,"* June 1987

Special Guest Speaker for Emergency Medical Services Personnel and their response to the Crime Scene for:

1984 - St. Peter's Medical Center Area First Aid Council, New Brunswick, N.J.
1984 - Plainfield Rescue Squad, New Jersey
1984 - Essex County and the Cedar Grove Rescue Squad, New Jersey
1984 - New Jersey State First Aid Council 56th Annual Mid-Year Assembly, Cherry Hill, New Jersey
1983 - New Jersey State First Aid Council 55th Annual Convention, New York
COMMUNITY SERVICE

Medical Director, Farmington EMS, Farmington, IA, 2018-present

Life Member Bound Brook Rescue Squad, Inc., 1974-present

Delegate-at-Large to the 5th District of the New Jersey State First Aid Council, 1983-present

Community Member, Bridgewater Township Emergency Medical Services Committee, 2001-03

Vice-President 5th District of the New Jersey State First Aid Council, 1983-85

Democratic Male Committee Member, Bridgewater Township District 26, 2004-2008

Former ACLS (American Heart Association) Instructor 1994-2007

Former Instructor American Red Cross Standard & Advanced First Aid & Emergency Care (10 years)

Former Instructor American Heart Association C.P.R. (8 years)

Former Instructor NJ State First Aid Council Extrication (4 years)

Former member Somerset County's Citizen Advisory Task Force on Domestic Violence for Battered Spouses & Child Abuse (1 year)

Former member Bound Brook School District Citizen's Advisory Thoroughness & Efficiency Committee (2 years)
**2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS**

**Jeffrey M. Goodloe, MD, FACEP**

### Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?

I’m encouraged by our evidence-based, data-driven approach to all of these three areas that present important challenges, and vital future opportunities for emergency physicians and ACEP. Let’s look at each:

**Workforce:** Any study that predicts a future state of emergency physician supply and demand is inherently limited by the imprecision and inability to perfectly account for all potential future dynamics (e.g., pandemics, legislative actions expanding or limiting the capabilities of emergency physicians, and/or finances of the US healthcare system). That said, the study by Marco et al., [DOI:https://doi.org/10.1016/j.annemergmed.2021.05.02](https://doi.org/10.1016/j.annemergmed.2021.05.02) represents a thoughtful forecasting, one that included a multitude of emergency medicine organizations. At least one subsequent study has questioned the supply and demand estimates of the Marco publication. Still, our own solutions to protecting AND expanding opportunities for future generations of emergency physicians are best derived and executed when based on rigorous research—not fear, false confidence, or reactionary emotions of futility. As full-time core faculty at a university-based medical school/community hospital-based emergency medicine residency program, I honestly believe there will continue to be great opportunities for educated and industrious board-certified emergency physicians. ACEP can and must continue to lead, via advocacy and practice resources, in sustaining present practice models and defining new practice settings that are ideal for the emergency physician’s skillsets. Which leads us to…

**Scope of Practice:** While our DC-based national advocacy team is always prepared to address federal level scope of practice issues, the core issue, pointedly involving nurse practitioners and physician assistants seeking “independent practice” authority, is a state-by-state battle best fought not with traditional legislative weaponry, but with the superior power of emergency physicians “armed” with data—didactic and clinical—comparing physician, nurse practitioner, and physician assistant training and levels of expertise. While hesitant to laud one state chapter of ACEP over another, I vigorously applaud our colleagues in Louisiana and Indiana for important wins at their respective legislatures that protected patient safety AND scope of practice in positive ways for the emergency physician. Do we expect the challenges to continue? Surely. Fortunately, we can equally count on the solidarity of state ACEP chapter leaders and members, empowered by our national ACEP resources, to be ready to address those oft emotionally laden challenges with verifiable patient-centered, pro-physician data. This is just one example of why it is incumbent upon our Board of Directors and staff to lead in…

**College Sustainability:** The future of emergency medicine is strengthened most by a strong ACEP, an ACEP that is appropriately focused on the individual emergency physician. This is not to say we have diminished interest in our patients’ welfare or our specialty. Rather, we’ve reached clarity that the better we can support the emergency physician, the better care our collective patients receive. Further, in doing so we elevate the importance of our specialty for the well-being of all of us, for each of us may one day become a patient requiring the unique abilities of our colleagues in emergency medicine. Our ACEP Strategic Plan, released this year, serves us all in focusing our energies on areas that matter most to our present and future members, maintaining fiscal responsibility and building trust in leadership.

Thus, I emphasize my initial comments of being encouraged by our strategic approach to each one of these three key areas. Hard work, building talent, and a listening, responsive leadership will promote the success we all deserve – now and ahead.

### Question #2: Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?

Career Fulfillment and Member Engagement. Even a cursory review at [https://www.acep.org/strategicplan/](https://www.acep.org/strategicplan/) will show my bias about career fulfillment. You’ll find on reviewing the many leaders--members and staff--involved (over one hundred!) that I’m incredibly privileged to co-lead the Career Fulfillment Team with David McKenzie, CAE, our incredible reimbursement director. Now, you might jump to the conclusion that we believe all career fulfillment is found through money, money, and more money. No. Does money matter to emergency physicians? Well, sure, just as it matters to non-emergency physicians, too! Just ask our neighbors, friends, and patients. Money is only part of the equation. We all want to feel valued and respected in non-monetary ways, too. Due process, safe work environments, clinical and administrative opportunities at hospital and healthcare systems, ACEP state chapter, and national ACEP levels can enhance our emergency medicine careers. I’m concerned
about the dynamics of a US healthcare system that can exploit our dedication and commitment to patients, which reach far beyond the regulatory demands of EMTALA.

How do we improve career fulfillment? Many ways, including success in workforce and scope of practice dynamics through a strong, vibrant ACEP. We listen to one another, seek areas of common ground over the challenges and limits to advancing our careers, then equally invest in “best practices” among our members, helping to share local successes so they disseminate throughout our members’ practices.

When we do this, genuinely promoting our members, creating opportunities to highlight their insights, experiences, and talents, we create increasingly accessible resources available through ACEP. These solutions can be internet-accessible—creating guides, educational forums, and point-of-care apps. We can create stronger peer networks, virtually and through in-person events. As ACEP becomes more tangible in helping emergency physicians in the workplace, in personal development, and in wellness to name just few key areas of importance, this tangibility advances member engagement and loyalty—leading to a bigger, stronger, more creative ACEP. This isn’t a “zero sum” equation whereby one emergency physician’s advance must come at another emergency physician’s loss. Our unity on career enhancements in emergency medicine serves to strengthen us all.

**Question #3: What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?**

“Well, it depends” …isn’t this an “answer” we often find ourselves leading with when talking with our patients, residents and medical students, our families, and each other? In the more formal setting of ACEP meetings, particularly those prognosticating the future of our specialty, there are significant differences of opinion about the propriety and the impact of an increasing footprint of private equity ownership in emergency medicine practices. In the more informal setting of social media posts, texts, calls, and emails I receive as an incumbent member of the Board of Directors, the balance of input strongly suggests that social issues take center stage as a divisive subject—challenging what ACEP should or should not say. Let’s talk about both!

Private equity--good or bad? Whatever your answer, is it an inherent or “intuitively obvious to all” one? And are opinions based upon concrete data? I’ve worked for several different group ownership models, including 15 years ago as part-owner of a regional emergency medicine group, with over one hundred of my emergency physician colleagues. I’ve been employed by a group with only a couple of partners, by a democratic group of six to eight physicians covering a single hospital in a rural area, by a multi-state/national contract management group, and for the past 15 years by a university Board of Regents in the role of a medical school’s residency core faculty. By the way, each of these practice models “managed” a contract in the sense we/they/all of us wanted to retain the contract and our future work opportunities! Do I have concerns that focus on profit can come at the expense of good patient care? Yes. But that’s not fully evidence-based to date. We need solid studies to answer a question so many of us have about this. Our partner organization, the Emergency Medicine Foundation, is an outstanding, independent, high-quality research organization committed to the promotion and funding of quality research that can realize valid answers to these questions, unencumbered by the prevailing emotion and “politics” of the day.

Social issues--ACEP’s “lane” or not? Often the answer is found in how a particular issue impacts our patients. Just as quickly as some members reach a “single right answer”, a considerable number of members may conclude the opposite is true. This is a frequent challenge for the Board of Directors as we seek to articulate the views of our nearly 40,000 members. We listen and we simply make the best call to channel your views into statements--public ones and formal ACEP policy ones--always trying to craft responses that respect all of our members. That, friends and colleagues, is necessary for our College’s health—we can differ mightily in opinion based upon professional and/or personal beliefs though I believe we must just as mightily respect one another. The old saying is true that, “United we stand, divided we fall.” We need to stand--for each other, so that we can each and every one be standing, literally and figuratively, for our patients when and where they most need our abilities and unique expertise.
Jeffrey M. Goodloe, MD, FACEP

Contact Information
3720 E 99th PL, Tulsa, OK 74137 (Home)
Phone: 918-704-3164 (Cell)
E-Mail: jeffrey-goodloe@ouhsc.edu (Work); jeffreygoodloe911@gmail.com (Personal/ACEP)

Current and Past Professional Position(s)
Attending Emergency Physician – Hillcrest Medical Center Emergency Center – Tulsa, OK
Professor of Emergency Medicine; EMS Section Chief; Director, OK Center for Prehospital & Disaster Medicine
University of Oklahoma School of Community Medicine – Tulsa, OK
Chief Medical Officer, Medical Control Board, EMS System for Metropolitan Oklahoma City & Tulsa, OK
Medical Director, Oklahoma Highway Patrol
Medical Director, Tulsa Community College EMS Education Programs
Item Writer, EMS Examination & myEMSCert modules; Item Writer & Co-Editor, EMS LLSA, ABEM

Past Positions
Attending Emergency Physician – St. John Medical Center – Tulsa, OK
Attending Emergency Physician – Saint Francis Hospital Trauma Emergency Center – Tulsa, OK
Attending Emergency Physician – Medical Center of Plano – Plano, TX
Medical Director, Plano Fire Department – Plano, TX
Medical Director, Allen Fire Department – Allen, TX

Education (include internships and residency information)
EMS Fellowship – University of Texas Southwestern Medical Center at Dallas (1998-99)
Emergency Medicine Residency – Methodist Hospital of Indiana/Indiana Univ School of Medicine (1995-98)
The Medical School at University of Texas Health Science Center at San Antonio (1991-95)
Baylor University – Waco, TX (1987-91)

MD - 1995

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.)
All MOC components current for present cycle recertification in 2029
ABEM EMS Medicine Initial Certification 2013, All MOC components current & certification extended to 2027
factoring service on EMS Subboard for ABEM

Professional Societies
ACEP member since 1991 (medical student, resident, fellow, active, FACEP)
OCEP (Oklahoma College of Emergency Physicians – State ACEP Chapter)
AMA
NAEMSP (FAEMS)
SAEM
ACHE

Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter, Oklahoma State Medical Association, Tulsa County Medical Society

National ACEP Activities – List your most significant accomplishments
Secretary-Treasurer, ACEP Board of Directors (2021-present)
Member, ACEP Board of Directors (2019-present)
Member, Council Steering Committee, ACEP Council
Chair, Reference Committee, ACEP Council
Member, Reference Committee, ACEP Council
Councillor, Oklahoma College of Emergency Physicians
Councillor, EMRA
Chair, EMS Committee
Member, EMS Committee
Member, Bylaws Committee
Member, Internal & External Membership Committee Taskforces

ACEP Chapter Activities – List your most significant accomplishments

President, Oklahoma College of Emergency Physicians
Vice-President, Oklahoma College of Emergency Physicians
Councillor & Board Member, Oklahoma College of Emergency Physicians

Practice Profile

Total hours devoted to emergency medicine practice per year: 2860 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 30% Research 5% Teaching 10% Administration 55%*
Other: *predominantly EMS medical oversight & national ACEP duties ___% 

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am employed full time by the University of Oklahoma School of Community Medicine. My roles include serving as medical school faculty as a professor of emergency medicine and clinically as an attending faculty physician in the Hillcrest Medical Center Emergency Center (Comprehensive Stroke Center, full-service cardiovascular institute site – including ECMO and VAD surgeries, Level III Trauma Center, regional burn center for geographical areas of four states, Level III NICU) supervising residents in Emergency Medicine, Internal Medicine, Family Medicine, OB/GYN, fellows in Pediatric Emergency Medicine, and medical students. The University of Oklahoma Department of Emergency Medicine faculty partially staffs four emergency departments in Tulsa and Oklahoma City, employing a university academic group/regional democratic private group collaborative structure. I am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching hospitals in Tulsa. I also serve as the Chief Medical Officer for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 2,700 credentialed EMS professionals working in an ambulance service, fire departments, law enforcement agencies, industrial emergency response teams or emergency communications centers. I further serve as a tactical emergency physician and Medical Director for the Oklahoma Highway Patrol, responding on emergency tactical missions across the entire state. Additional practice roles include special events medical support planning for metropolitan Oklahoma City and Tulsa and as an educational program medical director for EMT and Paramedic education at Tulsa Community College. I also frequently lecture at national educational meetings, such as the EMerald Coast Conference (10 ACEP state chapter annual conference in Florida) and EMS State of the Science – A Gathering of Eagles.

Expert Witness Experience (I am interpreting such as courtroom testimony – JG)
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 1 Cases Plaintiff Expert 0 Cases

No expert witness work since election to the ACEP Board of Directors in 2019.
CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Jeffrey M. Goodloe, MD, FACEP

1. Employment – List current employers with addresses, position held, and type of organization.

   Employer: University of Oklahoma School of Community Medicine
   Address: Department of Emergency Medicine, 1145 S. Utica Ave, 6th Floor
   Position Held: Professor; EMS Section Chief; Director – OK Ctr for Prehospital/Disaster Med
   Type of Organization: Medical School

   Employer: _____________________________
   Address: _____________________________
   Position Held: _____________________________
   Type of Organization: __________________

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.

   Organization: American College of Emergency Physicians
   Address: 4950 W. Royal Ln
   Irving, TX 75063
   Type of Organization: Medical Specialty Society
   Leadership Position: Secretary-Treasurer & Member, Board of Directors
   Term of Service: 2019-present (Member); 2021-present (Secretary-Treasurer)

   Organization: Emergency Medicine Foundation
   Address: 4950 W. Royal Ln
   Irving, TX 75063
   Type of Organization: 501(c)3 Nonprofit Organization for Funding Emergency Medicine Research
   Leadership Position: Chair & Member, Board of Trustees
   Term of Service: 2018-present (Member); 2021 (Treasurer); 2022 (Chair)
3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Jeffrey M. Goodloe, MD, FACEP Date June 9, 2022
July 25, 2022

Re: Endorsement of Jeffrey M. Goodloe, MD, FACEP for re-election to the ACEP Board of Directors

Dear Councillors,

On behalf of the Oklahoma College of Emergency Physicians (OCEP), I write to enthusiastically endorse the re-election of Dr. Jeffrey M. Goodloe to the ACEP Board of Directors.

Dr. Goodloe is well known nationally within ACEP due to his dynamic, servant leadership, on full display during his first term on the ACEP Board of Directors. Dr. Goodloe’s fellow board members signal their agreement by electing him the national ACEP Secretary-Treasurer this year. Results-focused, team-building leadership is a decades-long “Jeff Goodloe hallmark” starting prior to his EMRA presidency in the late 1990s. He has been a 15-year active councillor, serving on Council Steering Committee and reference committees, including chairing a reference committee.

Dr. Goodloe is dependably active in advocacy at both state and federal levels, respected among Oklahoma’s State and US Representatives and Senators. Tellingly, both US Representative Kevin Hern (OK-01) and US Representative Markwayne Mullin (OK-02) have designated him as the “emergency medicine expert” on their respective healthcare panels. Dr. Goodloe has personally arranged visits by each of these Congressmen to his local emergency department, including spending time with emergency medicine residents at the University of Oklahoma School of Community Medicine. Rep. Mullin counts on Dr. Goodloe’s insights to help frame his own advocacy for patients struggling with opioid use disorder. With Dr. Goodloe at his immediate side in multiple town halls in Oklahoma, Rep. Mullin pointed out, “Clearly, emergency medicine is not the problem; they (emergency medicine physicians) are part of our answer!”

Dr. Goodloe is an active promoter of an Emergency Medicine future solidified by research, recently serving as Secretary-Treasurer, and now serving as Chair of the Emergency Medicine Foundation Board of Trustees. Within EMF, he is known as an avid recruiter of ACEP members to join him in the Wiegenstein Legacy Society.

Jeff Goodloe is a voice trusted by generations of ACEP leaders, including multiple ACEP presidents, evidenced in part by a two-year term as Chair of the EMS Committee and multiple appointments to other committees and task forces, either as a member or as board liaison.
Dr. Goodloe has effectively led OCEP as a Board Member since 2007 and as President in 2016-2019, helping create a resurgence in activity and interest at the state level. Just this past week, OCEP held its most successful meeting in over 15 years, in notable part due to Jeff’s energy and encouragement of chapter members’ engagement in both OCEP and ACEP. Further, Jeff led OCEP in electing our first resident member to full Councillor status with concurrent election to our board of directors. We are excited to increasingly promote the next generation of emergency medicine leaders in Oklahoma.

Dr. Goodloe has represented us well throughout the years, helping OCEP councillors understand the history behind resolutions and the potential full impact of resolutions on the ACEP members we represent. He is a consummate team player and leader, encouraging involvement of any OCEP member willing to serve and focusing on the mentorship of younger members.

We are certain that Dr. Goodloe would verify the above, though reluctantly, given his modest, deferential leadership style. I submit to you that it is hard to find a more giving, humble leader with unquestionable integrity and ethics.

In closing, OCEP respectfully and strongly encourages the ACEP Council to re-elect Jeffrey M. Goodloe, MD, FACEP to the ACEP Board of Directors.

Kindest professional regards,

James R. Kennedye, MD, MPH, FACEP
President, Oklahoma College of Emergency Physicians
Councillors,

I am humbled, honored, and motivated by your support for my service to you and all College members over my past three years on the ACEP Board of Directors. Throughout a mostly “pandemic” dynamic, I have so enjoyed the myriad of opportunities to support, assist, and lead exciting projects that highlight my over 30 years as an active member of ACEP.

As Board liaison, I collaborated with an incredible team, led by Dr. Michael Wadman, of experienced and insightful emergency physicians providing high quality emergency medicine to rural communities. Our charge from the Board of Directors was: 1) To facilitate the collective understanding of rural emergency physicians’ unique challenges and to identify the limitations presented to rural EM settings, 2) To Identify strategies that strengthen and create new opportunities for training and post-graduate careers in rural emergency medicine, and 3) To create “best practices” for ACEP to advance emergency care in rural America. I am especially proud of the timeliness of this work in 2020, given the current robust deliberations about the supply and demand dynamics of our workforce in the coming decade.

Our report, unanimously “approved” by the Board of Directors, can be found here: https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/.

Following this task force, I was appointed Board liaison and co-lead with Dr. Benjamin Hatten for the ACEP Task Force on Hyperactive Delirium with Severe Agitation. This journey included challenging long-held clinical beliefs with contemporary, peer-reviewed, published research and insights shared by members with particularly poignant recent experiences. I’m grateful for this service and its impact on my ability to better serve both patients suffering a dynamic crisis and those caring for these patients in the streets (our EMS colleagues) and in the ED (us). ACEP is deploying this report to highlight enhanced “best practices” that benefit these important patients and the providers of their care.

This work, also unanimously “approved” by the Board of Directors, can be found here: https://www.acep.org/by-medical-focus/hyperactive-delirium/. When you get to the dozens of comparative pharmaceutical tables, this reflects the amazing Ben Hatten’s countless hours of work. I am thrilled to get to know him through this project and consider him both colleague and friend.

These are just a couple of the impactful and tangible work products I’ve been so fortunate to help create. Our Pediatric EM Committee has produced so many policy statements and publications that it’s hard to count them all. Each is an example of what committed ACEP members can achieve together. The ACEP strategic plan allows multiple generations of College leaders, members, and staff to build a winning vision that serves us well over the next three to five years.

The preceding brief synopsis of my past three years of Board service spurs my enthusiasm to ask for your vote to re-elect me to the Board of Directors for the next three years. I will consider your vote a signal to continue my support of you, your family, and your future in emergency medicine.

The past three years once again prove the mettle of the emergency physician. I stand ready for the challenges that we face and am honored to represent you wherever and whenever these challenges emerge.

Jeffrey M. Goodloe, MD, FACEP
JEFFREY M. GOODLOE, MD, FACEP

For Re-Election to the ACEP Board of Directors

Accountable service
Consensus builder
Enthusiastic commitment
Proven leadership

ACEP Secretary-Treasurer
Board Liaison
- Task Forces: Hyperactive Delirium & Rural Committees: EMS & Pediatric EM
- Sections: EMS, Pediatric EM, & Tactical
- Amer Coll Surgeons Comm on Trauma
Past Council Steering Committee Member
Past Council Reference Committee Chair
Past EMS Committee Chair
Past State Chapter President & Councillor
Past EMRA President & Councillor

Proudly endorsed by:

Jeffrey M. Goodloe, MD, FACEP
1145 S. Utica Ave, Suite 600 | Tulsa, OK 74104 | 918-704-3164 (Cell)

jeffrey-goodloe@ouhsc.edu | jeffreygoodloe911@gmail.com
Jeffrey Michael Goodloe, MD, NRP, FACEP, FAEMS, LSSBB

Address: Department of Emergency Medicine
The University of Oklahoma School of Community Medicine
1145 South Utica Avenue, 6th Floor
Tulsa, Oklahoma 74104

Telephone: (918) 579-2364 (Department Office)
(918) 704-3164 (Cell)
Fax: (918) 579-2369 (Department Fax)

E-mail: jeffrey-goodloe@ouhsc.edu (EMS/EM/University)
jeffreygoodloe911@gmail.com (ACEP/Special Projects)

II. EDUCATION

<table>
<thead>
<tr>
<th>School/College</th>
<th>Field of Study</th>
<th>Degree Earned</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>The University of Texas Medical School at San Antonio</td>
<td>Medicine</td>
<td>MD</td>
<td>1991-95</td>
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<tr>
<td>Baylor University Waco, Texas</td>
<td>Biology</td>
<td>BS, cum laude</td>
<td>1987-91</td>
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<td>Scott &amp; White Memorial Hospital Texas A&amp;M University Health Science Center Temple, Texas</td>
<td>EMS</td>
<td>EMT-Paramedic</td>
<td>1990</td>
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<tr>
<td>Oklahoma City Community College Oklahoma City, Oklahoma</td>
<td>EMS</td>
<td>EMT-Intermediate</td>
<td>1989</td>
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<td>McLennan Community College Waco, Texas</td>
<td>EMS</td>
<td>EMT-Basic</td>
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POST-DOCTORAL TRAINING:

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<th>School/College</th>
<th>Field of Study</th>
<th>Degree Earned</th>
<th>Year</th>
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<tbody>
<tr>
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<td>EMS</td>
<td>Fellowship</td>
<td>1998-99</td>
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<tr>
<td>Indiana University School of Medicine Methodist Hospital of Indiana Indianapolis, Indiana</td>
<td>Emergency Medicine Residency</td>
<td>1995-98</td>
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III. PROFESSIONAL EXPERIENCE

1. Academic:

2012-Present   Professor and EMS Section Chief  
                Director - Center for Prehospital and Disaster Medicine  
                Department of Emergency Medicine  
                The University of Oklahoma School of Community Medicine

2007-2012      Associate Professor and EMS Division Director  
                Department of Emergency Medicine  
                The University of Oklahoma School of Community Medicine

2004-2014      Clinical Assistant Professor  
                Division of Emergency Medicine, Department of Surgery  
                The University of Texas Medical School  
                Southwestern Medical Center at Dallas

1998-1999      Assistant Instructor  
                Division of Emergency Medicine, Department of Surgery  
                The University of Texas Medical School  
                Southwestern Medical Center at Dallas  
                Faculty Clinical Duties at Parkland Memorial Hospital

1994-1995      Clinical Instructor  
                Department of Emergency Medical Technology  
                School of Allied Health  
                The University of Texas Health Science Center at San Antonio

1994-1995      Instructor  
                Emergency Medicine Collaborative Teaching Program  
                Department of Emergency Medicine  
                The University of Texas Medical School  
                The University of Texas Health Science Center at Houston

2. Administrative:

2018-Present   Medical Director
2010-2016      Oklahoma Highway Patrol Special Response Teams  
                Tactical, Emergency Medical Services Unit  
                Riot Control, Bomb, Dive

2014-Present   Medical Director  
                Tulsa Community College  
                Emergency Medical Services Education Program
2011-Present  Emergency Medicine Advisor  
Oklahoma City Thunder Professional Basketball Club  
National Basketball Association  

2010-Present  Medical Director  
Special Operations Medical Oversight and Support (SOMOS)  
Department of Emergency Medicine, EMS Section  
University of Oklahoma School of Community Medicine  

2009-Present  Chief Medical Officer & Medical Director  
Medical Control Board, Emergency Medical Services System for  
Metropolitan Oklahoma City & Tulsa, Oklahoma  
Metropolitan Medical Response System  

2008-2009  Associate Medical Director  
Medical Control Board, Emergency Medical Services System for  
Metropolitan Oklahoma City & Tulsa, Oklahoma  
Metropolitan Medical Response System  

2003-2007  EMS Medical Director  
Allen Fire Department  
Allen, Texas  

2001-2007  Medical Director, Emergency Response Team  
Plano Police Department  
Plano, Texas  

2000-2007  Medical Director, Automated External Defibrillation Program  
City of Plano, Texas  

2000-2007  Medical Director, Emergency Medical Technician Education  
Plano Independent School District  
Plano, Texas  

1999-2007  EMS Medical Director  
Plano Fire Department  
Plano, Texas  

1996-1998  Associate EMS Medical Director  
Hendricks County EMS Consortium (Avon Fire Department,  
Brownsburg Fire Department, Danville Fire Department,  
Plainfield Fire Department)  
Hendricks County, Indiana  

3. Hospital/Agency  

2011-Present  Hillcrest Medical Center, Tulsa, Oklahoma  
Emergency Medicine Residency Faculty & Emergency Physician
2009-2011  St. John Medical Center, Tulsa, Oklahoma
            Emergency Medicine Residency Faculty & Emergency Physician

2007-2009  St. Francis Hospital, Tulsa, Oklahoma
            Emergency Medicine Residency Faculty & Emergency Physician

2006-2011  International Hot Rod Association, Norwalk, Ohio
            Track Rescue Team Physician

2000-2019  Texas Motor Speedway/North Hills Track Hospital
            Fort Worth, Texas
            Track Physician for:
            NASCAR Monster Energy Cup Series
            NASCAR Xfinity Series
            NASCAR Camping World Truck Series
            IndyCar Series

1999-2007  Medical Center of Plano, Plano, Texas
            Emergency Physician

1997-1998  Indianapolis Motor Speedway/Hanna Emergency Medical Center
            Track Physician for:
            Indy Racing League & NASCAR Winston Cup Series

1996-1998  Hendricks Community Hospital, Danville, Indiana
            Emergency Resident Physician

1996-1998  Indianapolis Raceway Park, Clermont, Indiana
            Track Physician for:
            National Hot Rod Association US Nationals

1996-1998  Methodist Hospital of Indiana, Methodist Health Group
            Indianapolis, Indiana
            LifeLine Helicopter EMS, Flight Physician

1992-1995  American Medical Transport, Rural/Metro Corporation
            Pasadena, Texas
            EMT-Paramedic

1989-1991  American Medical Transport, Rural/Metro Corporation
            Waco, Texas
            EMT-Intermediate & Paramedic

IV. MILITARY EXPERIENCE

None
V. BOARD CERTIFICATION

Emergency Medicine, American Board of Emergency Medicine
Initial Certification 1999; Recertification 2009, 2019 (expires 12/31/2029)
Emergency Medical Services Medicine, American Board of Emergency Medicine
Initial Certification 2013 (expires 12/31/2027)

VI. LICENSES/CERTIFICATIONS

Physician Licenses:
- July 1996 - Present, Indiana
- August 1998 - Present, Texas
- July 2007 - Present, Oklahoma

EMS Licenses/Certifications:
- National Registry of Emergency Medical Technicians
  - Paramedic (active status)
- EMT-Tactical (active status)

Lean/Six Sigma Certifications (accredited by IASSC):
- Black Belt
  - Creative Insights, Inc.
- Green Belt
  - University of Oklahoma Gallogly College of Engineering
- White/Yellow Belt – Fundamentals of Lean/Six Sigma
  - University of Oklahoma Gallogly College of Engineering

VII. RESEARCH AND SCHOLARSHIP

1. Grants/Funded Projects
   a. 2015 EMS Medical Director Course and CQI Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2015 and entailed delivery of the State of Oklahoma EMS Medical Director Course and CQI Practicum in Antlers, Altus, and Fairview. Direct funding at $6,000 by Rogers EMS Consulting.
   b. 2014 EMS Medical Director Course and Practicum. Principal Instructor and Course Coordinator for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Section. Under contract with Rogers EMS Consulting. Project was completed in June 2014 and entailed delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Ardmore and Lawton. Direct funding at $12,500 by Rogers EMS Consulting.
   c. 2013-14 Update State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department
of Emergency Medicine, EMS Section. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in April 2014 and entailed development of EMS treatment protocols that are endorsed as the official 2014 State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum in Muskogee and Stillwater. Direct funding at $40,000 by Oklahoma State Department of Health.

d. 2011-12 Development of State of Oklahoma EMS Treatment Protocols and EMS Medical Director Course and Practicum. Principal Developer for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Under contract with the Oklahoma State Department of Health Protective Health Services EMS/Trauma Division. Project was completed in September 2012 and entailed development of EMS treatment protocols that are endorsed as the official State of Oklahoma EMS treatment protocols for use by all ground-based EMS agencies. Additional deliverable components included development of update methodologies and curriculum refinement and delivery of the State of Oklahoma EMS Medical Director Course and Practicum. Direct funding at $169,000 by Oklahoma State Department of Health.

e. 2010-11 Development of a white paper on EMS System Design. Principal Editor for University of Oklahoma School of Community Medicine, Department of Emergency Medicine, EMS Division. Project was completed in July 2011 with deliverable exceeding expectation of commissioning entity. Authors were personally recruited from Los Angeles, Salt Lake City, Indianapolis, Birmingham, and Charlotte. Co-Editor is Dr. Stephen H. Thomas. Direct funding at $27,000 by Emergency Medical Services Authority in Tulsa, Oklahoma.

2. Research Projects


i. IRB Waived/3330. Airway Management in Adult, Non-Traumatic Cardiopulmonary Arrest in a Large, Urban EMS System. Principal


m. IRB Waived. US Metropolitan Municipalities EMS Medical Directors Consortium (Eagles) Traumatic Shock and Hemorrhage Control Standards of Care Survey. Principal Investigator.


o. IRB Approved 16038. Prehospital Barriers to the Use of Therapeutic Hypothermia for Cardiac Arrest. Senior Investigator. Poster


presentation at the Texas Department of State Health Services 2011 EMS Conference Research Forum. Project involved an EM resident that presented the poster as well.


3. **Teaching Materials Developed**

   **a.** State of Oklahoma EMS Medical Director Course and Practicum for Oklahoma State Department of Health. Full course developed and delivered in Muskogee, Stillwater, Ardmore, and Lawton in March – June 2014, McAlester, Tulsa, Lawton, and Enid in July/August 2012. Beta course developed and delivered in Oklahoma City in June 2010.

   **b.** Oklahoma Trauma Education Program (OTEP) 2008. Materials on multi-system trauma management and transfer, and hand injury management and transfer. Peer reviewed within the Department of Emergency Medicine.

4. **Invited Participation in Academic Conferences**

   **a.** National EMS Board Certification Review Course – Dallas, Texas (August 2017 & September 2015), Tucson, Arizona (January 2014), Seattle, Washington (October 2013), and Las Vegas, Nevada (September 2013). Sponsored by ACEP and NAEMSP. Served as course curriculum developer and faculty lecturer.
b. National EMS Medical Director’s Course – Bonita Springs, Florida – (January 2013). Sponsored by NAEMSP. Served as faculty lecturer, panelist, and case study discussion leader.

c. National EMS Information System (NEMSIS) 3.0 Development Review in Conjunction with EMS Benchmarking in ST Elevation Myocardial Infarction, Out of Hospital Cardiac Arrest, and Stroke – Atlanta, Georgia - (March 2010). Sponsored by the CDC and EMS Performance Improvement Center at University of North Carolina Chapel Hill. Served as an expert opinion contributor, representing The US Metropolitan Municipalities EMS Medical Directors Consortium.

d. Patient Safety in EMS Roundtable - Niagara Falls, Ontario, Canada - (June 2009). Sponsored by The Canadian Patient Safety Institute (CPSI), the Emergency Medical Services Chiefs of Canada (EMSCC), the Calgary EMS Foundation, and members from a pan-Canadian Patient Safety in EMS Advisory Group. Served as an expert opinion contributor and led discussion group.

5. Other Academic Activity


c. 2\textsuperscript{nd} Annual Oklahoma Resuscitation Academy – April 2015, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.


e. Tactical Emergency Medicine Care in a Military Medicine, Law Enforcement, and Emergency Medicine Collaborative Training Program. Accepted for poster presentation at Innovations in EMS Fellow Education Symposium at National Association of EMS

f. Oklahoma Resuscitation Academy – April 2014, Oklahoma City. Course Coordinator for 2-day national resuscitation conference.

VIII. PUBLICATIONS

1. Peer-Reviewed


2020


**Non-peer reviewed**

2021  **Goodloe JM**. COVID-19 Updates. Accessible at okctulomd.com

2020  **Goodloe JM**. COVID-19 Updates. Accessible at okctulomd.com


2. **Chapters in Textbooks**


Other:

a. Abstracts or Posters

2017 Goodloe JM (presenter), Vinson LD (EM resident), Cox, ML, Burns BD. Paramedic compliance with a novel defibrillation


**Goodloe JM** (presenter), Arthur AO, Rhoades T (medical student), Holder P (EM resident), Winham JW, Thomas SH. EMT-Basic Acquisition and Transmission of 12-lead ECG Using a Novel Device (ReadyLink™). Poster Presentation, Canadian Association


Device (ReadyLink™). Poster Presentation, American College of Cardiology Annual Meeting, San Francisco, California. Abstract in Journal of American College of Cardiology (JACC), March 12, 61(10_S), Supplement A.


Dixon JD, Arthur AO, Williams E (EM resident), Goodloe JM (presenter), Thomas SH. Ambulance Patients are More (or Less) Likely to be Insured. Poster Presentation, National Association of EMS Physicians Annual Meeting, Bonita Springs, Florida. Abstract in Prehospital Emergency Care 17(1), 132.

2012 Crane RD (EM resident), Arthur AO, Dunn K (medical student), Thomas ST, Goodloe JM (presenter). Emergency Medical Services Initiation of Therapeutic Hypothermia in Post-Return of Spontaneous Circulation from Cardiac Arrest: Chillingly Low Rates and Contributing Factors. Poster Presentation, Texas Department of State Health Services 2012 EMS Conference, Austin, Texas.


2012  

**Goodloe JM** (presenter), Hartline J (medical student), Crane RD (EM resident), Johnson KV (medical student), Reddick EA (EM resident), Synovitz CK. A Statewide Survey of Emergency Department Standards of Care for Acute Coronary Syndromes - Variability and Opportunity for Advancement. Poster Presentation, American College of Cardiology Annual Meeting, Chicago, Illinois. Abstract in Journal of the American College of Cardiology (JACC), March 27, 59(13), Supplement A, A113


2011  


**Goodloe JM** (presenter), Swope MS (EM resident), Arthur AO, Thomas SH. Use of an Ambulance Siren Low Frequency Enhancer, Howler™ in a Large, Urban Emergency Medical Services (EMS) System - Do Collision Rates Decrease? Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.


Brown EJ (presenter/EM resident), Synovitz CK, Gilpen J, **Goodloe JM**, Burns BD, Justice W, Halcome C. Residents Gain Confidence in Trauma Skills During Special Operations Medical
Specialist Course. Poster Presentation, University of Oklahoma - Tulsa Annual Research Forum.


2010 Goodloe JM (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative Change. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Reginald TJ, Phillips M (EM resident), Goodloe JM (presenter), Thomas SH. Timeliness of post-intubation capnography application - effects of educational intervention on paramedic performance. Poster Presentation, Texas Department of State Health Services EMS Conference Research Forum. Austin, Texas.

Goodloe JM (presenter), Dixon J, Reginald TJ, Phillips M (EM resident), Sacra JC, Thomas, SH. EMS Override of Emergency Department Diversion Requests - Effects of An Administrative


2009 Stewart CE (presenter), Synovitz C, Goodloe JM, King B, Deal KE, Munn J. Octoberfest Tent Collapse. Poster Presentation, World Congress on Disaster and Emergency Medicine, Victoria, British Columbia.

2008 Stewart CE (presenter), Synovitz CK, Goodloe JM, King B, Deal KE, Munn J. Octoberfest Tent Collapse, Poster Presentation, University of Oklahoma, College of Medicine, Tulsa, OK.


b. Editorials, position papers, background papers

CURRICULUM VITAE


c. Original invited lectures and presentations published for distribution


2021  Goodloe JM. Grand Rounds/Visiting Professorship. FDNY/Northwell Health EMS Fellowship. Life Advice for an EMS Physician. Webinar (August)


Goodloe JM, Gallagher JM, Duerring S, Ferguson W. EMS Panel Discussion. EMerald Coast Conference. Miramar Beach (Sandestin) Florida (June).

2019  **Goodloe JM.** Tornadoes in Oklahoma: Implications for “Vulnerable” Populations. SAEM Regional Conference UT Southwestern Medical Center – Dallas, Texas (September)

**Goodloe JM, Gallagher JM, Duerring S, Ferguson W.** EMS Panel Discussion. EMErald Coast Conference. Miramar Beach (Sandestin) Florida (June).


**Goodloe JM.** Does Anybody Really Know What Time It Is (That Makes a Clinical Difference AND a People Difference in 2019!). Advanced Topics in Medical Direction Pre-Conference. National Association of EMS Physicians Annual Meeting – Austin, Texas (January)


**Goodloe JM.** Termination of Cardiac Arrest Resuscitation – Do We Known When to Say When? Hillcrest Medical Center Fall CME Symposium. Kansas City, Missouri (September)
2018  **Goodloe JM**, Jobrack J. “EMS Update on Anaphylaxis” 2018 Indiana Emergency Response Conference. Indianapolis, Indiana (September)


Fowler R, **Goodloe JM**. Stop the Bleed Education Debate. Advanced Topics in Medical Direction Pre-Conference; Gallagher JM, **Goodloe JM**, Howerton DS. Credentialing Pearls: Tales of Bumps, Bruises, & Success. National Association of EMS Physicians Annual Meeting – San Diego, California (January)

2017  **Goodloe JM**. 1) Catalyst for Analysis: Cardiac Arrest Resuscitation Analytic Discoveries. 2) Active Compression Decompression CPR: Bi cycling the Pump in Intrathoracic Pressure Regulation. 3) Tipping the Scales in Defibrillation: Leveraging Weight-Based Energies & Vectors. Eagles Pre-

2017 **Goodloe JM.** Advances in Sudden Cardiac Arrest Care – Outside & Inside the Hospital. Hillcrest Medical Center Fall CME Symposium. Dallas, Texas (October)

**Goodloe JM.** Progressive Resuscitation: Advances in Cardiac Arrest & Stroke Care. Saint Francis Hospital Trauma & Stroke Symposium. Tulsa, Oklahoma (September)


2016  **Goodloe JM.** Optimal Cardiopulmonary Resuscitation Practices and Active Compression-Decompression CPR. Hillcrest Medical Center Grand Rounds – Tulsa, Oklahoma (July).


Ossmann E, **Goodloe JM, Braithwaite SA.** Pinnacle Power Seminars. How Evidence-Based Medicine will Reshape the Practice of EMS: A Clinical Update. Pinnacle EMS Leadership Conference – Scottsdale, Arizona (July)

**Goodloe JM, Beck EH, and Racht E.** 1) Cardiac Arrest Analytics: Constructing and Reading the Dashboard. 2) Optimal Team Dynamics of Pre-Hospital Cardiac Arrest Resuscitation. Emergency Cardiovascular Care Update (ECCU) 2014 – Las Vegas, Nevada (June).


2013 Goodloe JM. 1) The EMS Praxis for Anaphylaxis. 2) High-Risk Patients: Case Studies to Keep You on the Leading Edge. 3) Team Dynamics in Cardiac Arrest Resuscitation: Can We Save More Lives? Yes, We Can! North Lake Tahoe Fire Protection District 18th Annual Paramedic Refresher and CE Program – Incline Village, Nevada (December)

Goodloe JM. Pearls in Out of Hospital Mechanical Ventilation. Pre-Conference/Satellite Symposium, Air Medical Transport Conference – Virginia Beach, Virginia (October)


2013  **Goodloe JM.** 1) EMS System Design. 2) Political Pitfalls in EMS Medical Direction Panel Forum. 3) EMS Case Study Curriculum Discussion Leader. National EMS Medical Director’s Course (NAEMSP) – Bonita Springs, Florida (January)


**Goodloe JM.** TRANscending a New Understanding through EXAMination of an Old ACID: The Role of Tranexamic Acid (TXA) in Preoperative Trauma Management. Fifth Annual EMS Conference - Tulsa, Oklahoma (August). EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.


**Goodloe JM.**  EMS Standards of Care Alterations in Response to Snowstorm. Mid-America Regional Council Emergency Rescue Committee Meeting – Kansas City, Missouri (February).


2011  **Goodloe JM.**  1) EMS Capnography 2011 - Where are we? Where should we be? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services.


**Goodloe JM.**  The Importance of Regional Collaboration. Heart Alert: Southwest Texas Regional Advisory Council for Trauma Regional Cardiac Summit - San Antonio, Texas (February).


2010 Goodloe JM. 1) EMS Termination of Resuscitation: Best Practices for a Difficult Task. 2) EMS Capnography 2010 - Where are we? Texas EMS Conference - Austin, Texas (November). Texas Department of State Health Services


Goodloe JM, Winham JO, Reginald TJ, Howerton DS. The State of the State of EMS Emergency Cardiovascular Care in Oklahoma. Third Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.


Goodloe JM. The Science & Art of Prehospital Trauma Care - What Does "Clinically Important" Time Management Really Mean? Trauma Symposium: A New Decade of Trauma Care Oklahoma City, Oklahoma (May). OU Medical Center

CURRICULUM VITAE


2009 **Goodloe JM.** 1) Patient Refusals: Isn't It Just Sign on the Line?
   2) Ventilations and Compressions: The Science Behind Blowing Slow and Pumping Fast. Texas EMS Conference - Fort Worth, Texas (November). Texas Department of State Health Services


**Goodloe JM.** EMS Termination of Resuscitation: When We Know That We Know When It’s When to Say When (or Do We?). EMS Medical Directors Seminar - Galveston, Texas (September). Texas College of Emergency Physicians.

**Goodloe JM.** H1N1 Flu: Implications for EMS. Flu Facts for the Frontline Symposium - Tulsa, Oklahoma (September). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.

**Goodloe JM,** Reginald TJ, Howerton DS. The State of the State of Therapeutic Hypothermia in Oklahoma. Second Annual EMS Conference - Tulsa, Oklahoma (August). EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine.


Goodloe JM, Reginald TJ, Howerton DS. Capnography. First Annual EMS Conference - Oklahoma City, Oklahoma (August). Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine-Tulsa.

2007  Goodloe JM. Advancing the System: Credentialing and Evaluating Personnel. EMS Medical Directors Seminar - Dallas, Texas (September). Texas College of Emergency Physicians


2000  Goodloe JM. Pediatric Airway Management & Rapid Sequence Intubation. Medical City Hospital of Dallas Annual EMS Conference. Dallas, Texas (March). Medical City of Hospital of Dallas.

IX.  TEACHING ACTIVITIES

1.  Scheduled Teaching Assignments, 2007-Present
   a.  Medical Student & Resident Teaching
      i.  Bedlam Clinic Attending Shifts
      ii. OU Medical Student Interest Group – Invited speaker on EMS
      iii. OU Medical Student Emergency Medicine Rotation – attending supervision and teaching in emergency department
iv. Basic Disaster Life Support Course
v. Advanced Disaster Life Support Course
vi. Emergency Resident Core Orientation course on ECGs – 4 hours
vii. Emergency Resident Core Orientation course on EMS – 4 hours
viii. Emergency Medicine attending supervision and teaching, 10+ ED shifts/month, 10 hours/shift, 4-6 residents/shift, 1-4 medical students/shift.

2. Teaching Initiatives

a. Faculty Teaching

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<th>Course Description</th>
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<td>EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES</td>
<td>OUDEM Residency</td>
<td>December</td>
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<td>FOUNDATIONS</td>
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<td>PERSONAL DEVELOPMENT: JOBS/CONTRACTS</td>
<td>ODDEM Residency</td>
<td>December</td>
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<td>EMS ORIENTATION</td>
<td>IHI Residency</td>
<td>November</td>
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<td>EMS ORIENTATION</td>
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<td>FOUNDATIONS</td>
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<td>PERSONAL DEVELOPMENT: CONTRACTS</td>
<td>ODDEM Residency</td>
<td>September</td>
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<td>EMS MEDICAL STUDENT LECTURE</td>
<td>OUDEM Residency</td>
<td>August</td>
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<td>EMS INTERN ORIENTATION</td>
<td>OUDEM Residency</td>
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<td>EMS MEDICAL OVERSIGHT CLINICAL CASE STUDIES</td>
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<td>CRITICAL CARE ADVANCED RESUSCITATIONS</td>
<td>ODDEM Residency</td>
<td>March</td>
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<td>2020</td>
<td>REIMBURSEMENT UPDATES IN EM</td>
<td>OUDEM Residency</td>
<td>December</td>
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<td>FOUNDATIONS</td>
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<td>PERSONAL DEVELOPMENT: JOB HUNT II</td>
<td>ODDEM Residency</td>
<td>December</td>
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EMS MEDICINE UPDATES
STROKE; COVID; AIRWAY
OUDEM Residency – October

FOUNDATIONS
PERSONAL DEVELOPMENT: PERSONAL FINANCE I
OUDEM Residency – October

EMS INTERN ORIENTATION
OUDEM Residency – July

IMPLICATIONS OF SARS-CoV-2 & COVID-19
OUDEM Residency – March

2019
RUMINATIONS OF ACADEMIC REALITIES
TERMINATION OF RESUSCITATION
OPIOID USE DISORDER
THE EVIDENCE OF EBM
OUDEM Residency - September

EMS INTERN ORIENTATION
OUDEM Residency – July

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2018
EMS INTERN ORIENTATION
OUDEM Residency – July

MASS CASUALTY INCIDENT/DISASTER PLANNING
TORNADO RELATED EMERGENCIES
OUDEM Residency – March

TRAUMA EMERGENCIES (ABEM In Service Exam Review)
OUDEM Residency – February

2017
THE PRACTICE OF EMS MEDICINE
OUDEM Residency – Medical Student Lecture – August

DEFIBRILLATION STRATEGIES
RENAL EMERGENCIES
OUDEM Residency – August

EMS INTERN ORIENTATION
OUDEM Residency – July
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<thead>
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<th>Year</th>
<th>Course Title</th>
<th>Location/Date</th>
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<td>2017</td>
<td>EFFICIENCY IN EMERGENCY DEPT DISCHARGE</td>
<td>OUDEM Residency – May</td>
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<td>TRAUMA EMERGENCIES (ABEM In Service Exam Review)</td>
<td>OUDEM Residency – February</td>
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<td>2016</td>
<td>EMS CASE STUDIES &amp; PROTOCOL REVIEW</td>
<td>OUDEM Residency – November</td>
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<td>TRAUMA EMERGENCIES (ABEM In Service Exam Review)</td>
<td>OUDEM Residency – February</td>
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<td>2015</td>
<td>CARDIAC ARREST RESUSCITATION PRACTICUM</td>
<td>OUDEM Residency – November</td>
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<td>CARDIAC ARREST JOURNAL CLUB</td>
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<td>TRANEXAMIC ACID IN EMERGENCY MEDICINE</td>
<td>OUDEM Residency – April</td>
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<td>CARDIAC ARREST ILCOR STANDARDS OF CARE</td>
<td>OUDEM Residency – April</td>
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<td>THE PRACTICE OF EMS MEDICINE</td>
<td>OUDEM Residency – Medical Student Lecture – March</td>
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<td>2014</td>
<td>EBOLA &amp; EMS/ED CONSIDERATIONS</td>
<td>OUDEM Residency – October</td>
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<td>THE PRACTICE OF EMS MEDICINE</td>
<td>OUDEM Residency – Medical Student Lecture – September</td>
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<td>Clinical Application of Laboratory Diagnostics in ACS (highly sensitive Troponin assay) &amp; Pediatric Fever Without Source</td>
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2011  EMS INTERN ORIENTATION  
OUDEM Residency - July  

THE ART AND SCIENCE OF CARDIOPULMONARY  
RESUSCITATION - ELEMENTAL OR DETRIMENTAL?  
OUDEM Residency - July  

ARRHYTHMIAS - ECG ANALYSIS  
OU School of Medicine - Second Year Medical Students - April  
Advanced Cardiac Life Support  

TACTICAL COMBAT CASUALTY CARE  
OUDEM SOMOS Program - April  
Cadaver Lab for Oklahoma Highway Patrol EMTs  

CARDIOVASCULAR EMERGENCIES  
OUDEM Residency - January  
Review for ABEM In-service Examination  

2010  EMS BASE STATION  
OUDEM Residency - December  
OK State EMS Medical Director's Course & Practicum  

ECG CONFERENCE  
OUDEM Residency - September  

ECG CONFERENCE  
OUDEM Residency - August  

EMS INTERN ORIENTATION  
OUDEM Residency - July  

ECG CONFERENCE  
OUDEM Residency - July  

EMS BASE STATION  
OUDEM Residency - June  
OK State EMS Medical Director's Course & Practicum  

ECG CONFERENCE  
OUDEM Residency - June  

ECG CONFERENCE  
OUDEM Residency – March  

EMS & CARDIOVASCULAR EMERGENCIES  
OUDEM Residency – February
2009  TRAUMA AIRWAY MANAGEMENT SKILLS PRACTICUM
       OUDEM Residency – December

       ECG CONFERENCE
       OUDEM Residency – December

       ECG CONFERENCE
       OUDEM Residency – August

       ECG CONFERENCE
       OUDEM Residency - July

       EMS INTERN ORIENTATION
       OUDEM Residency – July

       BIOTERRORISM
       Oklahoma Disaster Institute - July
       Basic Disaster Life Support

       EMS REFUSALS OF CARE CONSIDERATIONS
       OUDEM Residency - June

       EMS CASE STUDIES
       OUDEM Residency - February

2008  CHILDREN WITH SPECIAL HEALTHCARE NEEDS
       OUDEM Residency - November

       CPAP/NON-INVASIVE VENTILATION
       OUDEM Residency - October

       12-LEAD ECG ANALYSIS PART III
       OUDEM Residency - September

       12-LEAD ECG ANALYSIS PART II
       OUDEM Residency – August

       EMS R2/EM INTERN ORIENTATION
       OUDEM Residency - July

       12-LEAD ECG ANALYSIS PART 1
       OUDEM Residency - July

1999  UROGENITAL TRAUMA
       UT Southwestern Emergency Medicine Residency
1998  ACUTE ABDOMINAL AORTIC ANEURYSM
UT Southwestern Emergency Medicine Residency
Morbidity & Mortality Conference

b. Emergency Medical Services Continuing Education Teaching

2021  COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2020  COVID-19 Updates from Office of the Medical Director
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2018  PROTOCOL UPDATES 2018
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring the OMD Team
Limiting epinephrine in ventricular fibrillation cardiac arrest
Limiting oxygen in acute coronary syndromes
Early utilization of double sequential external defibrillation
Early deployment of ResQCM and efficiencies in resuscitation
Water submersion injuries

2017  CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
Featuring Dr. Keith Lurie
Resuscitation team roles and dynamics
Continuity of chest compressions
Active Compression Decompression CPR
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2016  DOUBLE SEQUENTIAL EXTERNAL DEFIBRILLATION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

ACTIVE COMPRESSION DECOMPRESSION CPR
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa

2015  SPINAL MOTION RESTRICTION
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa
2013  TRANEXAMIC ACID
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Hemostasis options in traumatic hemorrhage
What is tranexamic acid (TXA)? Historical uses of TXA
Review of CRASH-2 and MATTERs research studies of TXA
Protocol changes and review & Operational handling of TXA
Interview with Dr. William Havron, OU Trauma Services

PRAXIS FOR ANAPHYLAXIS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Defining anaphylaxis
Cardiovascular collapse form of anaphylaxis
World Allergy Organization treatment guidelines
Epinephrine treatment of anaphylaxis
Review of recent publications/abstracts regarding anaphylaxis
Protocol changes and review

EMS CAPNOGRAPHY
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Basic of the capnography waveform
Uses of capnography in EMS
Advanced concepts of capnography and research review
Protocol review

2012  CPR TEAM DYNAMICS
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Resuscitation team roles and dynamics
Continuity of chest compressions
Timing of defibrillation
Passive oxygenation in limited rescuer situations
Supportive care strategies
Practical lab and video production

2011  CPR CHEST COMPRESSION TECHNIQUES
Office of the Medical Director/Medical Control Board
EMS System for Metropolitan Oklahoma City and Tulsa CE
Compression rate with metronome use
Compression techniques
Practical lab

2007  SIMPLE, COOL CHANGES IN PARAMEDIC AIRWAY CARE
Plano Fire Department Paramedic CE
Intubation techniques
CURRICULUM VITAE

CURRICULUM VITAE FOR JEFFREY M. GOODLOE, DEPARTMENT OF EMERGENCY MEDICINE

Cricoid pressure vs. bimanual laryngoscopy
Airway bougie
Evaluation of a new alternative airway
   When to abandon intubation attempts
   Combitube vs. King LTS-D
Airway Management in Narcotic Overdoses
   Titrating naloxone

EMS OCCUPATIONAL EXPOSURE:
IF IT HAPPENS TO YOU, WHAT WILL YOU DO?
Plano Fire Department EMT & Paramedic CE
Best practices & local experiences
Post-exposure management:
   EMS needlestick injuries
   EMS respiratory exposures
Infectious agents of concern
   Hepatitis B & C; HIV; TB, Meningitis

2006 MASS CASUALTY FUNCTIONAL EXERCISES
Plano & Allen Fire Departments EMT & Paramedic CE
33 Full Scale Fire Rescue/EMS Exercises

CRITICAL THINKING IN PARAMEDIC PATIENT CARE
Plano & Allen Fire Departments Paramedic CE
Critical thinking concepts required to correctly deliver paramedic level care per EMS treatment protocols

PEDIATRIC CARDIAC CARE
Plano & Allen Fire Departments EMT & Paramedic CE
Pediatric CPR & PALS
Pediatric Vascular Access
Neonatal CPR & NALS
Pediatric Cardiac Arrest Scenario Exercises

TACHY/BRADYDYSRHYTHMIAS
Allen Fire Department Paramedic CE
AHA guidelines for bradydysrhythmias & tachydysrhythmias

ARTIFICIAL CIRCULATION: THE ROLE OF THE AUTOPULSE
Allen Fire Department EMT & Paramedic CE
Artificial circulations physiology
Suboptimal CPR effect
AutoPulse outcomes trials review & functional exercises

TACHY/BRADYDYSRHYTHMIAS
Plano Fire Department Paramedic CE
AHA guidelines for bradydysrhythmias & tachydysrhythmias
Diltiazem
Case studies

2006
ARTIFICIAL CIRCULATION: THE ROLE OF THE AUTOPULSE
Plano Fire Department EMT & Paramedic CE
Artificial circulation physiology
Suboptimal CPR effect
AutoPulse outcomes trials review
Functional AutoPulse exercises

IMMEDIATE TRIAL: MODULE 2
Allen Fire Department Paramedic CE
Acute Coronary Syndromes
Glucose-Insulin-Potassium Infusion Physiology
Patient Care Enrollment & Logistics

IMMEDIATE TRIAL: MODULE 1
Plano Fire Department Paramedic CE
Acute Coronary Syndromes
12-Lead ECG Interpretation
Glucose-Insulin-Potassium Infusion Physiology

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Allen Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol

CHEMICAL RESTRAINT
Allen Fire Department EMT & Paramedic CE
Alternatives to physical and chemical restraint
Indications for physical and chemical restraint
Pharmacology of diazepam & haloperidol

ADULT RESUSCITATION 2006:
INCORPORATING NEW AHA GUIDELINES
Allen Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

ADVANCED AIRWAY PLACEMENT CONFIRMATION
Plano Fire Department Paramedic CE
Confirmation Devices, Rationale, & Protocol
2006 CHEMICAL RESTRAINT
Plano Fire Department Paramedic CE
Alternatives to physical and chemical restraint
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ADULT RESUSCITATION 2006:
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Plano Fire Department EMT & Paramedic CE
2005 AHA Guideline Process
Adult CPR
Ventricular Fibrillation/Pulseless Ventricular Tachycardia
Pulseless Electrical Activity & Asystole

2005 AIRWAY & RESPIRATORY DISTRESS MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Airway management devices & techniques
Respiratory distress/arrest scenario exercises

COLD WEATHER EMS MEDICAL MANAGEMENT
Plano & Allen Fire Departments EMT & Paramedic CE
Heat loss mechanisms & body core temperature
EMS treatment of hypothermia
EMS treatment of cold-related tissue injuries
EMS treatment of cold-water immersion
HOLIDAY SEASON TOXICOLOGY
Plano & Allen Fire Departments Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

VENOUS ACCESS IN EMS
Plano & Allen Fire Departments Paramedic CE
Goals & anatomy of venous access
Venous access techniques & complications
Difficult venous access tips & “When access fails” management

TOXICOLOGY I
Allen Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

LAW ENFORCEMENT “LESS LETHAL” TACTICS:
MEDICAL CONCEPTS & CARE
Allen Fire Department EMT & Paramedic CE
Benefits & risks of pepper spray
Basic function of the Taser & removal of Taser probes
Medical consequences with “less lethal” tactics
Medical evaluation & transport priorities of “less lethal” patients
2005

ADULT INTRAOSSEOUS ACCESS
Plano Fire Department Paramedic CE
Anatomy & physiology of intraosseous access
EZ-IO intraosseous access procedure & credentialing

TASERS: MEDICAL CONCEPTS & CARE
Plano Fire Department EMT & Paramedic CE
Basic function of the Taser
Medical events post-Taser use
Risks for post-Taser cardiac arrest & removal of Taser probes
Post-Taser medical evaluation and transport priorities

BURNS & LIGHTNING INJURIES
Allen Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Allen Fire Department EMT & Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

ASSISTED CHEST COMPRESSION: AUTOPULSE
INTRODUCTION
Allen Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System overview

BURNS & LIGHTNING INJURIES
Plano Fire Department EMT & Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
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EXPLOSIVE EVENT INJURIES
Plano Fire Department EMT & Paramedic CE
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ASSISTED CHEST COMPRESSION: AUTOPULSE DEPLOYMENT
Plano Fire Department EMT & Paramedic CE
AutoPulse Resuscitation System implementation system-wide

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
City of Plano Public Safety Communications Annual EMD Training
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
Pre-arrival instructions – emphasis during this presentation
Ventilation
Chest compression (including assistive devices)
Defibrillation

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Allen Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
Anecdotal experience of AFD
Reviews of relevant research
Future directions of MFI within AFD & protocol changes

2004

VASOPRESSIN UPDATE: NEW HOPE FOR ASYSTOLE PATIENTS?
Allen Fire Department Paramedic CE
Pathophysiology of asystole
Pharmacology of vasopressin
Research review and protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Allen Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care

MEDICATION FACILITATED INTUBATION: PERSPECTIVES, CHALLENGES, & DIRECTIONS
Plano Fire Department Paramedic CE
Span of intubation options
Evaluate intubation options using:
Anecdotal experience of PFD
Reviews of relevant research
Future directions of MFI within PFD & protocol changes

OPTIMAL EMS OPERATIONS & PATIENT CARE
Plano Fire Department EMT & Paramedic CE
Review of best practices in EMS operations & patient care
2004

START TRIAGE
Allen Fire Department EMT & Paramedic CE
Principles of triage in mass casualty incidents
START (simple triage and rapid treatment) triage procedure
Application of START triage to patient scenarios

MEDICAL NECESSITY DOCUMENTATION IN EMS
Allen Fire Department EMT & Paramedic CE
Concept of “medical necessity” documentation in EMS
Detail several specifics of required documentation by insurances
Patient care documentation as a component of customer service
Avoidance of fraudulent billing practices

SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Allen Fire Department EMT & Paramedic CE
SAM Sling indications and usage

MEDICAL NECESSITY DOCUMENTATION IN EMS
Plano Fire Department EMT & Paramedic CE
Concept of “medical necessity” documentation in EMS
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SAM SLING: NEW STABILIZATION FOR PELVIC FRACTURES
Plano Fire Department EMT & Paramedic CE
SAM Sling indications and usage

NO TRANSPORT CASE REVIEWS
Plano Fire Department EMT & Paramedic CE
Review of no transport cases for protocol/operations compliance

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Allen Fire Department EMT & Paramedic CE
Illnesses of CSHCN
EMS assessments and interventions in CSHCN
Improve comfort level with CSHCN, related devices/meds, and parents of CSHCN

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?
Allen Fire Department EMT & Paramedic CE
Critical appraisal of EMS cardiac arrest care
Review of numerous research studies indicating need for changes:
  Pre-arrival instructions & Ventilations
  Chest Compressions & Defibrillation
2004  12-LEAD ECG ANALYSIS  
Plano Fire Department Paramedic CE  
Functional exercises in 12-lead analysis  

THE ABCDs of CPR: ELEMENTAL OR DETRIMENTAL?  
Plano Fire Department EMT & Paramedic CE  
Critical appraisal of EMS cardiac arrest care  
Review of numerous research studies indicating need for changes:  
  Pre-arrival instructions; Ventilations  
  Chest compression (including assist devices); Defibrillation  

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?  
Allen Fire Department EMT & Paramedic CE  
Review CPR First Defibrillation research  
Pathophysiology benefits of CPR prior to defibrillation  
Scenario-based review for protocol changes  

SPINAL IMMOBILIZATION: NEW DIRECTIONS IN EMS  
Allen Fire Department EMT & Paramedic CE  
Perspectives on EMS spinal immobilization  
Research on “selective” EMS spinal immobilization  
Scenario-based review for protocol changes  

CRICOTHYROTOMY  
Plano Fire Department Paramedic CE  
Anatomy & procedural review  
Skill credentialing  

TERRORISM RESPONSE & EMERGENCY CARE  
Plano Fire Department EMT & Paramedic CE  
Suicide bomber identification and incident reviews  
Suicide bomber implications for EMS operations  
Mass casualty operations in terrorism response  

CPAP IN EMS  
Allen Fire Department EMT & Paramedic CE  
Physiology of CPAP & indications for use  
CPAP regulator and mask functional exercises  

12-LEAD ECG ANALYSIS  
Allen Fire Department Paramedic CE  
Functional exercises in 12-lead analysis  

DEFIBRILLATION: SOONER IS NOT ALWAYS BETTER?  
Plano Fire Department EMT & Paramedic CE  
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Pathophysiology benefits of CPR prior to defibrillation
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<td>NEW EMS TREATMENT PROTOCOLS REVIEW</td>
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BURNS & LIGHTNING INJURIES
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management
Lightning injuries & EMS lightning injury care

EXPLOSIVE EVENT INJURIES
Plano Fire Department Paramedic CE
Risks identification & complicating factors
Injury prediction based upon type of explosive and patients
Crush syndrome and its field treatment
Primary, secondary, and tertiary explosion injury paradigm

NERVE AGENTS, ORGANOPHOSPHATES, & CYANIDE
Plano Fire Department Paramedic CE
Pathophysiology and field treatments

CAPNOGRAPHY UPDATES IN EMS
Plano Fire Department Paramedic CE
Review of use in intubation confirmation
Use in non-intubated patients
   COPD, Asthma, Undifferentiated dyspnea
Review of new capnograph within LP12 monitor

MEGACODE MANAGEMENT
Plano Fire Department Paramedic CE
Tachy/Bradydysrhythmia management using case studies
Megacode functional exercises with SimMan

2002

ORAL INTUBATION
Plano Fire Department Paramedic CE
Review of Intubation CQI Tracking
Oral intubation techniques

EMS MANAGEMENT OF MEDICAL EMERGENCIES
Plano Fire Department Paramedic CE
Case study reviews of PFD EMS incidents

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

TOXICOLOGY III
Plano Fire Department Paramedic CE
Beta-blockers, Calcium channel blockers, Antihistamines
Cocaine, Marijuana, Ecstasy
2002

ARRHYTHMIA RECOGNITION
Plano Fire Department Paramedic CE
Functional exercises in basic ECG arrhythmia recognition

TOXICOLOGY II
Plano Fire Department Paramedic CE
NSAID, ASA, TCA, SSRI, GHB, PCP, LSD

TREATMENT SECTOR OPERATIONS IN MCIs
Plano Fire Department Paramedic CE
Tabletop exercises in designing, deploying, and operating an EMS treatment sector during multiple patient events

TOXICOLOGY I
Plano Fire Department Paramedic CE
Acetaminophen, Opiates/Narcotics, Benzodiazepines
Barbiturates, Toxicology Documentation

2001

WEAPONS OF MASS DESTRUCTION – BIO & CHEM
Plano Fire Department Paramedic CE
Biological classes of WMD and agents
Chemical classes of WMD and agents

SPORTS INJURIES
Plano Fire Department Paramedic CE
Identification & EMS treatment of multiple orthopedic injuries

12-LEAD ECG ANALYSIS
Plano Fire Department Paramedic CE
Functional exercises in 12-lead analysis

RESUSCITATE: DO OR DO NOT?
Plano Fire Department Paramedic CE
Texas Law relating to: Advance Directives & OOH DNR
Medical Power of Attorney
Applying DNR Texas Law to EMS situations

EMS MANAGEMENT OF THERMAL BURNS
Plano Fire Department Paramedic CE
Pathophysiology & classification of burns
Systemic assessment of the burn patient
EMS burn management

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises
<table>
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<td>2001</td>
<td>12-LEAD ELECTROCARDIOGRAMS</td>
<td>Plano Fire Department Paramedic CE</td>
<td>ECG lead electrophysiology, Correlating ECG leads with anatomy, Systemic analyzing of the 12-lead ECG, Correlating abnormal ECGs with cardiac pathophysiology</td>
</tr>
<tr>
<td>2000</td>
<td>CARDIAC ARREST MANAGEMENT</td>
<td>Plano Fire Department Paramedic CE</td>
<td>ACLS updates, CPAP in COPD &amp; CHF Management, Physiology of CPAP &amp; indications for use, CPAP regulator and mask functional exercises</td>
</tr>
<tr>
<td>1999</td>
<td>TRAUMA MANAGEMENT I</td>
<td>Plano Fire Department Paramedic CE</td>
<td>BTLS-derived curriculum, Mechanisms of Injury, Scene Assessment &amp; Initial Trauma Care, Airway Management in Trauma, Thoracic Trauma, Shock Evaluation &amp; Management, Spinal &amp; Head Trauma, Trauma Care in the Cold</td>
</tr>
</tbody>
</table>

1999 12-LEAD ELECTROCARDIOGRAMS
1999  Plano Fire Department Paramedic CE
      ECG lead electrophysiology
      Correlating ECG leads with anatomy
      Systemic analyzing of the 12-lead ECG
      Correlating abnormal ECGs with cardiac pathophysiology

AIRWAY MANAGEMENT
Plano Fire Department Paramedic CE
Basic & advanced techniques in airway management
Airway management scenario exercises
(co-taught with Brian Zachariah, MD, FACEP)

CRITICAL CARE PARAMEDIC PHARMACOLOGY I & II
AMR-Dallas Critical Care Paramedic School
Developed & taught 8-hour pharmacology curriculum
(co-taught with Robert Suter, DO, FACEP; Brian S. Zachariah,
MD, FACEP; and John Myers, MD, FACEP)

c. Other Teaching

2020   THE ROLE OF EMS SYSTEMS & HOW EMS SYSTEMS CAN
       “FLATTEN THE CURVE”
       COVID-19 Oklahoma Update ECHO (Friday, April 10)

2011   THE STATE OF TULSA TRAUMA CARE
       Tulsa Metro Chamber Health Panel
       (co-panelists Thomas SH, Yeary E, Sacra J, Williamson S, Dart B)

2000-2007 EMERGENCY MEDICAL SERVICES:
       A NATIONAL & LOCAL HISTORY
Plano Fire Department Citizens Fire Academy
      EMS Historical Developments
      City of Plano EMS History
      Modern EMS Capabilities
      EMS Assessment & Treatment Equipment Display
      The Modern MICU Tour
      Citizen Question & Answer Sessions
      (co-taught with Ken Klein, RN, EMTP)

1999   TRAUMA REGIONAL ADVISORY COUNCILS:
       IMPACT UPON TRAUMA CARE IN TEXAS
University of Texas School of Public Health – Health Policy
       Presentation

1998   ALTERED MENTAL STATUS
Methodist Hospital of Indiana Emergency Medicine Residency
       Case Conference Presentation
Case review of treated otitis media progressing to meningitis with near-fatal outcome. Patient initially seen by me at time of diagnosis with meningitis.

1998 EMS OCCUPATIONAL HAZARDS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Infectious disease risks assumed by EMS personnel
Post-exposure management of needlestick injuries, respiratory exposure, and contact exposure involving EMS personnel
Contributing factors and characteristics of EMS vehicle accidents
Risks of violence in the EMS environment
Occupational injuries sustained in EMS
EMS-related stressors
Importance of well-being practices in EMS

1997 MASS CASUALTY INCIDENTS
Methodist Hospital of Indiana Emergency Medicine Residency Grand Rounds
Classification of Mass Casualty Incidents & Notable MCIs
Emergency Physician role in MCIs
Treatment priorities & resource utilization in MCIs

1996 ACUTE ABDOMINAL AORTIC ANEURYSM
Methodist Hospital of Indiana Emergency Medicine Residency Morbidity & Mortality Conference Presentation
Case review of AAA initially presenting as renal colic.

1996 CHOOSING AN EMERGENCY MEDICINE RESIDENCY
Tulane University School of Medicine
Residency application, evaluation, and interviewing strategies

X. PROFESSIONAL SERVICE

1. Hospital clinical service

a. Hillcrest Medical Center Emergency Department - Tulsa (July 2011 - Present) Academic/clinical emergency medicine in regional referral hospital. Residency faculty and active medical staff responsibilities.


c. St. Francis Hospital Trauma Emergency Center - Tulsa (August 2007 - July 2009). Clinical emergency medicine in Level II
Trauma Center. Residency faculty and active medical staff responsibilities.

d. For additional clinical activities, please see section on hospitals.

2. Leadership service to professional societies and organizations

a. Secretary/Treasurer, American College of Emergency Physicians (2021-Present)

b. Member, Board of Directors, American College of Emergency Physicians (2019-Present)

Liaison to:

Finance Committee (2021-Present)
Audit Committee (2021-Present)
American College of Surgeons Committee on Trauma (2020-Present)
Excited Delirium Task Force (2020-Present)
FDA CDER Testimony Jan 2021
Nominating Committee (2020)
Cruise Ship Medicine Section (2020-2021)
Trauma & Injury Prevention Section (2020-2021)
EMS Committee (2019-Present)
Pediatric Emergency Medicine Committee (2019-Present)
EMS Section (2019-Present)
Tactical Medicine Section (2019-Present)
Pediatric Emergency Medicine Section (2019-Present)
Rural Emergency Medicine Task Force (2019-2020)
American Academy of Emergency Nurse Practitioners (2021-Present)

c. Board of Trustees, Emergency Medicine Foundation

Chair (2022-Present)
Chair-Elect (2021)
Secretary-Treasurer (2021)
Member (2019-Present)

d. Candidate, Board of Directors, American College of Emergency Physicians (2019)

e. EMS Subboard, American Board of Emergency Medicine LLSA Co-Editor (2021-Present)

Member (2019-Present)

f. Member, Bylaws Committee, American College of Emergency Physicians (2018-2019)

g. Candidate, Board of Directors, American College of Emergency Physicians (2018)
h. Member, Advocacy Committee, National Association of EMS Physicians (2016-Present)

i. Member, Standards & Practice Committee, National Association of EMS Physicians (2016-2021)


k. Chair, EMS Committee, American College of Emergency Physicians (2016-2018)


n. Vice President (2012-2016) Oklahoma Chapter, American College of Emergency Physicians.


p. Member, EMS Committee, American College of Emergency Physicians (2011-present). Leading nationwide effort to improve EMS Medical Director understanding of Drug Enforcement Administration regulations regarding controlled substances. Working in multi-association taskforce to bring EMS Medical Director concerns to the DEA lead office in Washington, DC.


r. Member, EMS Committee, American College of Emergency Physicians (2010-2011). Led the extensive revision of ACEP Policy: "Leadership in EMS", approved by ACEP Board of Directors without editing. Also, reviewed for subsequent revision of ACEP Policy "Interfacility transportation of the critical care patient and its medical direction."

s. Councillor, American College of Emergency Physicians
   OCEP (2018-2019)
   OCEP Alternate Councillor (2017)
   Oklahoma Chapter Board of Directors (2008-2016)
Service as a councillor involves representing the physicians from the respective chapter/organization at the ACEP Council Annual Meeting. The ACEP Council considers and acts upon business matters and clinical positions of the College in a manner like a "House of Representatives" of a state/national government.

t. Site Reviewer, Commission on Accreditation of Ambulance Services (2001-2012). Perform on-site review of EMS organizations seeking to meet CAAS accreditation. Each review involves 2-3 days of extensive administrative and clinical operations review, with numerous interviews of leadership and front-line clinical personnel to evaluate compliance with over 200 standards.

u. Organization and Course Reviewer, Continuing Education Coordination Board for Emergency Medical Services (2000-2012). Review submissions for individual courses and organizations seeking CECBEMS accreditation and/or accreditation granting privileges. Multiple courses/organizations have been personally reviewed each year of service.


y. Member, Membership Committee, American College of Emergency Physicians (1997-1998)

z. Board of Directors, Emergency Medicine Residents' Association
   Immediate Past President (1997-1998)
   President (1996-1997)
   President-Elect/Treasurer (1995-1996)

aa. Vice President, Board of Directors, Indiana State Medical Association Resident Medical Society (1996-1998)


c. Member, Commission on Legislation, Indiana State Medical Association (1996-1998)


ee. Member, Section Affairs Committee, American College of Emergency Physicians (1996-1997)

ff. Member, LifeLine/EMS Committee, Methodist Hospital of Indiana (1995-1998)

gg. Member, EMS Committee, Texas College of Emergency Physicians (1994-1995)

hh. Emergency Medicine Student Association, The University of Texas Medical School at San Antonio
3. Editorial service
   a. Editorial Board, Prehospital Emergency Care (2015-Present)
   f. Guest Associate Editor, EM International (2011)
   g. Editorial Board, Journal of Emergency Medical Services (2010-Present)
   h. Reviewer, Internal and Emergency Medicine (2010-Present)
   i. Reviewer, Access Emergency Medicine (2009-Present)
   j. Reviewer, Critical Care (2009-Present)
   k. Reviewer, Prehospital Emergency Care (2009-Present)

4. Educational symposia development service
   a. Chairman & Course Coordinator, 5th Annual EMS Symposium – 2012 EMS Ways to Treat Trauma & Advance Trauma Care. EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2012 in Tulsa, Oklahoma. Keynote Speaker – Paul Pepe, Chair of Emergency Medicine, University of Texas Southwestern Medical Center & Medical Director, Dallas Metropolitan Area BioTel (EMS) System.
   b. Chairman & Course Coordinator, 4th Annual EMS Symposium - EMS Expanding Scopes of Practice & The Future of Oklahoma EMS, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2011 in Tulsa, Oklahoma. Keynote Speaker - John Freese, Chief Medical Director, Fire Department New York.
   c. Chairman & Course Coordinator, 3rd Annual EMS Symposium - EMS Cardiovascular Emergencies, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2010 in Tulsa, Oklahoma. Keynote Speaker, Corey Slovis, Chair of Emergency Medicine, Vanderbilt University School of Medicine & Medical Director, Nashville Fire Department.
   d. Course & Curriculum Developer - State of Oklahoma EMS Medical Director's Course & Practicum - Initial Course June 2010 in Oklahoma City, Oklahoma.
   e. Chairman & Course Coordinator, 2nd Annual EMS Symposium - Therapeutic Hypothermia, EMS Division, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine, August 2009 in Tulsa, Oklahoma. Keynote
Speaker, Brent Myers, Director & Medical Director, Wake County, North Carolina EMS System.

f. Chairman & Course Coordinator, 1st Annual EMS Symposium - Airway Management, Oklahoma Institute for Disaster and Emergency Medicine, Department of Emergency Medicine, The University of Oklahoma College of Medicine - Tulsa, August 2008 in Oklahoma City, Oklahoma. Keynote Speakers, Allen Sims and Kelly Curry, Montgomery County, Texas Hospital District EMS System.

5. Professional service
   a. Exam Writer, National Registry of Emergency Medical Technicians (2011)
   b. Member, Oklahoma Emergency Medical Services for Children Advisory Committee (2011-Present).
   d. Member, Medical Audit Committee, Oklahoma State Department of Health, Trauma Division (2008-2013)
   e. Interim Medical Advisor, Oklahoma State Department of Health, EMS Division (2008-2009)
   f. Member, University of Oklahoma College of Medicine - Tulsa, Department of Emergency Medicine Chair search committee (2008)
   g. Member, Medical Direction Subcommittee, Oklahoma Emergency Response Systems Development Advisory Council (2007-2013)

6. Volunteer clinical service
   a. The University of Oklahoma School of Community Medicine Bedlam Clinic
      Attending Physician (2011-2014)
   b. Baylor University Volunteer EMS
      Director of Communications (1990-1991)
      Lieutenant/Paramedic (1990-1991)

7. Grant review service

8. Research abstract review service
      2011 Annual Meeting & Regional Meetings
      2010 Scientific Assembly
XI. ADMINISTRATION [College and University Service]

2007-Present Chief, EMS Section, Department of Emergency Medicine, The University of Oklahoma School of Community Medicine

XII. MEMBERSHIPS, HONORS, AWARDS and SPECIAL RECOGNITION

1. Memberships

a. American College of Healthcare Executives (2019-Present)

b. Texas Medical Association (2017-2019)

c. Tarrant County Texas Medical Society (2017-2019)

   Oklahoma Chapter (2007-Present)
   Indiana Chapter (1995-1998)


f. Oklahoma State Medical Association (2007-2013)

g. Oklahoma County Medical Society (2009-2013)

h. Tulsa County Medical Society (2007-2013)

i. Indiana State Medical Association (1995-1998)

j. Emergency Medicine Residents' Association (1991-Present/Life Member)


2. Honors

a. Fellow of the Academy of EMS (2017-present)

b. US Metropolitan Municipalities EMS Medical Directors Consortium Corey M. Slovis Award recognizing excellence in EMS education (2014)

c. Fellow of the American College of Emergency Physicians (2002-present)

d. American Medical Association/Glaxo Wellcome Achievement Award recognizing leadership in organized medicine (1997)

e. Texas College of Emergency Physicians Outstanding Senior Medical Student in Emergency Medicine (1995)

XIII. PROFESSIONAL GROWTH AND DEVELOPMENT

1. Continuing Education

a. NIHSS Certification 2021

b. ABEM EMS Subboard Exam Meeting 2021

c. EMS State of the Science XXII Meeting 2021
d. Opioid Analgesics in the Management of Acute and Chronic Pain 2021
e. Clinician’s Guide Recognizing & Responding to Human Trafficking 2021
f. Preventing Clinician Burnout 2021
g. Suicide Assessment & Prevention 2021
h. EMErald Coast Conference 2021
i. EMS State of the Science Weekly Webinars 2020 – Present
j. National Association of EMS Physicians Annual Meeting 2021
k. ABEM EMS Subboard Exam Meeting 2020
l. National Whole Blood in EMS Academy
m. National Association of EMS Physicians Annual Meeting 2020
n. EMS State of the Science XXI Meeting 2019
o. National Association of EMS Physicians Annual Meeting 2019
p. EMS State of the Science XX Meeting 2018
q. National Association of EMS Physicians Annual Meeting 2018
r. EMS State of the Science XIX Meeting 2017
s. National Association of EMS Physicians Annual Meeting 2017
t. EMS State of the Science XVIII Meeting 2016
v. National EMS Board Review Certification Course 2015
w. National EM Board Review Certification Course 2015
x. EMS State of the Science XVII Meeting 2015
z. National Association of EMS Physicians Annual Meeting 2014
aa. EMS State of the Science XVI Meeting 2014
bb. National EMS Board Review Certification Course 2013
cc. RACI Conference on Resuscitation and Critical Care 2013
dd. EMS State of the Science XV Meeting 2013
ff. Advanced Trauma Life Support Instructor Course 2012
gg. EMS State of the Science XIV Meeting 2012
ii. Oklahoma ACEP Annual Meeting 2011
jj. ACEP Scientific Assembly 2011
ll. Texas College of Emergency Physicians EMS Med Director Seminar 2010
mm. National Association of EMS Physicians Annual Meeting 2010
nn. Oklahoma ACEP Annual Meeting 2009
oo. Texas College of Emergency Physicians EMS Med Director Seminar 2009
qq. Oklahoma ACEP Annual Meeting 2008
rr. Texas College of Emergency Physicians EMS Med Director Seminar 2008
tt. Oklahoma ACEP Annual Meeting 2007
ww. ATLS Instructor
xx. ACLS renewal
yy. BCLS renewal
zz. FEMA NIMS ICS course 100
aaa. FEMA NIMS ICS course 200
bbb. FEMA NIMS ICS course 300
ccc. FEMA NIMS ICS course 400
ddd. FEMA NIMS ICS course 700
eee. FEMA NIMS ICS course 800
fff. BDLS
ggg. ADLS
hhh. NDLS Instructor
iii. ABEM Lifelong Learning Self-Assessment Test 2021
jjj. ABEM Lifelong Learning Self-Assessment Test 2020
kkk. ABEM EMS Lifelong Learning Self-Assessment Test 2018
lll. ABEM Lifelong Learning Self-Assessment Test 2018
mmm. ABEM Lifelong Learning Self-Assessment Test 2017
nnn. ABEM Lifelong Learning Self-Assessment Test 2016
ooo. ABEM EMS Lifelong Learning Self-Assessment Test 2016
ppp. ABEM Lifelong Learning Self-Assessment Test 2015
qqq. ABEM ConCert Board Recertification Test 2015
rrr. ABEM EMS Lifelong Learning Self-Assessment Test 2014
sss. ABEM Lifelong Learning Self-Assessment Test 2014
ttt. ABEM Lifelong Learning Self-Assessment Test Patient Safety
uuu. ABEM Lifelong Learning Self-Assessment Test 2013
vvv. ABEM Lifelong Learning Self-Assessment Test 2012
www. ABEM Lifelong Learning Self-Assessment Test 2011
xxx. ABEM Lifelong Learning Self-Assessment Test 2010
yyy. ABEM ConCert Board Recertification Test 2009
zzz. ABEM Lifelong Learning Self-Assessment Test 2008
aaaa. ABEM Lifelong Learning Self-Assessment Test 2007
bbbb. ABEM Lifelong Learning Self-Assessment Test 2006
cccc. ABEM Lifelong Learning Self-Assessment Test 2005
dddd. ABEM Lifelong Learning Self-Assessment Test 2004

2. Coursework

a. Ultrasonography in the emergency department
b. 19th Annual High-Risk Emergency Medicine
c. 13th Annual National Emergency Medicine Board Review

XIV. COMMUNITY SERVICE

1. Civic Organizations

b. Habitat for Humanity - Waco, Texas (1990-91)
   Service Project of Alpha Epsilon Delta, Texas Beta Chapter
CV updated 03/01/22
**Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?**

ACEP is charting the correct path in addressing workforce issues, scope of practice and College sustainability, although significant challenges exist to counter major forces in each of these areas.

**Workforce**

The recently published workforce paper in Annals is being reexamined anew and the data challenged by work done by SAEM to be published at the time of this writing. Still, ACEPs strategy is to proactively address the issue, assuming the potential of a large surplus of EPs within a few years. ACEP’s strategy is multifold.

1. ACEP leadership is directly engaging with corporate medicine to ensure that business interests do not supersede educational imperatives. In this regard, ACEP leadership met with HCA the largest for-profit hospital system, that had started 16 new residencies within the last 5 years. ACEP leadership has also met with Envision and Team regarding contract fairness standards, staffing, due process and to promote the new PA/NP supervision requirements.

2. ACEP leadership has engaged with other pertinent EM societies to advocate that the ACGME to “Raise the Bar”. Indeed, a consensus has been reached. While the ACGME cannot consider total number of residencies and national workforce issues within their accreditation of new programs, they can look at requirements that tighten eligibility criteria to start (or maintain) a program, increasing standards for “academic” faculty, including more stringent examination of ghost faculty engaged in the programs in name only.

3. ACEP with other organization partners (e.g., SAEM), is looking at redefining emergency practice beyond the “4-walls” concept to expand the subspecialty options allowing expanded workforce opportunities (see below). These are not limited to geriatric EM, hospice and palliative care, home health and post-acute care, disaster health, administration, proceduralist, intensive care, addiction medicine, POC ultrasound (beyond EM), observation, acute psychiatry, telehealth, tactical and law enforcement medicine, etc.

**Scope of Practice**

ACEP’s strategy to address scope of practice and fight independent practice of NP/PAs is spot on. ACEP issued a strong statement underscoring the primacy of the EP, and the rights and needs of every patient to be overseen in real time by an EP. A task force to potentially establish ED accreditation and establish national standards, is chaired by J. Adrian Tyndall, MD, FACEP.

Expansion of EP scope of practice opportunities are noted above.

**College Sustainability**

College sustainability has three main aspects: membership, financial security, and operations/administrative integrity, (including transparency).

**Membership** issues have three key issues. As EM has matured, and scope expanded there has been a proliferation of professional societies directed toward subsegments of EM. Even interested medical students and residents now have options. ACEP now competes for members, yet individual EPs tend to restrict membership and rightfully can only engage in (and afford) a certain number of such societies. Many younger members do not recall the long road to specialty and respect pioneered by ACEP, and thus, historic attachment is lacking among many younger members (and potential members). A second key issue is the diversity of philosophical and political thought among members. Positions taken and action on difficult issues that address members’ needs can be divisive. Finally, members who are not engaged, or feel there is little room for their inclusion, activity, or perspective, will feel alienated and ultimately will leave or not join in the first place. ACEP’s new strategic plan (see Q1 above) specifically addresses all three of these main concerns. ACEP must continue to develop
personalized, issue-based engaged opportunities, create new leadership and other development programs, and revise its dues structure. Allowing transparency in official positions and dialogue should also go a long way toward engagement. Acting on the key vision to make ACEP a home, community, and personal identity for all EPs is the crux of the strategic plan.

**Financial Security** of the College is under threat due to the financial climate of the country, and the need to modernize development of programs and processes necessary to address members concerns. Again, the strategy emanates from the strategic plan that directs the college to streamline processes. These include system review of all programs, reconsidering membership pricing and developing new alternate sources of revenues.

**Operational Efficiency** also has to be reviewed at all levels, with particular attention paid to transparent communications. Means to communicate via multiple modalities should be developed. The newly developed ACEP web-site design and landing page should help find all policies, committee work, and actions on all resolutions is a key means toward appropriate transparency.

**Question #2:** Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?

The newly developed ACEP strategic plan (https://www.acep.org/strategicplan/) has five pillars and 23 imperatives. One would have to recognize that each of these imperatives is of top-line importance. All of them need to be addressed. I can’t find a means to put any two above the other 21 issues. Thus, I’ll approach this question from a different perspective.

Inherent in the essentials of the strategic plan is the underlying drive to proactively address and promote the dignity of the emergency physician in all deliberations, and the nobility inherent in emergency practice. Our many threats—feeling like cogs in a system, CMG and sense of autonomy loss, encroachment of scope of practice, fair remuneration, fair treatment, due process, violence in the workplace, diminish our sense of self and our specialty. Upholding and advancing the dignity of the emergency physician and respect for our practice must be the unwavering compelling force in addressing the key priorities, and all activities of the College.

**Question #3:** What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?

Judging by engaged exchanges, SoMe posts, and resolutions brought before council, a major divisive issue is how to address the very real threats from the corporate practice that in many ways increasingly dominates emergency practice, diminishes the dignity of, and weakens the autonomy of EPs. In some cases, CMGs even seek to diminish the scope and essentiality of the EP in its key environment—the emergency department. Many members are impatient at the pace at which ACEP leadership is addressing the issues related to CMGs, misunderstanding legal and advocacy tools available to ACEP. Indeed, ACEP needs to, and is now addressing, the issues head on through advocacy for due process, fair treatment, scope of practice, transparent reporting by employers, and setting standards of practice applicable to all ED practices regardless of ownership. We are a data driven organization and ACEP should continue to investigate and provide data/evidence that supports/refutes contentions related to CMGs and sets the agenda forward. ACEP should further develop its own leadership and advocacy training to allow broader membership engagement. Finally, virtually all ACEP members understand that a college of this size has members with a wide diversity of opinion. All of these must be respected. However, all members appreciate transparency of deliberation, discussion, and formulation of policy initiatives.
CANDIDATE DATA SHEET

Gabor D. Kelen, MD, FRCP(C), FACEP

Contact Information
1307 Malvern Ave
Baltimore MD, 21204
Phone: 410-404-8640
E-Mail: gkelen1@jh.edu

Current and Past Professional Position(s)

Current:
Chair, Department of Emergency Medicine, Johns Hopkins University School of Medicine
Emergency Physician-in-Chief, Johns Hopkins Medicine
Director, Johns Hopkins Office of Critical Event Preparedness and Response
Professor, Emergency Medicine, Johns Hopkins University School of Medicine
Professor, Anesthesiology and Critical Care Medicine, Johns Hopkins University School of Medicine
Principle Staff, Applied Physics Laboratory, JHU
Member, Section 8, National Academies of Science
Board of Directors, Society for Disaster Medicine and Public Health Preparedness

Previous:
Program Director Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1986-2010)
President Society of Teachers of Emergency Medicine (1988-90)
Chair Medical Board, Johns Hopkins Hospital (2005-08)
Vice Chair Medical Board, Johns Hopkins Hospital (2002-05)
Member Board of Trustees (ex officio), Johns Hopkins Hospital (2005-8)
Research Director Department of Emergency Medicine, Johns Hopkins University (1984-2005)
President Association of Academic Chairs of Emergency Medicine (2005-6)
Chair Cedar Emergency Services Board of Directors (2000-01)
Board of Advisors Johns Hopkins Clinical Practice Association (1997-2000)
Board of Directors Baltimore Substance Abuse Systems, Inc. (1997-2001)
Board of Directors Johns Hopkins Bayview Physicians Association (1996-2001)
Board of Directors Emergency Medicine Foundation (1993-95)
Program Director Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1984-86)
Chief Resident Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1983-84)
Director, National Center for the Study of Preparedness and Catastrophic Response (PACER)

Education (include internships and residency information)
Internship: St Michael’s Hospital, Toronto, Ontario, Canada
Residency: St. Michael’s Hospital, Toronto, Ontario, Canada
EM Residency: Johns Hopkins Hospital

MD, University of Toronto School of Medicine (1979)
Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified
FRCP(C), 1985—(recertifies with ABEM)

Professional Societies
American College of Emergency Physicians (1983-)
Society for Academic Emergency Medicine (1989-)
Association of Academic Chairs of Emergency Medicine (1993-)
Society for Disaster Medicine and Public Health Preparedness (2015-)
National Academies of Science—Elected (2005)
College of Physicians and Surgeons of Ontario (CPSO) (1985)
Royal College of Physicians and Surgeons of Canada (1985)

National ACEP Activities – List your most significant accomplishments
ACEP Board of Directors (2019-current)
ACEP Workforce Task Force (2018-)
ACEP Council Steering Committee (2017-9)
Councilor (AACEM) (2010-)
EMRA (1983-4)
Congressional Testimony on HIV and HCWs (Subcommittee on Health and Environment) for ACEP (1990)
AIDS Task Force Committee (1987-1992),
EMF Board of Directors (1988-1990)
Testimony to National Commission on AIDS in behalf of ACEP (1991)
Chair, AIDS Task Force Committee (1991-1992)
EMF Board of Directors (1993-1995)
EMF Centers of Excellence Grant Panel (1994-1995)
Chair, Infectious Disease Committee (1992-1993)
Chair, Public Health Committee (1993-1995)
Designated Spokesperson (1991-)
Society of Teachers of Emergency Medicine (was part of National ACEP until 1989)
Faculty Development Committee (1985-1988)
Board of Directors (1987-1989)
President (1988-1990)

National ACEP Awards
Outstanding Contribution to Research Award

ACEP Chapter/Section Activities – List your most significant accomplishments
Maryland Chapter
Emergency Medicine Award, Maryland Chapter (1994)
Chairman of the Year Award, Maryland Chapter (2019)

AACEM
President (2005-6)
ACEP inaugural Council Representative (2010-)
Lead effort to create AACEM Section in ACEP (2009)
Boarding Task Force
Kelen et al. Emergency Department Crowding: The Canary in the Health Care System.
    NEJM Catalyst September 28, 2021 (AACEM Position Paper)
Representative to Council of Academic Societies of AAMC (2000-10)
Membership Task Force (2003-4)
Practice Profile

Total hours devoted to emergency medicine practice per year: 720 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 25 % Research 10 % Teaching 10 % Administration 45 %

Other: 10% EM Societies Activities

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Academic Practice
Employed by University
Oversee 4 hospital practices (including nursing): academic, teaching affiliate, two community hospitals

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.)

Chair, Department of Emergency Medicine, Johns Hopkins Medicine
Emergency Physician-in-Chief, Johns Hopkins Medicine
Chair: Unified Command, Johns Hopkins Medicine
Director, Johns Hopkins Office of Critical Event Preparedness and Response

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 3 Cases  Plaintiff Expert 3 Cases
CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Gabor D. Kelen, MD, FRCP(C), FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

   Employer: Johns Hopkins University
   Address: Baltimore MD
   Position Held: Chair, Department of Emergency Medicine
   Type of Organization: University

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

   Organization: Association of Academic Chairs of Emergency Medicine
   Address: 
   Type of Organization: Professional
   Leadership Position: Previous President, Multiple Committees and Task Forces
   Term of Service: 1994-

   Organization: Emergency Medicine Foundation
   Address: 
   Type of Organization: Research Grant Agency

   Organization: Society for Disaster Medicine and Public Health Emergencies (DMPHP)
   Address: 
   Type of Organization: Professional
   Leadership Position: Founding Board of Directors/
   Term of Service: 2011-
3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:
9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO  ☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO  ☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Gabe D. Kelen, MD  Date  June 26, 2022
August 2, 2022

Dear ACEP Nominating Committee,

It gives me great pleasure on behalf of the Association of Academic Chairs of Emergency Medicine (AACEM) to nominate Gabe Kelen, MD as a candidate for the ACEP Board of Directors at the upcoming elections during the ACEP Council meeting.

Dr. Kelen has had a long and distinguished career as a board-certified Emergency Physician. He has been a member of ACEP since 1983 and has chaired multiple ACEP initiatives and committees. He has served the specialty of EM by being a leader of SAEM, ACEP, AACEM, and STEM. He has also held leadership positions in multiple other national agencies and societies all while running one of the most successful departments of Emergency Medicine for over 25 years. I have found him personally to be one of the hardest working, knowledgeable, approachable and brilliant individuals in our specialty today.

AACEM is proud to endorse Dr. Kelen for the Board of Directors and feel his vast experience as department chair and his work with ACEP, SAEM and multiple other organizations have more than prepared him for the rigors of this role. He will bring balance to the board as a voice of reason and experience, while representing the best interests of academic and community emergency physicians.

Sincerely,

Richard Hamilton, MD, MBA
Dear Friends,

I was the first recipient of the EMF career development grant. Due to that pivotal opportunity, my career took off, and I have been privileged to serve in leadership roles within ACEP and many other organizations. I would like to use my experience and acquired expertise to continue to give back to the College and the field. I ask that you re-elect me to the ACEP Board of Directors for a second term.

My last shift (literally yesterday), like pretty much all your shifts, was burdened by: too many patients, overwhelming boarding, challenging critical ill patients, endless distractions (e.g., “sign this EKG”), frustrating documentation requirements, unfamiliar nursing personnel, the easy dismissiveness of a consultant, and contending with violent patients. This COVID era has imposed its additional burdens. Indeed, we went from “Hero to Zero” in a matter of months, adding to our sense of demoralization. While not expressed in those words, there is a sense that EM physicians’ hard efforts are progressively underappreciated by employers, other specialists, institutional leaders, and sometimes even patients. Increasingly, we lack control over our work environment, from ivory tower academia to smaller community clinical practice. We are overwhelmed by chasing too many meaningless metrics and short-sighted patient safety protocols focused on specific conditions that force us to ignore other patients. This actually increases our overall department safety risk and heightens our litigation exposure.

These slights lead to great moral harm, denigration of our worth, and inhibit respect for our unique practice. In all my professional endeavors, including representing you on the Board, my unwavering guide is a simple singularity--what brings the highest level of dignity and respect to EPs and the field. Attending to this tenet drives the solutions to many of our challenges.

We are uniquely positioned to overcome these issues because the healthcare landscape is rapidly changing, giving us a potential edge in the marketplace of ideas that could redefine emergency medicine. ACEP is the only organization that can lead us to a new practice paradigm, where we can vastly expand the concept of emergency medicine and bring us into greater prominence and autonomy. Yes, it’s essential to address today’s challenges, but it’s also time to stake out our future. In the famous words of Wayne Gretzky, “I skate to where the puck is going to be, not where it has been.” Coupled with Einstein’s quote above, our future overcomes or renders moot the issues of today. My personal vision is that Emergency Medicine becomes the dominant specialty for all unscheduled acute and decompensated care, essentially eclipsing the primacy of the major specialties of the previous century. Indeed, we should strive to move the symbol on the ACEP logo, currently somewhat off to the side, right smack in the middle, where it should belong.

I’ll end where I started. I neither seek nor would profit in further career advancement. But I wish to give back. I have been fortunate to have broad clinical, business, administrative, teaching, academic, and research experience. I have a strong advocacy background, having testified before several congressional subcommittees and other federal and state agencies. I am seeking the privilege to represent you again on the Board. With you, I will tackle our current challenges, always consider all voices of our membership, particularly dissenting views, and work for the continued ascendency of our specialty and for the distinction of emergency physicians everywhere.

“If you want to make important contributions, do important work.”

--Dan Nathans, Nobel Laureate
Gabe Kelen, MD, FRCP(C), FACEP, PGY 41
ACEP BOD Incumbent Candidate
Leadership, Experience, Expertise,

ACEP Leadership
Councilor (10 years)
Steering Committee
PA/NP Task Force
Academic Affairs Task Force
Chair, AIDS Task Force
Chair, Public Health Committee
President STEM
National ACEP Speaker
Congressional Testimony X 4
ACEP Designated Spokesperson
EMF BOD (two terms)
EMF Center of Excellence Panel
EMF External Reviewer
White House Representative (GWB)
Editor, Tintinalli
Annals Reviewer

Clinical Leadership
Full-Time Clinician
Emergency Physician-in-Chief, JHM
Best Physicians in Region (Baltimore Mag)
Board of Trustees, Johns Hopkins Hospital
Chair, JH Emergency Physicians, LLC
JHHS/JHU Disaster Director

Administrative Leadership
Department Chair
Unified Commander (JHM COVID)
Residency Director
Research Director
Center Director (CEPAR and PACER)
President, STEM (SAEM)
President, AACEM
Board of Directors, SAEM
Chair, Medical Board JHH
National Academies of Science (elected)
ACEP Research Award
MD ACEP Emergency Medicine Award
MD ACEP Chairman of the Year
EMF Legacy Grantee
Academic Excellence Award SAEM)
Leadership Award (SAEM)
Distinguished Service Award (AACEM)
Teacher of the Year (JHU EM Residency)

Recognition

*Endorsed by ACCEM
**Management Proficiency**

**Responsible for 4 EDs**
- 2 Community
- 1 Teaching Affiliate
- 1 Academic Medical Center (JHH)

**Personnel Reporting**
- 1500 individuals
- Nursing Reports to Chair (Hire/Fire)

**Budget Managed**
- ~$150,000,000

**JHU/SOM Clinical Practice Ass’n**

**JHU Finance Committee**

**COVID Unified Command Lead (JHM)**
- 62K personnel; 6M patients

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**Advocacy**

**NEJM Catalyst**

**Gabor D. Kelen, MD, Richard Wolfe, MD, Gail D’Onofrio, MD, MS, Angela M. Mills, MD, Deborah Diercks, MD, Susan A. Stern, MD, Michael C. Wadman, MD, and Peter E. Sokolove, MD**

September 28, 2021

**Emergency Department Crowding: The Canary in the Health Care System**

The solution for this serious threat to ED staff and harm to patients cannot come from a single department, but through engagement of and ongoing commitment by leaders throughout the hospital and, more broadly, by those in the payer and regulatory segments of the health care system as well.

**Summary**

Emergency department crowding is a sentinel indicator of health system functioning. While often dismissed as mere inconvenience for patients, impact of ED crowding on avoidable patient morbidity and mortality is well documented but remains largely underappreciated. The physical and moral harm experienced by ED staff is also substantial. Often seen as a local ED problem, the cause of ED crowding is misaligned health care economics that pressures hospitals to maintain inefficient high inpatient census levels, often preferring high-margin patients. The resultant back-up of admissions in the ED concentrates patient safety risks there. Few efforts (even well-meaning ones) address the economically driven root causes of ED crowding, i.e., the need to achieve minimal financial hospital margins. The key to a sustainable solution is to realign health care financing to allow hospitals to keep inpatient capacity below a critical threshold of 90%; beyond that, hospital throughput dynamics will inevitably lead to ED crowding.

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**Media Releases (recent)**

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*Endorsed by ACCEM and Maryland ACEP*
CURRICULUM VITAE

GABOR DAVID KELEN, M.D., FRCP(C), FACEP

Home Address
1307 Malvern Ave.
Baltimore, Maryland 21204
(410-339-7262)

Office Address
Department of Emergency Medicine
Suite 6-100, 1830 E. Monument Street
Baltimore, Maryland, 21287
Phone: (410-955-8191)
E-mail: gkelen@jhmi.edu

EDUCATION

· B.Sc. Carleton University, Ottawa (1974)
  (Honors with distinction) (Experimental Physiological Psychology)

· M.D. University of Toronto (1975-79)

· Internship University of Toronto
  St. Michael's Hospital (07/79-06/80)

· Residency University of Toronto
  Internal Medicine
  St. Michael's Hospital (07/81-06/82)
  Women's College Hospital (11/80-01/81)

· Fellowship/Residency Johns Hopkins University, Baltimore
  Emergency Medicine
  Johns Hopkins Hospital (07/82-06/84)

AWARDS AND HONORS

· Ontario Scholar (1970)
· Dr. H. Katznelson Award; First in Class (Carleton University) (1972)
· James A. Gibson Award; First in Biology (Carleton University) (1972)
· Fellowship and Research Grant, Carleton University (1974)
· Graduate Scholarship, Carleton University (1974)
· Career Development Award, Emergency Medicine Foundation (1988-89)
· (W.M. Keck) Clinician Scientist Award, Johns Hopkins University (1988-90)
· Hal Jayne Academic Excellence Award, Society for Academic Emergency Medicine (1992)
· Outstanding Contribution to Research Award, American College of Emergency Physicians (1993)
· Emergency Medicine Award, Maryland Chapter of ACEP (1994)
· The Best Physicians in the Region, Baltimore Magazine (2000)
· Elected, National Academy of Medicine (formerly IOM), National Academies of Sciences (2005)
· Leadership Award, Society for Academic Emergency Medicine (2007)
· Elected, Alpha Omega Alpha Society (2008)
Appointed, Senior Principal Staff, Johns Hopkins Applied Physics Laboratory (2008)
· Johns Hopkins Institute for Excellence in Education Award (2015)
· **Distinguished Service Award**, Association of Academic Chairs of Emergency Medicine (2018)
· **Teacher of the Year Award**, Johns Hopkins Emergency Medicine (2018)
· **Chairman of the Year Award**, American College of Emergency Physicians (Maryland Chapter) 2019
· **Physician of the Year Award**, Health Care Heroes, The Daily Record, 2021
· **Best Doctors, Baltimore**, Baltimore Magazine, November 2021

**SPECIALTY QUALIFICATIONS**

· Board Certification The Royal College of Physicians and Surgeons of Canada (Emergency Medicine) (1985-)


· Fellow (FRCPC) The Royal College of Physicians and Surgeons of Canada (1986) (#300714)

· Fellow (FACEP) The American College of Emergency Physicians (1987)

· Fellow (FAAEM) The American Academy of Emergency Medicine Founding Member (1994)

**LICENSURE**

· Diplomat The Medical Council of Canada (1979)

· Diplomat College of Physicians and Surgeons of Ontario (#31901) (1980-)

· Diplomat (License) The Maryland Board of Medical Examiners (#D30854) (1984-)

**ACADEMIC APPOINTMENTS**

· Professor Department of Emergency Medicine, Johns Hopkins University School of Medicine (1993-)
· Professor
  Anesthesiology Critical Care Medicine, Johns Hopkins University School of Medicine (2018-)

· Joint Appointment
  Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health (1996-)

· Senior Scientist
  Center for Emergency Care and Disaster Preparedness, University of Alabama at Birmingham (2004-)

· Principal Staff
  Applied Physics Laboratory, Johns Hopkins University (2008-)

CURRENT POSITIONS

· Chair
  Department of Emergency Medicine, Johns Hopkins University School of Medicine (1993-)

· Director
  Johns Hopkins Office of Critical Event Preparedness and Response (CEPAR) (2002-)

· Director (PI)
  National Center for the Study of Preparedness and Catastrophic Event Response (2005-)

· Member
  Advisory Council, Johns Hopkins Center for Health Policy and Health care Transformation (2011-)

· Emergency Physician-in-Chief
  Department of Emergency Medicine, Johns Hopkins Hospital (1993-)

· Chair, Board of Directors
  Johns Hopkins Emergency Medical Services, LLC (2001-)

· Presidential Advisory Council
  Carleton University, Ottawa (1996-)

· Active Staff
  The Johns Hopkins Hospital (1984-)

· Consultant
  Residency Program Site Consultant, Society for Academic Emergency Medicine (1991-)

PREVIOUS POSITIONS

· Program Director
  Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1986-2010)
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<td>Chair</td>
<td>Medical Board, Johns Hopkins Hospital</td>
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<td>Vice Chair</td>
<td>Medical Board, Johns Hopkins Hospital</td>
<td>2002-05</td>
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<td>Member</td>
<td>Board of Trustees (ex officio), Johns Hopkins Hospital</td>
<td>2005-08</td>
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<td>Research Director</td>
<td>Department of Emergency Medicine, Johns Hopkins University School of Medicine</td>
<td>1984-2005</td>
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<td>President</td>
<td>Association of Academic Chairs of Emergency Medicine</td>
<td>2005-06</td>
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<td>President Elect</td>
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<td>2004-05</td>
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<td>2003-04</td>
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<td>Chair, Board of Directors</td>
<td>Cedar Emergency Services</td>
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<td>Baltimore Substance Abuse Systems, Inc.</td>
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<td>Johns Hopkins Bayview Physicians Association</td>
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<td>Johns Hopkins Bayview Medical Center</td>
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<td>Board of Directors</td>
<td>Emergency Medicine Foundation</td>
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<td>Chair</td>
<td>American College of Emergency Physicians Public Health Committee</td>
<td>1993-95</td>
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<td>Director</td>
<td>Emergency Medicine Residency Program, Johns Hopkins University School of Medicine</td>
<td>1984-86</td>
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<td>Acting Director</td>
<td>Department of Emergency Medicine, Johns Hopkins Hospital</td>
<td>1992-93</td>
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<tr>
<td>Acting Director</td>
<td>(Autonomous) Division of Emergency Medicine, Johns Hopkins University</td>
<td>1992-93</td>
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<td>Associate Professor</td>
<td>Division of Emergency Medicine, Johns Hopkins University</td>
<td>1989-93</td>
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Assistant Professor Division of Emergency Medicine, Johns Hopkins University (1985-89)

Editor Society of Teachers of Emergency Medicine Letter (1985-88)

Instructor Division of Emergency Medicine, Johns Hopkins University (1984-85)

Associate Editor Society of Teachers of Emergency Medicine Letter (1984-85)

Chief Resident Emergency Medicine Residency Program, Johns Hopkins University School of Medicine (1983-84)

Research Scholar Non-Medical Use of Drugs Dir. (Grant: National Health & Welfare, Canada). Carleton University, Ottawa (05/73-09/74; 05/74-09/75)

Consultant Bureau of Epidemiology, National Health & Welfare, Ottawa (01/75-03/75)

Research Assistant Bureau of Biologics, Drugs Directorate, Health Protection Branch; National Health & Welfare, Ottawa (05/77-09/77)

ELECTED POSITIONS

Board of Directors American College of Emergency Physicians (2019-)

Councilor (AACEM) American College of Emergency Physicians (2010-19)

Member Alpha Omega Alpha, Johns Hopkins University (2008-)

Member National Academy of Medicine (Institute of Medicine), National Academies of Sciences (2005-)

Chair Medical Board, Johns Hopkins Hospital (2005-08)

President Association of Academic Chairs of Emergency Medicine (2005-06)

Secretary/Treasurer Association of Academic Chairs of Emergency Medicine (2003-04)
· Agenda Committee Johns Hopkins University School of Medicine Advisory Board of the Medical Faculty (1996-99; 2003-06; 2021-)

· Vice Chair Johns Hopkins Hospital Medical Board (2002-05)

· Board of Advisors Johns Hopkins University Clinical Practice Association (1997-2000)

· Board of Directors Society for Academic Emergency Medicine (1988-90)

· President Society of Teachers of Emergency Medicine (1988-90)

EDITORIAL BOARD

Society of Teachers of Emergency Medicine Letter (1984-88) (Editor-in-Chief, 1985-88)
American Journal of Emergency Medicine (1986-)
Academic Emergency Medicine (Special Editor: November 2003, November 2004)
Bioterrorism and Biosecurity (2003-2009)
Journal of Disaster Medicine and Public Health Preparedness (2006-)
Health Security (2020-)

MANUSCRIPT CONSULTANT (Peer Review)

Annals of Internal Medicine
American Journal of Medicine
Academic Emergency Medicine
Journal of General Internal Medicine
European Journal of Medicine
Archives of Ophthalmology

Annals of Emergency Medicine
American Journal of Emergency Medicine
Journal of the American Medical Association
Journal Acquired Immunodeficiency Syndrome
Journal Urban Health

PEER REVIEW CONSULTANT

Peer Review ADAMHA/NIH (1993-97)
External Reviewer EMRA Scientific Paper Competition, Ohio Chapter (1988)
Consulting Protocol Reviewer Centers for Disease Control (1988)
External Reviewer Society for Academic Emergency Medicine Abstracts (1995-)
External Reviewer Emergency Medicine Foundation Center of Excellence Grant (1994, 1995)
Study Section Bioterrorism Review Committee/AHRQ (2004)
Study Section Healthcare Safety and Quality Improvement Research Study Section (2011-)
CONSULTANCIES FOR THE DEVELOPMENT OF EMERGENCY MEDICINE

McGill University - Royal Victoria Hospital (1991)
Barnes Hospital - University of Washington (1992)
Booth Hospital - Cornell University (1993)
New York Hospital - Cornell University (1994)
University of Puerto Rico (1997)
Medical College of Virginia (1998)
University of Maryland (2001)
Rhode Island University (2001)
Milton S. Hershey Medical Center - Pennsylvania State University (2002)
Ohio State University (2002)
University of Utah (2002)
Beth Israel Medical Center (2003)
University of Medicine and Dentistry of New Jersey (Robert Wood Johnson) (2006)
University of Alabama (2006)
University of Illinois, Chicago (2006)
Coney Island Hospital, NYC, (2008)
University of Massachusetts, Worcester, MA, (2012)
Harvard University, Beth Israel Deaconess, Boston, MA, (2015)

FORMAL MEDICAL SCHOOL TEACHING ACTIVITIES

· JHU Medical Student Research Prefect (1986-), 87 students
· Sponsor: NIH Medical Student Research Training Grant (9T35HL07606; 1989)
· Sponsor: EMF Medical Student Research Training Grant (1989)
· Research Fellow Preceptor (1986-99), 9 fellows
· Medical Student Advisor (1992-)
· Introduction to Clinical Skills Course (1999-2002)
· Introduction to Clinical Medicine Course (2002-6)
· First Year Preceptor (2002-)
· Lectures at JHU School of Medicine
  · Cardiopulmonary Resuscitation (1985,86)
  · Approach to Trauma (1985-88, 90-91, 95-)
  · Nosocomial Risk of AIDS (1989)
  · Differential of Consequence (2004-05)
DOCTORAL THESIS ADVISEES

Matthew H-M. Ma - Ph.D., Health Policy and Management. System Performance and Appropriateness of Care for Elderly Trauma Patients. Johns Hopkins University Bloomberg School of Public Health, 1996


Deborah E. Trautman - Ph.D., Policy Sciences Graduate School. Intimate Partner Violence and Emergency Department Screening. University of Maryland, Baltimore County, 2004

Julius Pham - Ph.D. State of Healthcare Quality in Emergency Medicine. Department of Emergency Medicine, Johns Hopkins University School of Medicine, 2008

Gai Cole, Dr.Ph. Capturing Nursing Effort in the Emergency Department to Improve Socioeconomic Effectiveness. Johns Hopkins University, Bloomberg School of Public Health, 2014

Michelle Patch, MSN, APRN-CNS, ACNS-BC. Prevalence and Associated Characteristics of Emergency Department Visits by Women after Non-Fatal Intimate Partner Strangulation and Subsequent Diagnostic and Treatment Experiences: A Mixed Methods Study. Johns Hopkins University School of Nursing, 2019

OTHER UNIVERSITY TEACHING ACTIVITIES

· HIV Testing. AIDS and Public Policy, JHU School of Hygiene and Public Health (1992)
· Ethical Issues in HIV Testing. AIDS and Public Policy, Johns Hopkins Bloomberg School of Public Health (1993-95, 1997)
· First Responder Communications Challenges. Public Health Emergency Preparedness, Johns Hopkins Bloomberg School of Public Health (Feb 2008, Feb 3rd, 2010)

COMMITTEES

NATIONAL

AGENCY FOR HEALTHCARE POLICY AND RESEARCH (AHRQ)
· Office of the Forum Quality and Effectiveness in Health Care, Technical Advisor (1991)
CENTERS FOR DISEASE CONTROL (CDC)
- Representative, CDC/HMA Partnership Council

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
- Chair, Medical Surge Work Group, Joint Advisory Working Group (2008-2014)

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)
- Chair, Infectious Disease Committee (1992-1993)
- Chair, Public Health Committee (1993-1995)
- Designated Spokesperson (1991-)
- ACEP Council Steering Committee (2017-)
- ACEP Workforce Task Force (2018-)

SOCIETY OF TEACHERS OF EMERGENCY MEDICINE (STEM)
- Faculty Development Committee (1985-1988)
- Board of Directors (1987-1989)
- Chair, Nominations Committee (1987-1988)
- President (1988-1990)

ASSOCIATION OF ACADEMIC CHAIRS OF EMERGENCY MEDICINE (AACEM)
- Representative, Council of Academic Societies of the AAMC (2000-10)
- Secretary/Treasurer of the Executive Committee (2003-2004)
- President (2005-2006)
- ACEP Council Representative (2010-)

SOCIETY FOR ACADEMIC EMERGENCY MEDICINE (SAEM)
- Board of Directors (1988-1990)
- Representative to Emergency Medicine Foundation (1989-1994)
- Chair, Infectious Diseases Committee (1991-1994)
- Program Committee (1999)
- Chair, Research Committee (2000-2001)
- Chair, Investment Subcommittee (2005-2006)
- Research Fund Senior Council (2006-)
- Consultation Services Committee (2007-)
- Awards Committee (2008-)
- Finance Committee (2011-2)
- Program Committee (2011-)
- Abstract Subcommittee (2014-8)
· Faculty Development Committee (2018-)

EMERGENCY MEDICINE FOUNDATION (EMF)
· Board of Directors (1988-1990)
· Board of Directors (1993-1995)
· Centers of Excellence Grant Panel (1994-1995)

COUNCIL OF TEACHING HOSPITALS (Section of Emergency Medicine) (COTH)
· Executive Council (1992-)

INSTITUTE OF MEDICINE, NATIONAL ACADEMIES OF SCIENCES (IOM)
· Forum of Surge Capacity (Washington, D.C., June 2006)

SOCIETY FOR DISASTER MEDICINE AND PUBLIC HEALTH EMERGENCIES
· Founding Board of Directors (2011-)

JOHNS HOPKINS MEDICINE
· JHM Joint Council (2014-)

JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
· Advisory Board of the Medical Faculty (1992-)
· Committee of the Whole (1992-)
· Clinical Practice Association Board of Governors (1993-)
· Hospital Affiliations Task Force (1994)
· Faculty and Student Assistance Program Advisory Committee (1994-96)
· Pediatric Chair Search Committee (1995-1996)
· Medical Student Promotions Committee; third and fourth year (1995-1999)
· Chair, Johns Hopkins Bayview Director of Emergency Medicine Search Committee (1996)
· Professorial Promotions Committee (1996-2001);
  · Ad Hoc Acting Chair (1998-2001)
· Agenda Committee of the Advisory Board of the Medical School (1996-1999; 2003-2006)
· Board of Advisors, Clinical Practice Association (1997-2000)
· Chair, Clinical Practice Association Board of Governors Operations Oversight Committee (1997-98)
· Ad Hoc Committee to Revise Guidelines for the Promotions of Clinical Educators and Scholars (1997)
· Chair, Johns Hopkins Medicine United Way Campaign (1997, 1998)
· Clinician Scientist Award Selection Committee (1997-2005, 2010-)
· Faculty Budget Advisory Committee (1997-2004)
· Associate Professor Reappointment Committee (1997-2002)
· President=s Council on Urban Health (1998-2000)
· Chair, Dermatology Chair Search Committee (1998-99)
· Chair, Howard County General Hospital Director of Emergency Medicine Search Committee (1999)
· Research Advisory Council (2000-01)
· Medicine Chair Search Committee (2000-01)
· Surgery Chair Search Committee (2002)
· School of Medicine Human Resources Newsletter Advisory Group (2002-03)
· Change Newsletter Advisory Board (2002-05)
- Chair, Critical Event Preparedness and Response Executive Council (2002-)
- Education Policy Committee (2002-04)
- Education Policy Committee, Clerkship Directors Subcommittee (2002-04)
- Johns Hopkins Medicine Center for Information Services Advisory Board (2002-04)
- Public Health Preparedness and Leadership Chair Search Committee (2003-04)
- Johns Hopkins Medicine Board of Trustees Committee on Professional Liability (2006-8)
- Howard County General Hospital Director of Emergency Medicine Search Committee (2008)
- Johns Hopkins Medicine Leadership Council (2012-)
- Medicine Chair Search Committee (2013)
- Compensation Task Force (2014-5)
- Anesthesiology Critical Care Medicine Chair Search Committee (2014)
- Pediatric Chair Search Committee (2015-6)
- Faculty Compensation Committee (2015-)
- Chair, Department of Obstetrics Department Review Committee (2018)

JOHNS HOPKINS HOSPITAL (JHH)
- Medical Board (1992-),
- Adult Trauma QA Committee (1992-97)
- Pediatric Morbidity & Mortality Committee (1992)
- Pediatric EMSC Council (1992-93)
- Services Task Force (1994)
- Medical Advisory Council (1994-95)
- Re-engineering Steering Committee (1994-97)
- Clinical Quality Committee (1994)
- Contingency Planning Committee (1995-96)
- Chair, Urgent Care Planning Committee (1995-96)
- East Baltimore Primary Care Planning Committee (1995)
- East Baltimore Primary Healthcare Delivery System (1996-99)
- Management Services Reorganization Task Force (1996-98)
- Clinical Directors Communications (1996-)
- Medicaid Managed Care Executive Oversight Committee (1996-99)
- Urban Health Institute Council (1999)
- Johns Hopkins Medicine Operations SWAT Committee (2000-)
- Administrative Committee of the Medical Board (2000-08), Chair (2002-05)
- Agenda Committee for the Administrative Committee of the Medical Board (2002-08)
- Chair Administrative Committee of the Medical Board (2002-05)
- Performance Improvement Council (2002-08)
- Innovations in Quality Patient Care Steering Committee (2002-08)
- Capacity/Access Oversight Group (2004-)
- Vice Chair, Medical Board (2002-05)
- Johns Hopkins Medicine Executive Quality Improvement Council (2006-08)
- Chair, Medical Board (2005-2008)

JOHNS HOPKINS BAYVIEW PHYSICIANS ASSOCIATION
- Board of Directors (1996-2001)
EMERGENCY DEPARTMENT
· Chair, Research Committee (1985-98)
· Chair, Executive Committee (1992-)
· Chair, Programs Committee (1992-96)

SOCIETIES AND MEMBERSHIPS
· American College of Emergency Physicians (ACEP)
· Maryland Chapter of the American College of Emergency Physicians (MD ACEP)
· Society for Academic Emergency Medicine (SAEM)
· College of Physicians and Surgeons of Ontario (CPSO)
· Royal College of Physicians and Surgeons of Canada (RCPSC)
· Council of Teaching Hospitals (COTH): Emergency Medicine Section
· Association of Academic Chairs of Emergency Medicine (AACEM)
· American Academy of Emergency Medicine (Charter Member) (AAEM)
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<tr>
<td>1974</td>
<td>Research Scholar: &quot;Behavior control of brain serotonin in the rat&quot;. Department of Health and Welfare, Canada: Non-Medical Use of Drugs Directorate - RODA Grant: $1,200 (Advisor: B. Pappas, Ph.D., Carleton University)</td>
</tr>
<tr>
<td>1975</td>
<td>Research Scholar: &quot;5-Hydroxy-dopamine conditioning in mice&quot;. Department of Health and Welfare, Canada: Non-Medical Use of Drugs Directorate - RODA Grant: $1,400 (Advisor: B. Pappas, Ph.D., Carleton University)</td>
</tr>
<tr>
<td>1986-1987</td>
<td>Co-Principal Investigator: &quot;ADSOL flow characteristics in volume resuscitation: An in-vitro comparison of new infusion techniques&quot;. Arrow; Micro Medex; Baxter Travenol: $6,300</td>
</tr>
<tr>
<td>1987-1988</td>
<td>Principal Investigator (Sponsor): &quot;Risk of unsuspected exposure of emergency department personnel to HTLV-III antibody positive patients&quot;. American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000</td>
</tr>
<tr>
<td>1988</td>
<td>Co-Principal Investigator: &quot;Hepatitis B surface antigen among emergency department patients&quot;. Merck, Sharp &amp; Dohme: $23,000</td>
</tr>
<tr>
<td>1988-1989</td>
<td>Principal Investigator (Sponsor): &quot;A survey of knowledge and practices for risk reduction of HIV exposure in emergency health care providers&quot;. American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000</td>
</tr>
<tr>
<td>1988-1990</td>
<td>Principal Investigator: Co-variation of hepatitis B virus (HBV) and the human immunodeficiency virus in emergency patients. W.M. Keck Clinician Scientist Award: $60,000</td>
</tr>
<tr>
<td>1988-90</td>
<td>Principal Investigator: Unrecognized HTLV-1 infection in emergency patients. American College of Emergency Physicians/Emergency Medicine Foundation Career Development Grant: $25,000</td>
</tr>
<tr>
<td>1989</td>
<td>Preceptor: NIH Medical Student Research Training Grant (9T35HL07606): $1,600</td>
</tr>
<tr>
<td>1989</td>
<td>Co-Principal Investigator: &quot;Assessment of a rapid HIV-1 screen for emergency department patients&quot;. Genetic Systems: $10,000</td>
</tr>
<tr>
<td>1989</td>
<td>Principal Investigator (Sponsor): &quot;Assessment of emergency presentations of patients with symptomatic infection with HIV&quot;. Emergency Medicine Foundation Medical Student Training Grant: $2,400</td>
</tr>
</tbody>
</table>
12.  1988-1989  Principal Investigator: "Human immunodeficiency virus infection in hospital emergency department patients". Centers for Disease Control (200-88-0701(P)): $321,000

13.  1989-1990  Principal Investigator (Sponsor): "HIV infection in emergency department patients and risk of acquisition of HIV infection by emergency care providers". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000


15.  1990-1991  Principal Investigator (Sponsor): "Doubly hidden HIV infection among intravenous drug users in the emergency department". American College of Emergency Physicians/Emergency Medicine Foundation Research Scholars Fellowship Award: $25,000

16.  1990-1995  Co-Investigator: "Trials to promote behavior change to prevent HIV spread". National Institute of Mental Health (1 UO 1 MH48019-01): $1,800,000


19.  1992-1993  Co-Investigator (Site Principal Investigator): "Frequency and natural history of symptomatic primary HIV-1 infection". Abbott Laboratories: $131,250 ($37,500 to JHU)


23.  1993-1996  Principal Investigator: Early detection and treatment of HIV infection. NIAID (N01-AI-15123 (DATRI 002)): $344,408

24.  1994  Principal Investigator: Evaluation of the changes in HIV-1 burden in peripheral blood and lymphoid tissue following ZDV treatment in HIV-1 infected patients with CD4+cells between 100 and 400/mm³. NIAID (N01-AI-15123 (DATRI 012)): $75,000 (Award Declined by PI)
27. 1996 Co-Investigator: Center for Injury Research and Policy. Johns Hopkins University Bloomberg School of Public Health: 10%
28. 1997-1999 Co-Investigator: The role of alcohol in asthma. Alcoholic Beverage Medical Research Foundation: $80,000
29. 1998-2000 Preceptor: JHU Clinician Scientist Award (Richard Rothman, M.D., PhD): $130,000
30. 1998-2001 Principal Investigator: Center for the study of emergency and acute care health services and policy. Emergency Medicine Foundation: $250,000
31. 1998-1999 Co-Principal Investigator: Appropriate emergency department evaluation of fever in injecting drug users. AHCPR: $50,000
32. 2000-2002 Preceptor: JHU Clinician Scientist Award (Gary Green, M.D.): $130,000
33. 2000-2005 Co-Investigator: Cost effective algorithm to evaluate febrile IDU at risk for infective endocarditis. NCRR: $300,000 (PI: Richard Rothman, MD, PhD).
34. 2001-2004 Co-Investigator: Coronary thrombosis and risk in emergency department patients. NHLBI (R-01): $1,2500,000 PI (Gary Green, MD, MPH)
37. 2004-2006 Preceptor: JHU Clinician Scientist Award (Samuel Yang, M.D.): $130,000
40. 2007-11 PI. FY08 Homeland Security Preparedness Technical Assistance Program. FEMA (#104549), $550,000
41. 2008-2009 Principal Investigator: “Johns Hopkins GO Team.” HRSA/ HHS (1D1DHP10619-0): $236,367

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42. 2010-2012  Co-Investigator: Kentucky critical Infrastructure Protection Institute Program Management Support DHS (#108291) (PI Ed Hsu)
43. 2010-2013  Principal Investigator: National Center for the Study of Preparedness and Catastrophic Event Response@ (PACER). United States Department of Homeland Security (N00014-06-1-0991): $6,500,000
44. 2010-2013  PI. Principal Investigator. Surge Capacity Metrics, DHS-PACER (N00014-06-1-0991): $489,295
45. 2011-2013  Preceptor: JHU/SOM Clinician Scientist Award (JL Jenkins, MD, MSc): $130,000
46. 2014-2021  Co-PI: Johns Hopkins Center of Excellence for Influenza Research and Surveillance. NIAID--HHSN272201400007C $28,000,000 (Rothman/Pekosz)
48. 2017  PI (dual): Vitamin C, Thiamin, Steroid, (VICTAS), Clinical Trial Planning Group. Marcus Foundation Grant ($168,000)
49. 2017-2019  CO-PI: Vitamin C, Thiamin, Steroid, (VICTAS), Controlled Clinical Trial. Marcus Foundation Grant (~$10,000,000)
50. 2017-2019  PI (dual): Clinical Coordinating Center. Vitamin C, Thiamin, Steroid, (VICTAS), Controlled Clinical Trial. Marcus Foundation Grant (~$3,000,000)
51. 2018-  Inv; (S. Levin PI): R18 HS026640
52. 2019-  Inv; (A. Gurses PI): ED Diagnostic Safety AHRQ R01-027198-01

Patents and Inventions

3. HopScore: An Electronic Emergency Triage System 2014 (JHU #C12888)
4. PACER Application Suite (EMCAPS 2.0, Surge App, FluCast) 2014 (JHU C13027)
PUBLICATIONS

Texts


Peer-Review Manuscripts


   Edizione Italiana (JAMA) 6:496-505, 1989
   Southeast Asia (JAMA) 5:19-25, 1989
   Japan (JAMA) 262:36-45, 1990


132. Hsieh YH, Jung JJ, Shahan JB, Moring-Parris D, Kelen GD, Rothman RE. Emergency medicine resident attitudes and perceptions before and after an educational program and testing implementation. Acad Emerg Med 16:1165-1173, 2009


153. Dugas AF, Morton M, Beard R, Pines JM, Bayram J, Hsieh YU-H, Kelen GD, Usher-Pines L, Jeng K, Cole G, Rothman RE. Interventions to mitigate the impact of emergency department and hospital crowding during an infectious respiratory disease outbreak: results from an expert panel. PLOS Currents Disaster 17(5): 2013ecurrents.dis.1f277e0d2bf80f4b2bb1dd5f63a13993. doi: 10.1371/currents.dis.1f277e0d2bf80f4b2bb1dd5f63a13993


169. Regan L, Jung J, Kelen GD. Education Value Units. A mission-based approach to assigning and monitoring faculty teaching activities in an academic medical department. Acad Med 2016 91(12); 1642–1646. DOI: 10.1097/ACM.0000000000001110. ISSN: 1040-2446


Software


Chapters


Letters


38. Kelen GD, Riggs B. Management of protocols for nonpenetrating gunshot wounds. (Letter) J Trauma 24(9): 862-64, 1984


Other Non-Peer Review


Thesis (Honors)

Published Abstracts


25. Fleetwood D, Johnson G, Kelen GD. Acute presentations of patients with HIV infection to an emergency department. VIth International Conference on AIDS. Abstracts Book 2: 185, 1990


28. Quinn TC, Kelen GD, Meyers W, Fleetwood D, Brothers T, Kline R. Detection of HIV-1 infection by polymerase chain reaction (PCR) and culture in HIV-1 seronegative patients attending an emergency department. VIth International Conference on AIDS Abstracts (#Th.C.557) Book 6:264, 1990


44. Hirshon JM, Kirsch TD, Mysko WK, Ditre M, Kelen GD. The rotational assignment of patients to physicians improves ED patient flow. Acad Emerg Med 1(2):A10,1994


Kelen GD, Pezzin LE, Gordon TA. Increasing importance of the ED as the front door of the hospital. Acad Emerg Med 7(5):551, 2000

Haddock TA, Kelen GD, Rothman RE. Radiographic infiltrates are strongly associated with vital sign abnormalities: Physician judgment combined with a simple decision aid may reduce unnecessary chest x-rays. Acad Emerg Med 8(5):476, 2001


78. Kelen GD, Kraus CK, Brill JD, the CEPAR Research Group. Creation of hospital surge capacity by the early discharge of inpatients. Acad Emerg Med 12(5):23, 2005


80. Kelen GD, the CEPAR Research Group. Reverse triage: Criteria for immediate inpatient disposition for creation of hospital surge capacity. Presented at the 14th World Congress on Disaster and Emergency Medicine (#FPT2.3). Edinburgh, May 16-20, 2005


95. Beatrice Hoffman, Edward Bessman, Ru Ding, Gabor Kelen, Michael Kelen, Melissa McCarthy, Patrick Um. Influence of provider experience with abdominal aorta sonography on likelihood of a successful exam. Presented at the annual meeting of the European Society of Emergency Medicine, Munich, Germany, September 16, 2008.


46


NATIONAL/INTERNATIONAL INVITED PRESENTATIONS AND SYMPOSIA


3. Course Director: Regional Seminars in Emergency Medicine, Johns Hopkins University, Baltimore, MD, 1984-85


21. HIV and Other Blood Borne Infections in the ED. Visiting Professor Lecture Series. Royal Victoria Hospital, McGill University, Montreal, Canada, March 20, 1991


23. Moderator: Clinical Practice Papers. Society for Academic Emergency Medicine, Toronto, Canada, May 26, 1993

24. HIV Infection in Patients and Health Care Providers. Carolinas Medical Center Spring Symposium, Charlotte, NC, May 13, 1993


28. The Importance of Not Being ERnest. Welch Lecture Series, Johns Hopkins University, Baltimore, MD, April, 1995

29. Risk of HIV Transmission in the Work Place. Visiting Emergency Medicine Professor Series. Baylor Medical College, Houston, TX, June 16, 1995


33. HIV Screening and Counseling in the ED. VIIth International Conference on Emergency Medicine, Toronto, Canada, March 29, 1998

34. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? 1998-1999 Dean’s Lectures Series, Johns Hopkins University, Baltimore, MD, May 10, 1999

35. Organization of the Emergency Department. Emergency Medicine Symposium of the American Hospital, Istanbul, Turkey, November 1999

36. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Visiting Professor, State University of New York at Buffalo, NY, February 1999

37. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? University of Medicine and Dentistry of New Jersey, Camden, NJ, March 2000


42. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Department of Pediatrics Grand Rounds, Johns Hopkins University, Baltimore, MD, December 13, 2000


45. Cases in Acid Base Disorders. 12th Annual Emergency Medicine for the Critically Ill and Injured, Orlando, FL, February 23, 2001

46. Nosocomial Acquisition of HIV and Blood Borne Infections: Who's at Risk, the Patient or the Clinician? Neurosurgery Grand Rounds, Johns Hopkins University, Baltimore, MD, September 20, 2001


48. Major Academic Medical Center=s Role in Critical Event Planning and Response. The Public Health Response to Terrorism Symposium, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, January 14, 2002


50. Role of Emergency Medicine and the Academic Medical Center in Local, Regional and National Disaster Preparedness and Response. Emergency Medicine Session, Johns Hopkins Medical and Surgical Biennial Symposium, Baltimore, MD, May 2, 2003


54. Bench to Bedside: How Cutting Edge Molecular Diagnostic Tools Are Being Developed for the Diagnosis and Management of Infectious Diseases in Acute Care. Society for Academic Emergency Medicine, Boston, MA, May 16, 2004

55. Clinical Research and the HIPAA Privacy Rule. Society for Academic Emergency Medicine, Boston, MA, May 18, 2004


58. Risk of Bloodborne Infection in Emergency and Trauma Settings. Department of Surgery, Division of Trauma Lecture Series, Johns Hopkins University, Baltimore, MD, May 14, 2005


60. How to Develop a Successful Fellowship. Society for Academic Emergency Medicine, San Francisco, CA, May 19, 2006


64. Track Chair. Disaster Track. IVth Mediterranean Conference on Emergency Medicine, Sorrento, Italy, September 17, 2007

65. Moderator. Medical Implications of Large Scale Disasters (Disaster Track). IVth Mediterranean Conference on Emergency Medicine, Sorrento, Italy, September 17, 2007

66. Creation of Hospital Surge Capacity by Reverse Triage. IVth Mediterranean Conference on Emergency Medicine, Sorrento Italy, September 17, 2007


69. Moderator. Health System Preparedness. DHS University Network SUMMIT. March 18th, 2009


72. Moderator: DHS Summit. Altered Standards of Care During Crisis Events, March 12, 2010
73. Strategic Planning. Leadership Academy of the Society of Academic Emergency Medicine, Phoenix, Az, June 2, 2010


77. Research Rightness for your Department. AACEM Annual Meeting Leadership Forum, San Diego, CA, April 6, 2014

78. Strategic Planning. SAEM Annual Meeting Leadership Forum, Dallas TX, May 14, 2014

79. Dean’s Symposium on Ebola: Crisis, Context and Response, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, October 14, 2014


https://duckduckgo.com/?q=Gabe+Kelen&t=osx&pn=1&ia=videos&iai=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3DEMvNtCc2a7s&iax=videos

54
CONGRESSIONAL AND GOVERNMENT TESTIMONY (INVITED)


RECENT MEDIA (incomplete)

Meet the Press (NBC): Summit on Ebola; Dr. Anthony Fauci, National Institute of Allergy and Infectious Diseases; author Laurie Garrett, Council of Foreign Relations; Dr. Gabe Kelen, Johns Hopkins University; Sen. Bob Casey (D-Pa.); Sen. Roy Blunt (R-Mo.). Season 23, Episode 40, Oct 19, 2014

https://www.google.com/search?client=safari&rls=en&q=KELEN+MTP&ie=UTF-8&oe=UTF-8


http://thedianerehmshow.org/shows/2015-08-13/growing-use-of-synthetic-cannabinoids


# 2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Jeffrey F. Linzer, Sr., MD, FACEP

## Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?

I applaud the College’s goals of improving our workplace environment, providing resources to support EPs advocating for themselves and their patients, and providing a path for physician wellness and career fulfillment. I believe to meet these goals, ACEP needs to take a stronger stance on the issues of EM residency program expansion and non-physician providers coming into the workplace. In addition, the College’s strategic plan needs to meaningfully address increasing opportunities to provide high quality emergency care in underserved areas both urban and rural.

I support the College’s goal of using evidence-based scope of practice in both patient care and the business practice, including participation with the Emergency Care Quality Measures Consortium. EPs may be encouraged by their employer to document based on billing rather that patient care. The College must continue to support EPs nationally and through their state chapters to sustain workplace practices that are patient care focused.

To sustain a robust and engaged membership the College must actively engage emergency medicine physicians in training, partnering with and actively supporting EMRA and its mentorship of medical students and residents. ACEP needs to demonstrate its complimentary value to EMRA members that extends once they finish residency. The College needs to demonstrate its new Strategic Plan can provide tangible benefit to members in terms of their practice satisfaction and sustainability. The College will also benefit by retention of more seasoned members with lifetime service recognition.

## Question #2: Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?

The College needs to help simplify and streamline our practice and eliminate nuance and pointless frustration in our practice to ensure practice sustainability and fair compensation. Specifically, addressing misuse of ICD diagnosis codes by payers to deny reimbursement. Payers need to be held accountable for their “proprietary” diagnosis lists that inappropriately downcode. EHR vendors must make their diagnosis calculators more physician friendly so that the proper terminology can be easily found.

The report coming from the ED Accreditation Task Force will help provide direction for the College to meet its workplace strategic goal. We also need to work with our partner groups to help ensure that residencies are not just being developed as a source of inexpensive labor, but that they are providing high quality training preparing their trainees to provide care in a range of environments. We must take care that the expansion of programs does not risk dilution in the quality of training. While, through supply and demand, there is a potential that their influx could drive down reimbursement in competitive markets, this could be countered by ACEP supporting programs that could help reduce graduate medical school debt.

## Question #3: What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?

How to handle workplace safety, especially protection from violence, has become a front burner issue, tragically through recent incidents in Oklahoma, and beyond. Physician, staff, and patient safety are critical to an ED environment than can focus on healing and provide the best care. The challenge is how to achieve this goal. Disagreements range from the presence or absence of armed security to allowing patients and visitors to bring arms into the ED to how many visitors may be in the patient’s room. We must advocate for tangible protection measures to provide a safe environment for patient care. Facilities should use ACEP policies to help reduce the risk of violence in the ED. We deserve to feel safe and protected where we work each day.
CANDIDATE DATA SHEET

Jeffrey F. Linzer Sr., MD, FACEP

Contact Information
1188 Druid Walk, Decatur GA 30033 (home address)
1405 Clifton Rd NE, Division of Emergency Medicine, Atlanta GA 30322 (work address)
Phone: 404-408-2561 (mobile)
        404-785-7131 (work)
E-Mail: JLinzer@emory.edu

Current and Past Professional Position(s)
Current positions:
Professor of Pediatrics and Emergency Medicine, Emory University School of Medicine, Atlanta, GA
Medical Director for Business Affairs and Compliance, Division of Pediatric Emergency Medicine, Emory +
Children’s Pediatric Institute, Children's Healthcare of Atlanta
EMS/Pre-hospital Care Coordinator, Division of Pediatric Emergency Medicine, Emory + Children’s Pediatric
Institute, Children's Healthcare of Atlanta

Past positions
Co-Medical Director, Children’s Sedation Service
Associate Medical Director, Pediatric Emergency Care Center, Hughes Spalding Children's Hospital/Grady
Health System
Lead Physician ICD-10-CM Transition Core Leadership Team, Children’s Healthcare of Atlanta

Education (include internships and residency information)
Fifth Pathway Certificate California College of Medicine, University of California, Irvine-Long Beach Memorial
Medical Center Program, 1987
Pediatric residency, University of California, Irvine, Orange CA, 1987-90
Fellowship Allergy-Clinical Immunology, Children’s Hospital Los Angeles Los Angeles, 1990*92
Fellowship Pediatric Emergency and Transport Medicine, Children’s Hospital Los Angeles Los Angeles, 1992-
94

M.D. (diploma in medicine and surgery), Centro de Estudios Universitarios Xochicalco, School of Medicine,
Ensenada, Baja California, Mexico, 1986

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
American Board of Pediatrics, Pediatric Emergency Medicine, 1996-current
American Board of Pediatrics, Pediatrics, 1991-deferred

Professional Societies
American College of Emergency Physicians, Fellow
Georgia College of Emergency Physicians
American Academy of Pediatrics, Fellow
Society for Pediatric Sedation, Founding Member
American Pediatric Society, Member

National ACEP Activities – List your most significant accomplishments
Coding and Nomenclature Advisory Committee 2003-present
Represent the College to the ICD-10-CM/PCS Coordination and Maintenance Committee
Work group chair for ICD-10-CM implementation 2009-2013
Special Sub-committee for Billing Policy 2009
Member Steering Committee 2018, 2020
Member Reference Committee C Emergency Medicine Practice 2015
Member Reference Committee B Advocacy & Public Policy 2017
Member Reference Committee C Emergency Medicine Practice 2021

ACEP Chapter Activities – List your most significant accomplishments

Pediatric Taskforce (Chair) 1998-present
Board of Directors 2006-2018 (ex-officio as ACEP Councilor)
Alternate Counselor to ACEP Council 2008-2013
Counselor to ACEP Council (ex-officio BOD member) 2014-present
Nominating Committee 2014-present

Practice Profile

Total hours devoted to emergency medicine practice per year: 1215 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 62%  Research 3%  Teaching 20%  Administration 15%
Other: 0%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Academic practice, Emory + Children’s Pediatric Institute, 3 hospital pediatric healthcare system
CHOA Egleston (principal work site) is a quaternary care center, Level 1 pediatric trauma center, and cardiac and transplant 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.)

Medical Director for Business Affairs and Compliance
EMS/Pre-hospital Care Coordinator

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 3 Cases  Plaintiff Expert 3 Cases
CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Jeffrey F. Linzer Sr., MD, FACEP

1. Employment – List current employers with addresses, position held, and type of organization.

Employer: Emory + Children’s Pediatric Institute, Children's Healthcare of Atlanta
Address: Division of Emergency Medicine
1405 Clifton Rd, NE, Atlanta GA 30322
Professor of Pediatrics and Emergency Medicine
Medical Director for Business Affairs and Compliance
Position Held: EMS/Pre-hospital Care Coordinator
Type of Organization: Academic

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.

Organization: World Health Organization
Address: Avenue Appia 20
1211 Geneva, Switzerland
Type of Organization: United Nations agency dedicated to global health and safety
Leadership Position: Chair, Pediatric Topic Advisory Group ICD-11 Revision
Term of Service: 2010-2016

Organization: American Academy of Pediatrics
Address: 345 Park Blvd
Itasca, IL 60143
Type of Organization: Medical society
Leadership Position: Representative to the ICD-10-CM/PCS Editorial Advisory Board and ICD-10-CM Coordination and Maintenance Committee
Member Committee on Coding and Nomenclature
Term of Service: 1999-current

Organization: Agency for Healthcare Research and Quality
Address: 5600 Fishers Lane
Rockville, MD 20857
Type of Organization: Federal agency charged with improving the safety and quality of healthcare
Leadership Position: Member Neonatal/Pediatric Workgroup ICD-10-CM/PCS Conversion
Pediatric Quality Indicators Time-Limited Workgroup
Term of Service: 2012, 2016
Organization: Society for Pediatric Sedation

Address: 2209 Dickens Road
          Richmond, VA 23230

Type of Organization: Medical society

Leadership Position: Board of Directors and founding member

Term of Service: 2007-2015

(See additional sheet)

3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:
9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO  ☑ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO  ☑ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Jeffrey F. Linzer Sr.  Date  June 25, 2022

Additional disclosure: Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities

National Quality Forum
1099 14th Street NW, Suite 500,
Washington DC 20005
Not-for-profit organization for improvements in healthcare
Member Expert Panel on Coding Maintenance
2009-2010

State Office of EMS and Trauma Emergency Medical Services Medical Director’s Advisory Council
1680 Phoenix Boulevard, Suite 200
Atlanta, GA 30349
State of Georgia EMS oversight council
Member
1997-present

State Office of EMS and Trauma Emergency Medical Services Advisory Council
1680 Phoenix Boulevard, Suite 200
Atlanta, GA 30349
State of Georgia EMS oversight council
Member
2005-present

State Office of EMS and Trauma Emergency Medical Services for Children Advisory Council
1680 Phoenix Boulevard, Suite 200
Atlanta, GA 30349
State of Georgia EMS oversight council
Member
Chair 1995-1998
Member 2000-2002, 2007-present
Georgia College of Emergency Physicians  
6134 Poplar Bluff Circle, Suite 101  
Norcross, GA 30092  
ACEP state chapter  
Pediatric Taskforce (Chair) 1998-2018  
Board of Directors 2006-2018, ex-officio 2018-current

Anthem/WellPoint Physician’s Advisory Committee 2006-2016  
220 Virginia Avenue  
Indianapolis, IN 46204  
Court settlement advisory group, Neutral party member  
2006-2016
August 4, 2022

To the Council
ACEP 2022 Scientific Assembly San Francisco, California

The Georgia College of Emergency Physicians and the Section on Pediatric Emergency Medicine write to you today to highly recommend Jeffrey F. Linzer, MD, FACEP as a candidate for the national ACEP Board of Directors. As you will see from his Curriculum Vitae, Dr. Linzer has spent many years in leadership positions with the Georgia Chapter, has been a mentor to Section members, and has been involved with numerous national ACEP committees. He has worked tirelessly to support the mission of ACEP, the Section and GCEP.

Dr. Linzer’s energy and continued commitment to ACEP’s interests are outstanding and his leadership skills are impeccable. He has been involved in emergency services first in EMS and now as a leader in pediatric emergency medicine. He has worked collaboratively with other major medical societies and has represented ACEP’s interests with CMS and CDC/NCHS. His breadth of experiences will be of great asset to the College.

The leadership of the Georgia College of Emergency Physician and the Section on Pediatric Emergency Medicine wholeheartedly support the candidacy of Jeffrey F. Linzer, MD FACEP to the national ACEP Board of Directors.

Sincerely,

Tara M. Morrison, CAE, CMP
GCEP Executive Director

Tricia Swan, MD, M.ED, FAAP, FACEP
Chair, ACEP Pediatric Emergency Medicine Section
Dear Councillors and ACEP Colleagues,

It has been my privilege to work with such an outstanding group of physicians whose principal goal is support for the best care for patients in times of need as well as providing the safety net in our healthcare system when there is nowhere else to turn. While we may not always agree, the council allows us to have an honest and open debate in setting the goals of our College. In order to help bring these goals to fruition, I respectfully ask for your vote for the Board of Directors to help lead the implementation of your vision.

As we move into 2023, emergency physicians will be faced with a new documentation requirement. While already suffering from “clickitis” with the EHRs, I will bring to the Board my extensive experiences in dealing with coding and documentation to help lead the College in addressing these issues. I currently work with CMS and National Center for Healthcare Statistics, and previously worked with the World Health Organization, on coding issues. I am helping ACEP and another medical society to deal directly with Epic and its database provider to simplify and improve their coding interface. We must also continue our fight against payers who wrongly use diagnosis coding to down code the level of provided service and who try to take advantage of the No Surprise Act.

Our College needs to help simplify and streamline our practice and eliminate nuance and pointless frustration to ensure practice sustainability and fair compensation. We must stand-up to the unnecessary changes and details many institutions place on the physician so they have better statistics and reimbursement. We need to push back on the loss in productivity that these issues cause. As a good friend of mine said, “My hands were made for working with patients, not keyboarding.” As a member of the Board, I will use my expertise so that the EP can “work smarter, not harder” with simplified documentation, resulting in improvement in productivity and compensation.

Our College needs to continue its work in promoting care for our children. For 28 years I have helped prepare EM residents to provide the best care for this very vulnerable population. I have helped build a growing academic and clinical division into one of the leading pediatric emergency programs in the country. As an advocate for pediatrics with Georgia EMS, I have worked to improve pre-hospital care and safe transport. My ability as a consensus builder working with the College and other medical societies and healthcare agencies has helped pave the road to improved pediatric care. It is this expertise and perspective as a pediatric emergency physician that I will bring to the Board.

I will tirelessly work helping ensure workplace safety and violence prevention, and encouraging facilities to use ACEP policies to help reduce the risk of violence in the ED. The College needs to embrace information from its seminal Workforce Study of 2021, which for example, can help ensure that residencies are not just being developed as a source of inexpensive labor, but that they are providing high quality training preparing their trainees to provide care in a range of environments. We must also be the leader in developing sound policies and guidelines opposing arbitrary ones that adversely affect the EP practice.

I greatly appreciate the honor and the encouragement that I have received in becoming a candidate for the ACEP Board of Directors. I ask for your consideration and vote so that I may help lead our great organization into an exciting future.

Jeffrey F. Linzer Sr., MD, FACEP
Jeffrey F Linzer Sr., MD, FACEP

Vision
- A diverse workforce providing excellent emergency care
- Improved coverage in underserved areas
- Ensure practice sustainability and fair compensation
- Support of state chapters
- Improvements in EHR

Enthusiastically endorsed by The Georgia College of Emergency Physicians and the Section on Pediatric Emergency Medicine

<table>
<thead>
<tr>
<th>Service to the College</th>
<th>Service to the State</th>
<th>Experience</th>
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<tbody>
<tr>
<td>Member since 1998</td>
<td>Georgia College of Emergency Physician</td>
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<tr>
<td>Council since 2008</td>
<td>– Chair Pediatric Task Force</td>
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<tr>
<td>Current Member Committee on Nomenclature and Coding</td>
<td>– Board of Directors since 2006</td>
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<tr>
<td>ACEP Representative to ICD-10-CM/PCS Coordination and Maintenance Committee (CMS/NCHS)</td>
<td>– Member Nominating Committee</td>
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<td>Past Member, ACEP Council Steering Committee</td>
<td>State Appointed Member</td>
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<tr>
<td>Past Member Special Subcommittee for Billing Policy</td>
<td>– Georgia Emergency Medical Services Medical Director’s Advisory Council</td>
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<td>Past Member Reference Committees</td>
<td>– Emergency Medical Services Advisory Council</td>
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<td>– Developed Template for Pediatric Pre-Hospital Protocols</td>
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<td>– Chair of former Georgia Trauma System Development Committee Pre-Hospital Subcommittee</td>
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<td>– Member of former Georgia Altered Standards of Care Work Group</td>
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15 Years as EMS Provider
28 Years of Academic Practice at the only Level 1 stand alone Pediatric Trauma Center in Georgia
Division Medical Director for Compliance and Business Affairs
Division EMS Coordinator
Founding Member and former Co-Medical Director Sedation Service
Mentor to Fellows who are now in leadership and committee positions in ACEP and GCEP
Fellowships in Allergy-Immunology and PEM

Collaboration
- WHO
- CMS
- CDC
- NCHS
- AHRQ
- Specialty Medical Societies

Also, I’m the only candidate featured in a comic strip!
NAME: Jeffrey F. Linzer Sr., MD, FAAP, FACEP

OFFICE ADDRESS: Division of Pediatric Emergency Medicine
Children’s Healthcare of Atlanta
1405 Clifton Rd, NE
Atlanta, Georgia 30322
Tel: 404-785-7131
Fax: 404-785-7989

E-MAIL ADDRESS: jlinzer@emory.edu

CITIZENSHIP: USA

CURRENT TITLES AND AFFILIATIONS:

a. Academic appointments:

  Primary appointment:
  Professor of Pediatrics
  Emory University School of Medicine, Atlanta, Georgia
  Appointment effective September 1, 2014

  Secondary appointment:
  Professor of Emergency Medicine
  Emory University School of Medicine, Atlanta, Georgia
  April 2015–present

b. Clinical appointments:

  Attending Staff, Children’s Physician Group, Emory + Children’s Pediatric Institute
  (formerly Emergency Pediatric Group)
  Children’s Healthcare of Atlanta at Egleston, Atlanta, Georgia
  August 1994–present

  Attending Staff, Division of Pediatric Emergency Medicine
  Children’s Healthcare of Atlanta at Hughes Spalding, Atlanta, Georgia
  (Formerly Hughes Spalding Children’s Hospital/Grady Health System)
  August 1994–present

  Attending Staff, Children’s Sedation Service
  Children’s Healthcare of Atlanta at Egleston, Atlanta, Georgia
  September 2002–present

c. Other administrative appointments:

  Medical Director for Business Affairs and Compliance
  Department of Pediatrics
  Division of Pediatric Emergency Medicine
  Emory + Children’s Pediatric Institute, Children’s Healthcare of Atlanta
  May 2003–present
EMS/Pre-hospital Care Coordinator
Department of Pediatrics
Division of Pediatric Emergency Medicine
Emory University School of Medicine and
Emory + Children’s Pediatric Institute, Children’s Healthcare of Atlanta
September 1994-present

PREVIOUS ADMINISTRATIVE, ACADEMIC AND PROFESSIONAL APPOINTMENTS:

2012-2016 Lead Physician ICD-10-CM Transition Core Leadership Team
Children’s Healthcare of Atlanta

2003-2010 Co-Medical Director Children’s Sedation Service
Children’s Healthcare of Atlanta

1996-1999 Associate Medical Director Pediatric Emergency Care Center, Hughes Spalding
(site director) Children’s Hospital/Grady Health System, Atlanta, GA

2007-2014 Associate Professor Primary: Pediatrics, Secondary: Emergency Medicine

1994-2007 Assistant Professor Emory University School of Medicine, Atlanta, Georgia

1994-1996 Director Community Physician Outreach Education
Egleston Children’s Hospital, Atlanta, Georgia

1992-1994 Clinical Instructor (Pediatrics) University of Southern California School of Medicine,
Los Angeles, CA

1991-1994 Transport Physician Children’s Hospital Los Angeles, Los Angeles, CA

1989-1994 Pediatrician Department of Pediatrics, Kaiser Permanente Hospital,
Bellflower, CA

1989-1990 Urgent Care Pediatrician Harriman-Jones Intermed Care Center, Long Beach, CA

1988-1990 Transport Physician Children’s Hospital of Orange County, Orange, CA

1983-1986 Senior Paramedic Tuolumne County EMS, Sonora, CA

1983-1986 Senior Paramedic Doctor’s Ambulance, Modesto, CA

1979*1981 Director of Pre-Hospital Care Del Puerto Hospital-Patterson Hospital District
(California)

1978-1985 Flight Paramedic Mediflight of Northern California, Modesto CA

1976-1978 Training Supervisor Modesto-Ceres Ambulance/Mobile Life Support,
Modesto, CA

1976 Paramedic Santa-Ana-Tustin Community Hospital, Santa Ana, CA

1975-1976 Paramedic Dolphin-Medivac Ambulance, Pasadena, CA

LICENSURES/BOARDS:
California Physicians and Surgeons License 1988-present
DEA Registration 1988-present
ECFMG Registration (Fifth Pathway, ECFMG certificate exempt)  1986
FLEX
Georgia Physicians License  1994-present

SPECIALTY BOARDS:

American Board of Pediatrics  1991
Recertified  2006
Maintenance of Certification  deferred

ABP Sub-board in Pediatric Emergency Medicine  1996
Recertified  2020
Maintenance of Certification  current

EDUCATION:

1975  B.A. (with honors) University of California at Santa Barbara
1976  Mobile Intensive Care Paramedic Daniel Freeman Paramedic School
      Inglewood, CA
1978-1979 Graduate studies in biology and Chemistry University of the Pacific, Stockton, CA
1986  M.D. (diploma in medicine and surgery) Centro de Estudios Universitarios Xochicalco,
      School of Medicine
      Ensenada, Baja California, Mexico
1987  Fifth Pathway Certificate California College of Medicine, University of
      California, Irvine-Long Beach Memorial Medical Center Program

POSTGRADUATE TRAINING:

University of California, Irvine, Orange Resident, Pediatric  1987-1990
Children’s Hospital Los Angeles Los Angeles Fellow, Allergy-Clinical Immunology
      Dr. J. Church  1990-1992
Children’s Hospital Los Angeles Los Angeles Fellow, Pediatric Emergency and Transport Medicine
      Dr. N. Schoenfeld  1992-1994

EXECUTIVE AND LEADERSHIP TRAINING

Pediatric Executive Program Emory University School of Medicine  2005

COMMITTEE MEMBERSHIPS:

International:

World Health Organization
   ICD-11 Revision, Chair, Pediatric Topic Advisory Group  2010-2016

National:

American College of Allergy and Immunology
   Asthma and Respiratory Disease Committee  1990-1992
American Academy of Pediatrics
Section on Emergency Medicine
  RBRVS Committee 1993-2006
  Chair 1995-2006
  Committee on EMS-C 1993-2002
    Chair 1997-2000
  Liaison from the Committee on Coding and Nomenclature 2007-present
  Resource-Based Relative Value Scale (RBRVS) Project Advisory Committee 1995-1999
  Committee on Coding and Nomenclature 1999-present
    (Formerly the Committee on Coding and Reimbursement)
  Representative to the ICD-10-CM/PCS Editorial Advisory Board and ICD-10-CM Coordination and Maintenance Committee 1999-present
    (Formerly ICD-9-CM)

Maternal-Child Health Bureau White Paper Commission
EMS access for children 1997

American College of Emergency Physicians
  Coding and Nomenclature Advisory Committee 2003-present
    Work group chair for ICD-10-CM implementation 2009-2013
  Special Sub-committee for Billing Policy 2009
  Alternate Counselor 2008-2013
  Councilor 2014-present
  Member Reference Committee C Emergency Medicine Practice 2015
  Member Reference Committee B Advocacy & Public Policy 2017
  Member Steering Committee 2018, 2020

Anthem/WellPoint Physician’s Advisory Committee
Reimbursement subcommittee 2006-2016

Society for Pediatric Sedation
  Board of Directors 2007-2015
  Emergent Sedation Committee 2010-2018

National Quality Forum
  Expert Panel on Coding Maintenance 2009-2010

American Medical Association
  ICD-10-CM GEM Workgroup 2010

Society for Pediatric Sedation Quality Consensus Conference 2011

American Health Information Management Association 2012 ICD-10-CM Summit Program Advisory Council 2012

Agency for Healthcare Research and Quality
  Neonatal/Pediatric Workgroup ICD-10-CM/PCS Conversion 2012
    Pediatric Quality Indicators Time-Limited Workgroup 2016
  Noblis-CMS Physician Champion Community of Practice for ICD-10 2015
  US News and World Report
    Pediatric Gastroenterology/GI Surgery Survey Workgroup 2016-present

Regional and State:
California Rescue Paramedic Association Education Committee (Chair) 1980-1981

University of California Irvine Medical Center
Pediatric Residency Coordinating Committee 1988-1990

American Academy of Pediatrics
California Chapter, District 2 Committee on Emergency Medicine 1993-1994
Georgia Chapter Committee on Emergency Medicine 1996-2015
Coding & Compliance Committee (Liaison) 2003-present
Special Committee for DMA/Medicaid Services 2004-present

Georgia Department of Community Health
ICD-10 Unspecified Codes Physician Workgroup 2016-2017

Georgia Emergency Medical Services for Children Project
Interim Executive Committee 1994

Georgia EMS Region III Medical Control Committee 1995-2001

Georgia Emergency Medical Services for Children Advisory Council
Chair 1995-1998
Member 2000-2002, 2007-present

Georgia Emergency Medical Services Advisory Council
Liaison Member 1995-1998
Member 2005-present
Strategic Planning Workgroup 2019-present

Georgia Emergency Medical Services Medical Director’s Advisory Council
Developer of Pediatric Pre-hospital Guidelines 1998-present
Chair, Nominating Committee 2010, 2020
Member, Nominating Committee 2018-present
Scope of Practice Committee 2021

Georgia State Office of Emergency Medical Services and Trauma
Regulation Task Force 1996-1997
EMS and Trauma Reorganization Committee 1996
Georgia Trauma System Development Committee Chair Pre-hospital Subcommittee 2002-2005
Education and Testing Committee Meeting 2004
EMS Crisis Standard of Care Workgroup 2021

Georgia Department of Human Resources, Division of Public Health
Phase I Stakeholder’s Meeting, Planning for Shortages of Critical Healthcare Resources During Disasters 2008
Altered Standards of Care Work Group 2009

Georgia Medical Care Foundation PRO reviewer 1998-2015

Georgia College of Emergency Physicians
Pediatric Taskforce (Chair) 1998-present
Board of Directors 2006-2018
Alternate Counselor to ACEP Council 2008-2013
Counselor to ACEP Council (ex-officio BOD member) 2014-present
Nominating Committee 2014-present

Medical Association of Georgia, 2006
Physician Legislative Trauma Study Committee

Institutional:

Department of Pediatrics
Division of Emergency Medicine Physician Leadership Group 1995-present
Department Leadership Council (associate member) 1996-2019
(Formerly Division Directors Council)
EMCF Oversight Liaison 1999-present
Clinical Operations and Finance Committee 2006
EEC Finance Committee 2007
Divisional Coding and Compliance Team (lead) 2008-2009

Egleston Children’s Hospital
Sub-Committee
Egleston Pediatric Group Development Committee 1995-1996
Pharmacy and Therapeutics Committee 1995-1996
Olympic Steering Committee (Chair) 1995-1996
Asthma Care Path Committee 1995-1997
Asthma Center Committee 1995-1997
Trauma Committee Chair 1997-1998
EEC Flow and Function Committee 1997-1998

Children’s Healthcare of Atlanta
Trauma Committee 1998-2016
EEC Performance Improvement Team 1998-1999
Transport Advisory Council 1999-2002
Patient Care Policy Advisory Committee (Chair) 1999-2000
Vice-Service Chief, emergency medicine 2000-2001
Bioterrorism Task Force 2001-2002
EPG Electronic Tracking and Medical Record Development 2001-2002
Documentation Council 2001-2006
IBEX Physician Documentation Workgroup 2002-2009
Asthma Clinical Effectiveness Team Chair 2004-present
(Formerly Asthma Outpatient Guidelines Committee)
Mid-level Provider Billing for SRPAC 2004
Documentation Forms System Advisor 2006-present
Credentials Committee 2008-present
ED Coding Outsourcing Evaluation Committee 2010-2011
Epic ED Transition Group 2010-2011
Compliance Awareness and Education Subcommittee (Chair) 2013-2016
Operational Compliance Committee 2013-2018
Community Outreach Committee 2015-present

Hughes Spalding Children’s Hospital
PECC Operations Committee 1995-1998
PECC Department Head Committee 1995-1998
Multidisciplinary/QI Team 1996-1997
Pharmacy and Therapeutics Committee 1996-1999
Oversight Committee (formerly Medical Executive Committee) 1996-1999
Associate Medical Director, Pediatric Emergency Care Center 1996-1999
PAC-PECC Interface Committee 1997-1998
Hughes Spalding Emory Operations Group 1997-1998
PECC Operations Team Committee 1998-1999
Physician Leadership Group 1998-1999
EMCF/Pediatrics Liaison Committee 2000-2010

Grady Memorial Hospital Health Care System
Helicopter Planning Committee 1996
Hazardous Material/Decontamination Committee 1996
Disaster Planning Committee 1996
EMTALA Compliance Committee 1999
EMCF Physician Liaison Group 2000-2002

EDITORSHIPS AND EDITORIAL BOARDS:
Clinical Pediatric Emergency Medicine Editorial Board 1998-present
Coding Clinic for ICD-10-CM/PCS Editorial Advisory Board 1999-present
(formerly Coding Clinic for ICD-9-CM)
ED Coding Alert Editorial Advisory Board 2002-present
Pediatric Coding Alert Editorial Advisory Board 2002-2006
AAP Pediatric Coding Publications Editorial Board 2006-present
Pediatric Emergency Medicine Reports Editorial Board 2007-present

REVIEWER:
Manuscripts:
Annals of Emergency Medicine 2003-present
Trauma Reports 2004-present
Pediatric Emergency Medicine Reports 2005-present
The Cochrane Collaboration 2011-2012
Journal of Asthma 2012-present
American Pediatric Society 2012-present

Abstracts:
American Academy of Pediatrics Section on Emergency Medicine 2014
Pediatric Academic Societies 2011-2012, 2015-present

Examinations/Certifications:
American Academy of Professional Coders 2009
Certified Pediatrics Coder (CPEDC™) exam

HONORS AND AWARDS:
Outstanding Leadership, Trauma Committee, Egleston Children’s Hospital 1998
Emory School of Medicine Department of Family Medicine Teaching Award 2003
Dr. Zeb L. Burrell, Jr. Distinguished Service Award for Emergency Medical Service 2012
Emory School of Medicine Educator Appreciation Day Recognition 2021
SOCIETY MEMBERSHIPS:

American College of Asthma, Allergy and Immunology, Member 1990-2016
American Academy of Pediatrics, Fellow 1992-present
  Member, Sections on Emergency Medicine and Transport Medicine
American College of Emergency Physicians, Fellow 1998-present
  Member, Section on Pediatric Emergency Medicine
Medical Association of Georgia, Member 2006-2010
Society for Pediatric Sedation, Founding Member 2007-present
American Pediatric Society, Member 2012-present

RESEARCH FOCUS:

My current research includes evaluation of depression and medication adherence in asthmatic children, ability of EMS personnel to evaluate non-emergency conditions in children in the field and evaluation of pediatric emergency departments’ compliance with billing and coding guidelines.

Current projects (IRB approved)
  Principal Investigator:
  Multicenter prospective analysis of pediatric sedation practice: The Pediatric Sedation Research Consortium. CHOA IRB# 04-041
  The utilization of [ICD] E-codes for concussion patients and the potential impact on appropriate allocation of public health funding for injury prevention. CHOA IRB

Additional research experience
  Department of Environmental Studies, University of California, Santa Barbara
  Protoporphyrin synthesis project, heme synthesis investigation. 1978-1979
  Department of Chemistry, University of the Pacific
  Does theophylline improve pulmonary function when added to albuterol and methylprednisolone therapy in status asthmaticus? 1990-1991
  With Warren Richards, Childrens Hospital Los Angeles
  Orally administered intravenous immunoglobulin for chronic diarrhea in children with human immunodeficiency virus infection. 1991
  With Joseph A. Church, Childrens Hospital Los Angeles
  Project STAR (Support for Treatment of Asthma Research) 2001-2006
  Emory IRB (Funding: National Institute of Mental Health)
  With Marianne Celano, Emory University, Department of Psychiatry
  Rapid Anticonvulsant Medication Prior to Arrival Trial: RAMPART 2009-2012
  Emory IRB# AM4_IRB00011688 (Funding: National Institute of Neurological Disorders and Stroke)
  With David W. Wright, Emory University Department of Emergency Medicine
  Retrospective review of the efficacy and safety of deep sedation for cardiac MRI in children with congenital or acquired heart disease. 2010-2013
  CHOA IRB#10-164
  With Jana Stockwell, Emory University, Division of Pediatric Critical Care
  Evaluation of parental knowledge of asthma in emergency department 2011-2012
(ED) setting.
CHOA IRB# 11-139

GRANT SUPPORT:

Previous support:
Federally funded
1. U. S. D. O. T. Emergency Medical Services Grant, $20,000 1980
2. National Institute of Mental Health (R01 MH61726-01A1) 2001-2006
   Co-PI; 5 Year Renewable Amount of Funding: 3% of Emory salary
   P. I.: Marianne Celano, Ph.D.

CLINICAL SERVICE CONTRIBUTIONS:

Developed acute asthma management carepath for use at Egleston and Hughes Spalding EDs, pediatric trauma plan that is used at CHOA and is recommended for use by both Region 3 EMS and the State Office of EMS, and state pre-hospital (EMS) pediatric guidelines and protocols. Responsible for division billing and documentation compliance oversight.

FORMAL TEACHING:

a. Medical Student Teaching 1994-present
   Bedside teaching for M-3 and M-4 students on Pediatric and Emergency Medicine rotations
   Capstone lecture, Documentation Compliance 2015-present

b. Residency Programs 1994-present
   ESOM Resident Lecture series
   Seminar for graduating Pediatric residents
   Coding for the pediatrician 2005-present
   Resident Lecture series
   Common lower respiratory emergencies in children
   Evaluation and management of allergic emergencies
   The business of medicine
   Asthma management in the pediatric emergency department
   EMS service and communications: Towards a better understanding
   Heat related emergencies in children
   Documentation, coding and billing in the ED
   Documentation Basics for Junior Housestaff
   Basic diagnosis coding

Bedside teaching:
Pediatric, Emergency Medicine, Family Medicine and Transitional Residents

ESOM Pediatric Emergency Medicine Subspecialty Fellowship program:
Fellow lecture series
   EMS systems and communications: towards a better understanding
   Medical record documentation in the emergency department
   An overview of emergency medical services for children
   Documentation, coding and billing in the ED
   High dose albuterol in the pediatric emergency department
   Bronchiolitis and RSV
   EMTALA
   Emergency Medical Services: What it is and how we got there.
   Anaphylaxis

Bedside teaching:
Pediatric Emergency Medicine Fellows
Morehouse School of Medicine
Resident Lectures
- A review of allergic emergencies in children
- Documentation and coding basics
- Heat related emergencies in children
- Common lower respiratory emergencies

Bedside teaching
Pediatric Residents

c. Other

Advanced Cardiac Life Support, Provider 1986-present
Pediatric Advance Life Support, Instructor 1989-2020
Pediatric Advance Life Support, Provider 2020
Advanced Trauma Life Support, Provider 1993-present
Egleston Children's Hospital Division of Emergency Medicine 1994-1998
Community hospital outreach lecture series
- Fever without source in young children: Evaluation and management
- Emergency management of acute asthma in children

Paramedic Case Review Program 1995-1997
EMS Lecture Series 1995-present
- Prehospital management of acute asthma in children
- Respiratory emergencies in children

Children's Healthcare of Atlanta Community Outreach Program 2000-present
- Evaluation and management of allergic emergencies
- Common lower airway emergencies: Asthma and bronchiolitis
- Pediatric sedation

SUPERVISORY TEACHING:

Residency Program:
- Pediatric Emergency Medicine Subspecialty Resident Advisor
  James Parker, MD 2001-2004

Research Focus: Emergency Medicine Services, Child Safety
Published Manuscripts:


Published Abstracts:

National Presentations:
  Unpowered scooter injuries: Potential catastrophic consequences and a need for improved safety awareness.
  Platform presentation:
    MS-C National Meeting Dallas, 2002
  Poster Presentation:
Pediatric Academic Societies Annual Scientific Meeting, Baltimore, 2002
Society for Academic Emergency Medicine National Meeting, St. Louis, May 2001

Carmen Lebron, MD 2006-2007
Research Focus: Emergency Medicine Services
Regional Presentations:
  Cervical spine immobilization practice in a recently established emergency department in Tbilisi, Republic of Georgia.
Platform presentation:
  Southeastern Regional Society for Academic Emergency Medicine, Louisville, KY, March 2008

Kalpesh Patel, MD 2006-2007
Research Focus: Acute Management of Asthma/Bronchiolitis

Brian Costello, MD 2008-2011
Research Focus: ED Utilization
National Presentations:
  Evaluation of pediatric foreign body ingestion: Are nose-to-rectum radiographs routinely necessary?
Poster presentation:
  Pediatric Academic Societies, Annual Scientific Meeting, Vancouver, BC, 2010
Platform presentation:
  Society for Academic Emergency Medicine Annual Meeting, Phoenix, AZ, 2010

Jacob Beniflah, MD 2012-2015
Research Focus: Medical technology and advocacy
Published Manuscripts:
National Presentations:
  Poster presentation:
    Comparative assessment of a smartphone otoscope for the diagnosis and management of acute otitis media.
    American Academy of Pediatrics, National Conference and Exhibition, Orlando, FL, 2013
Platform presentation:
  Effects of immigration enforcement legislation on Hispanic pediatric patient visits to the pediatric emergency department.
  Pediatric Academic Society, Boston, MA, 2012

Tamar Robinson, MD 2014-2017
Research Focus: Health policy and quality improvement, Pediatric ED family education resource

Pallavi Ghuge, MD 2011-2012
Research Focus: ED Utilization

Doctoral Trainees Supervised
Doctoral Program in Maternal-Child Health
University of Alabama at Birmingham, School of Public Health
Chanda Mobley, MPH 2003-2005
(Dr Marianne Celano, Department of Psychiatry and Behavioral Sciences, primary supervisor)

Research Focus: Predictors of Morbidity, Adherence, and Psychosocial Risk Factors for Asthma in Low-Income African American Children

Published Abstracts:
- Predicting asthma symptoms in low-income children with persistent asthma: the role of medication adherence, depressive symptoms and behavior problems. J All Clin Immunol 2004;113(S):S100
- Predicting asthma morbidity at three month follow-up among low-income African American children with severe persistent asthma. J All Clin Immunol 2005;115(2)

National Presentations:
- Predicting Asthma Symptoms in Low-Income Children with Persistent Asthma: the Role of Medication Adherence, Depressive Symptoms and Behavior Problems.
  Platform presentation:
  Annual Meeting of the American Academy of Allergy, Asthma, and Immunology, San Francisco, 2004

Division
  Compliance orientation for new physician and APP staff
  Annual physician compliance review

MENTORSHIP
Junior faculty
- James Parker
- Taryn Renee Taylor
- Jacob Beniflah
- Constance Gong
- Carmen Sulton
- Lauren Middlebrooks
- Ruth Hwu

LECTURES, SEMINAR INVITATIONS, AND VISITING PROFESSORSHIPS:

1. Kaiser Permanente Hospital, Grand Rounds, Bellflower, CA 1991
   Management of Acute Exacerbations of Asthma in Children

2. Annual Paramedic Conference, City of Los Angeles 1992
   Field Management of Asthma in Children

3. Children’s Hospital, Los Angeles, Division of Emergency & Transport Medicine 1993
   Paramedic Tape Review: Pediatric Field Emergencies

4. Gold Coast Allergy Society, Santa Barbara, CA 1993
   Emergency Management of Asthma in Children

5. California Society for Respiratory Care Annual Meeting, Palm Desert, CA 1994
   Initial Assessment and Management of Pediatric Multisystem Trauma

6. EMS Symposium, Jekyll Island, GA 1995
   *What to Expect From Your Doctor if Your Child Has an Ear Infection*

8. Respiratory Care Conference, Atlanta, GA 1995
   *High Dose Albuterol in Acute Asthma in Children*

9. EMS Medical Director’s Annual Conference, Marietta, GA 1995
   *Rapid Sequence Intubation*

10. Egleston Children’s Hospital Festival Season Conference 1995
    *Office Management of Acute Asthma in Children*

11. Emory University School of Medicine Department of Emergency Medicine 1996
    *Grand Rounds*
    *Evaluation and Management of Allergic Emergencies*

12. DeKalb Medical Center Department of Pediatrics Decatur, GA 1996
    *Office Management of Acute Asthma in Children*

13. Injury Control and Pediatric Emergency Care Symposium, Columbus, GA 1996
    *An Overview of Emergency Medical Services for Children*

14. DeKalb Medical Center Conference on Summer Emergencies, Decatur, GA 1996
    *Heat Related Emergencies in Children*

15. Georgia Emergency Nurse’s Association, Atlanta 1996
    *Management of Acute Asthma in Children*

    *Fever Without Source in Young Children; Evaluation and Management of Acute Asthma in Children*

17. Egleston Children’s Hospital Grand Rounds 1996
    *Safety of Continuously Nebulized Undiluted Albuterol in Children with Severe Asthma*

18. Egleston Children’s Hospital Festival Season Conference, Atlanta 1996
    *Body Wars! Allergic Emergencies in Children*

19. Emory University School of Medicine Department of Emergency Medicine 1997
    *Grand Rounds*
    *Asthma Management in the Pediatric Emergency Department*

    *Evaluation and Management of Acute Allergic Emergencies*

    *Pediatric Prehospital Emergency Update*

22. Emory University School of Medicine Department of Emergency Medicine 1997
    *Grand Rounds*
    *Evaluation and Management of Acute Allergic Emergencies*

24. Emory University School of Medicine Department of Emergency Medicine Grand Rounds
   Documentation, coding and billing in the ED
   1998

25. Georgia EMS Medical Director’s Conference (Conference Director), Atlanta Panel Discussion (chair): Field Radio Communications with the Hospital
   1998

26. Pediatric Emergency Medicine Conference, Atlanta
   EMTALA and the Pediatric Patient
   Heat-Related Emergencies in Children
   1999

27. EMS Conference: Critical Illness and Injury of the Pediatric Patient, Atlanta
   Respiratory Emergencies, CPR and Intubation
   1999

28. Emory University School of Medicine Department of Emergency Medicine Grand Rounds
   ED Documentation and Billing: Survival Strategies for the Future
   1999

29. EMS workshop, Atlanta
   An Overview: The Pediatric Patient and EMS
   1999

30. Georgia EMS Medical Director’s Conference, (Conference Director) Atlanta Panel discussion (chair): Pediatric Trauma Guidelines
   1999

31. Children’s Healthcare of Atlanta at Scottish Rite, Starkids EMS Conference
   Pediatric Specialty Technologies: GI/GU Devices
   2000

32. Methodist LeBonheur Healthcare Germantown Hospital, Germantown, TN
   Allergic Emergencies in Children
   2000

33. LeBonheur Children’s Medical Center Grand Rounds, Memphis
   The Business of Medicine
   Ethics of Billing for Medical Services
   2000

34. Hughes Spalding Children’s Hospital, Department of General Pediatrics
   Workshop Series April 26, May 24 and June 28, Atlanta, GA
   Review of Billing and Coding in Pediatric Outpatient and Inpatient Services
   2000

35. Test 2000 Conference, Columbus, GA
   Triage and Transport of the Pediatric Patient
   2000

36. Georgia EMS Medical Director’s Conference (Conference Director), Atlanta
   2000

37. Emory University School of Medicine Department of Emergency Medicine Grand Rounds
   Documentation, Coding and Billing in the ED
   2001

38. Georgia EMS Region 3 EMS Conference, Atlanta
   An Overview: The Pediatric Patient and EMS
   2001

39. Children’s Healthcare of Atlanta at Scottish Rite Atlanta
   Billing & Coding for the Pediatric Hospitalist
   2001
40. Georgia EMS Medical Director’s Conference (Conference Director), Atlanta 2001


42. Medical College of Georgia, Department of Emergency Medicine Grand Rounds Documentation, Coding and Billing in the ED 2001

43. Emory University School of Medicine, Department of Emergency Medicine Grand Rounds Evaluation and Management of Acute Allergic Emergencies 2001

44. Children’s Healthcare of Atlanta Outreach Lecture, Marietta Evaluation and Management of Allergic Emergencies 2002

45. American Academy of Professional Coders, Greater Atlanta Chapter, Atlanta Diagnostic Coding for the ED: A Physician’s Perspective 2002

46. Children’s Healthcare of Atlanta Intermediate Care Services Outpatient Coding Basics 2002

47. Emory University School of Medicine, Department of Emergency Medicine Ground Rounds Asthma Management in Children in the Emergency Department 2002

48. Kosair Children’s Hospital, Louisville, KY, Division of Emergency Medicine Fellow’s Conference Evaluation and Management of Acute Allergic Emergencies 2002

49. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Sea Island, GA Effective Use of ICD-9 Codes in Your Practice 2003

50. Emory University School of Medicine, Division of General Pediatrics-Egleston Documentation and Coding for the Hospitalist 2004

51. Changes 2004, Georgia Association of EMS, Augusta, GA Triage and Transport of the Pediatric Patient 2004

52. Georgia College of Emergency Physicians annual conference, Hilton Head, SC Heat Related Emergencies in Children Pediatric Case Reviews 2004

53. American Academy of Professional Coders, Greater Atlanta Chapter, Atlanta, GA E&M – Ask the Expert 2004

54. Emory University School of Medicine Department of Emergency Medicine Grand Rounds Evaluation and Management of Allergic Emergencies 2005

55. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Sea Island, GA Right Coding: How It Can Affect Your Bottom Line 2005
56. American Academy of Pediatrics, Georgia Chapter, Pediatrics on Peachtree, Atlanta, GA
    Coding for Procedures
    The Basics in CPT and ICD-9 Coding and Documentation

57. Rockdale Medical Center, Department of Pediatrics, Conyers, GA
    Common Lower Airway Emergencies: Asthma and Bronchiolitis

58. Children’s Healthcare of Atlanta at Scottish Rite, Atlanta
    Billing & Coding for the Pediatric Hospitalist

59. Changes 2006, Georgia EMS Medical Director’s Workshop, Augusta, GA
    EMS Pediatric Update: 2006

60. Emory University School of Medicine Department of Emergency Medicine
    Grand Rounds
    Acute Lower Airway Emergencies: Asthma and Bronchiolitis

61. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Sea Island, GA
    Coding for Developmental Services
    Basics in CPT and ICD
    Coding for Procedures

62. American Academy of Pediatrics, Georgia Chapter, Pediatrics on the Parkway, Atlanta, GA
    Odds and Ends – Special Services Codes and Modifiers: What Your Practice Should Know
    What’s New for 2007: CPT & ICD

63. Children’s Healthcare of Atlanta at Egleston Grand Rounds
    Common Lower Airway Emergencies: Asthma and Bronchiolitis

64. Georgia EMS Medical Director’s Conference, Augusta, GA
    Pediatric Pearls

65. Columbus Regional Medical Center, Department of Pediatrics Grand Rounds
    Common Lower Airway Emergencies: Asthma and Bronchiolitis

66. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Sea Island, GA
    Basics in E&M and ICD Coding and Documentation
    Financing the Medical Home – Part Two: Coding for Procedures and Special Services
    Interactive Session: You Be the Coder!

67. American Academy of Pediatrics, Georgia Chapter, Pediatrics Just Off Peachtree, Atlanta, GA
    Pediatric Coding Seminar

68. Hamilton Medical Center, Dalton GA
    Children’s Healthcare of Atlanta Outreach Program
    Common Lower Respiratory Emergencies in Children

69. Children’s Healthcare of Atlanta at Hughes Spalding, Provider Coding Coding Workshop, Atlanta GA
    2007
Review of Billing and Coding in Pediatric Outpatient Services

70. Changes 2008, Georgia Association of EMS, Augusta, GA  
Common Pediatric Respiratory Emergencies  
2008

71. Medical College of Georgia, Department of Emergency Medicine Seminar  
Documentation, Coding and Billing in the ED  
2008

72. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL  
You Are the Coder  
2008

73. Emory University School of Medicine Department of Emergency Medicine Grand Rounds  
Common Lower Respiratory Emergencies in Children  
2008

74. American Academy of Pediatrics, Georgia Chapter, Pediatrics On the Parkway Atlanta, GA  
Keeping Up with the Pediatric Coding Race: A Review of Code Changes for 2009  
Common Lower Respiratory Emergencies in Children  
2008

75. Emory University School of Medicine Department of Pediatrics Pediatric Executive Program  
Basics for Documentation and Coding  
2009

76. Changes 2009, Georgia Association of EMS, Augusta, GA  
Medical Director’s Workshop  
Pediatric Pearls  
2009

77. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL  
2009 CPT & ICD-9 CM Changes: Your Mid-year Check-up  
Hot Coding Topics  
Top Ten Mistakes & Misunderstandings in Coding  
2009

78. Georgia College of Emergency Physicians, Mid-Georgia Meeting, Milledgeville, GA  
Pediatric Sedation  
2009

79. American Academy of Pediatrics, Georgia Chapter, Pediatrics On the Parkway Atlanta, GA  
Keeping Up with the Pediatric Coding Race: A Review of Changes for 2010  
Coding for Topics at Pediatrics on the Parkway  
2009

80. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL  
2010 CPT & ICD-9-CM Changes: Your Mid-Year Check-up  
Those Questions That Are Asked Over and Over Again! Your Questions, Our Answers  
2010

81. American Academy of Pediatrics, Georgia Chapter, Pediatrics On the Perimeter Atlanta, GA  
Keeping Up with the Coding Race: A Review of Changes for 2011  
Coding Topics at Pediatrics on the Perimeter  
2010
82. Emory University School of Medicine Department of Pediatrics  
   *Documentation Basics*  
   2010

83. Emory University School of Medicine Department of Pediatrics  
   Pediatric Executive Program  
   *Basics for Documentation and Coding*  
   2011

84. Emory University School of Medicine Department of Pediatrics  
   *Documentation Basics for Junior Housestaff*  
   2011

85. Children’s Healthcare of Atlanta at Scottish Rite, Atlanta  
   *Billing & Coding for the Pediatric Hospitalist*  
   2011

86. Georgia College of Emergency Physicians annual conference, Hilton Head, SC  
   *Pediatric Trauma: Do You Really Need All Those Tests?*  
   2011

87. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL  
   *2011 CPT Changes: Get Every Penny You Deserve! Transitioning from ICD-9 to ICD-10: Expanding Pediatric Diagnoses Will Still Help Your Bottom Line  
   Top 10 Coding Mistakes: Maximizing Your Profits and Documentation*  
   2011

88. Connecticut Children's Medical Center, Department of Emergency Medicine, Hartford, CT  
   *Seminar on Documentation and Compliance*  
   2011

89. American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL  
   *ICD-10-CM: Preparing Your Practice for the Big Transition*  
   2012

90. Children's Mercy Health Network, Kansas City, MO  
   *ICD: What Is It And How ICD-10-CM Can Help Your Bottom Line While Preparing For The Transition To ICD-10-CM  
   ICD: Preparing Your Practice For The Transition To ICD-10-CM*  
   2012

91. Healthcare Information and Management Systems (HIMSS)  
   *ICD-10 Needs Assessment for Providers (podcast)*  
   2012

92. Georgia College of Emergency Physicians Leadership and Medical Director’s Forum, Reynolds Plantation, GA  
   *EHR and the ED (panel discussion)*  
   2012

93. Emory University School of Medicine Department of Emergency Medicine  
   Grand Rounds  
   *Pediatric Respiratory Emergencies*  
   2013

94. Emory University School of Medicine Department of Pediatrics  
   Pediatric Executive Program  
   *Coding 101 & the Revenue Cycle*  
   2013

95. Children’s Healthcare of Atlanta, New Horizons Conference, Atlanta, GA  
   *ICD: What Is It And How ICD-10-CM Can Help Your Bottom Line*  
   2013

96. Georgia Pediatric Practice Managers Association spring meeting,  
   2013
<table>
<thead>
<tr>
<th>No.</th>
<th>Event Description</th>
<th>Location</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>97.</td>
<td>American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Atlanta, GA</td>
<td>Atlanta, GA</td>
<td>2013</td>
</tr>
<tr>
<td>98.</td>
<td>Children’s Healthcare of Atlanta (system), Atlanta, GA</td>
<td>Atlanta, GA</td>
<td>2013</td>
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<tr>
<td>100.</td>
<td>American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL</td>
<td>Amelia Island, FL</td>
<td>2014</td>
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<tr>
<td>102.</td>
<td>Nationwide Children’s Hospital Regional Affiliate Summit, Columbus, OH</td>
<td>Columbus, OH</td>
<td>2014</td>
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<tr>
<td>103.</td>
<td>American Academy of Pediatrics, Georgia Chapter, Pediatrics by the Sea, Amelia Island, FL</td>
<td>Amelia Island, FL</td>
<td>2015</td>
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<td>105.</td>
<td>Children’s Healthcare of Atlanta, New Horizons Conference, Atlanta, GA</td>
<td>Atlanta, GA</td>
<td>2018</td>
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<td>106.</td>
<td>McGovern School of Medicine, Department of Pediatrics, Houston, TX, Grand Rounds</td>
<td>Houston, TX</td>
<td>2019</td>
</tr>
</tbody>
</table>

**INVITATIONS TO NATIONAL OR INTERNATIONAL CONFERENCES:**

1. American Academy of Pediatrics Section on Transport Medicine Workshop  
   *Baby Sick Come Quick*  
   1992-1993

2. Southwest Virginia Pediatric Conference, Abingdon, VA  
   *Life Threatening Respiratory Emergencies in Children*  
   *Evaluation and Management of Acute Allergic Conditions*  
   1995

3. American Health Consultants' Pediatric Emergency Medicine Conference, Laguna Beach, CA  
   *Evaluation and Management of Acute Allergic Emergencies*  
   1997

4. National Congress on Childhood Emergencies, Washington, DC  
   1998
Acute Management of Asthma in Children

5. American Academy of Pediatrics annual meeting, San Francisco, CA Section of Emergency Medicine  
   ED Documentation and Billing: Survival Strategies for the Future  
   1998

6. Pediatric Emergency Medicine Conference, Park City, UT  
   COBRA and EMTALA in PEM  
   Cases in Pediatric Emergency Medicine  
   Sickle Cell Emergencies  
   2000

7. American Academy of Pediatrics, Section on Adolescent Medicine  
   Executive Committee, Charlotte, SC  
   Billing and Coding for Adolescent Medicine  
   2000

8. American Health Information Management Association, Society for Clinical Coding, Annual Convention, Chicago, IL  
   Diagnostic Coding for the ED: A Physician’s Perspective  
   2000

9. American Academy of Pediatrics annual meeting, San Francisco, CA Section of Emergency Medicine  
   EMTALA and the Pediatric Patient  
   2001

10. American Academy of Pediatrics annual meeting, Boston, MA  
    Coding 101  
    2002

11. American Academy of Pediatrics Coding Workshop, Williamsburg, VA  
    Coding for Specialist: Inpatient and Hospital Issues  
    The Special Needs of the Specialist  
    The Consulting Conundrum  
    2002

12. American Academy of Pediatrics annual meeting, New Orleans, LA  
    Coding 101  
    2003

13. The Coding Institute, Pediatric Practices Teleconference  
    Important Child Abuse Reporting Do’s and Don’ts  
    2004

    Coding 101  
    2004

15. American Academy of Pediatrics Coding Workshop, Williamsburg, VA  
    Coding 101: The Basics  
    Essentials of Coding and Documentation  
    The Efficiency Factor: Using Office Tools to Improve Coding and Billing Accuracy  
    Testing Your Coding Skills  
    2004

16. American Academy of Pediatrics annual meeting, Washington, DC  
    Advanced Coding: Teaching Old Dogs New Tricks  
    2005

17. American Academy of Pediatrics Coding and Management in Pediatric Practice Workshop, Newark, NJ  
    The Efficiency Factor: Using Office Tools to Improve Coding and Billing Accuracy  
    Simplifying Compliance Complexities  
    Challenges in Coding: Testing your skills  
    2005
30 Tips in 30 Minutes: Faculty Panel

18. Decision Health Teleconference
   Office Procedures for Pediatrics: Don't Lose Out On Missed Billing Opportunities
   2005

19. The Coding Institute, Pediatric and OBGYN Coding and Reimbursement Conference, Naples, FL
   Pediatric Power Coding Comprehensive A to Z
   Thirty Coding/Pay-up Tips in Sixty Minutes (panel discussion moderator)
   2006

20. American Academy of Pediatrics annual meeting, Atlanta, GA
   Moderator, Section on Emergency Medicine, Abstract Session II
   Advanced Coding: Teaching Old Dogs New Tricks
   Course on Pediatric and Neonatal Critical Care Transport Medicine,
   Panel: How Will Changes in Medicaid Reimbursement Affect Transport Teams?
   2006

   Coding 201
   2007

22. The Coding Institute, Emergency Medicine Coding & Reimbursement Conference, Denver, CO
   ED Coding Nuts & Bolts: Making Sure the Things You Do Every Day Get Paid
   Foreign Body Removal vs. I&D: They're More Alike Then You Think
   ED Services for the Crayola Set: How to Keep the Red Off Your Pediatric Claims
   2008

23. American Hospital Association, Webinar
   Pediatric Coding Challenges: A Physician Perspective for Coders
   2008

   Emergency Department Coding: A Physician Perspective
   2008

25. Centers for Medicare and Medicaid Services, Teleconference
   ICD-10-CM Overview
   2008

26. Society for Pediatric Sedation, Fourth International Multidisciplinary Conference on Pediatric Sedation, Philadelphia, PA
   Billing and Reimbursement: What Works
   2009

27. The Coding Institute, Emergency Medicine Coding & Reimbursement Conference, Orlando, FL
   Take the Confusion out of Diagnosis Coding
   Common ED Procedures
   Wound Care Coding
   2009

28. American Academy of Pediatrics annual meeting, Washington, DC
   ICD-9-CM Diagnoses: Translates Into Income
   2009

29. Society for Pediatric Sedation, Fifth International Multidisciplinary Conference on Pediatric Sedation, Louisville, KY
   Sedation for Cardiac MRI
   2010

30. American Academy of Pediatrics annual meeting, San Francisco, CA
   2010
How ICD-9 Can Help Your Bottom Line
Coding 201: Teaching Old Dogs New Tricks

31. The Coding Institute, Coding Update and Reimbursement Conference, Orlando, FL
   Updating Your Superbills with the New 2011 CPT and ICD-9 Codes
   ICD-10: Prep Your Pediatric Practice for the Basics Now
   ICD-10: Map Out Your Top Code Transition Strategy Now

32. Pediatric Academic Societies and Asian Society For Pediatric Research
   Joint Meeting, Denver, CO
   ICD-11 Pediatric Topic Advisory Group

33. Society for Pediatric Sedation Conference, Minneapolis, MN
   Sedating the Child with Congenital Heart Disease - Practical Tips for Screening and Management

34. American Academy of Pediatrics annual meeting, Boston, MA
   Coding 201: Teaching Old Dogs New Tricks

35. American Academy of Pediatrics, Webinar
   Preparing Your Practice for the Transition to ICD-10

36. American Health Information Management Association ICD-10 Summit
   Baltimore, MD
   Reflections of 2012 ICD-10 Summit Reactor Panel

37. Academic Pediatric Association Pediatric Hospital Medicine 2012
   Covington, KY
   Preparing for ICD-10-CM: What The Hospitalist Needs To Know

38. American Academy of Pediatrics annual meeting, New Orleans, LA
   ICD-10-CM in Emergency Medicine: What You Need To Know
   Preparing for ICD-10-CM (Plenary session)

39. American Academy of Dermatology annual meeting, Miami Beach, FL
   Preparing For ICD-10-CM

40. National Association of Pediatric Nurse Practitioners annual meeting, Orlando, FL
   Billing and Coding Basics in Pediatric Practice for the Primary Care Practitioner

41. American Academy of Pediatrics, Webinar
   ICD-10-CM: Postponed, Not Canceled!

42. American Hospital Association, Webinar
   ICD-10: The Implications for Physicians

43. American Academy of Pediatrics annual meeting, Orlando, FL
   Implementing ICD-10-CM Into Your Practice
   Coding 201: Teaching Old Dogs New Tricks

44. American Academy of Pediatrics, Webinar
   Transitioning to ICD-10 Part 1
45. National Association of Pediatric Nurse Practitioners annual meeting, Boston, MA  
   The Alphabet of Billing and Coding in Pediatrics: From CPT to ICD  
   2014

46. American Academy of Pediatrics, Webinar  
   Transitioning to ICD-10 Part 2  
   2014

47. Society for Pediatric Sedation Conference, Charleston, SC  
   Sedation Billing and Reimbursement  
   2014

48. American Academy of Pediatrics annual meeting, San Diego, CA  
   ICD-10-CM Is More Than A Four Letter Word  
   2014

49. Society for Pediatric Sedation Conference, St. Louis, MO  
   Billing and Coding for Professional Sedation Services  
   2015

50. National Association of Pediatric Nurse Practitioners annual meeting, Atlanta, GA  
   Coding for Inpatient-Provided Services  
   2016

51. International Conference in Pediatric Emergency Medicine, Riyadh, Saudi Arabia  
   Procedural Sedation and Analgesia  
   Patient Satisfaction and Patient Rights in the ED  
   Upper Airway Emergencies  
   Steroids in Bronchiolitis (panel discussion)  
   MDI vs. Nebulizer in the ED (panel discussion)  
   Chest X-ray in A-B-C (Asthma, Bronchiolitis and Croup) (panel discussion)  
   Cast vs. Splint in Fractures (panel discussion)  
   Wound Management (workshop)  
   2016

52. American Academy of Pediatrics annual meeting, San Francisco, CA  
   ICD 10-CM: The Horse IS Out of the Barn!  
   2016

53. American Academy of Pediatrics annual meeting, Chicago, IL  
   ICD 10-CM: The Horse IS Out of the Barn!  
   2017

54. Society for Pediatric Sedation Conference, Atlanta, GA  
   Regulatory Readiness (Plenary Session)  
   2018

55. Academic Pediatric Association Pediatric Hospital Medicine 2018, Atlanta, GA  
   Observation vs. Inpatient: Coding 101  
   2018

OTHER ACTIVITIES:

Abstracts presented at national meetings

   Hormone Secretion in Adolescents with Type I Diabetes Mellitus. Society for  
   Pediatric Research/American Pediatric Society Annual Meeting, New Orleans,  
   Louisiana, April 1991.

   Responses To Growth Hormone Releasing Factor in Adolescents with Type I  
   Diabetes Mellitus - Failure of Growth Hormone Suppression During Hyperglycemia


Site Reviews:
Department of Emergency Medicine, Medical College of Georgia, Augusta GA
Division of Emergency Medicine, Kosair Children’s Hospital, Louisville, KY
Department of Pediatrics, Columbus Regional Medical Center,
(now Piedmont Columbus Regional), Columbus GA
Department of Pediatrics, University of Texas Health Science Center at Houston

Congressional Appearances:
Capitol Hill Briefing with the Coalition for ICD-10, Washington, DC, 2014

Media Appearances:
American Academy of Allergy and Immunology Annual Meeting
Orlando, Florida 1992

Community Activities:
Member, Testerazo Community Clinic Project, Testerazo, Baja California, 1985
Volunteer Physician, Asthma Summer Camp, Los Angeles Chapter,
Asthma and Allergy Foundation of America, 1989
Assistant Scout Master, Boy Scout Troop 65, Long Beach Council,
Long Beach, California, 1992-94
EMS provider search committee Fulton County (Atlanta), 1995
Medical Provider, Peachtree Roadrace, Atlanta, 1995
Atlanta Committee for the Olympic Games EMS Sub-committee, 1995-96
Medical Director, De Kalb International Choral Festival, 1995-97
Troop Committee Secretary and Assistant Scout Master, Boy Scout Troop 175, Atlanta
Council, Decatur, Georgia, 1995-12
National Jamboree Troop Committee Chair, Boy Scout Troop 1708, Atlanta Council,
1996-97
Medical Officer, National Boy Scout Jamboree, 1997
President’s physician while visiting
Pack Committee Chair, Cub Scout Pack 528, Atlanta Council, 2000-05

BIBLIOGRAPHY:

Published and accepted articles in refereed journals:


Book chapters:


Other publications:


Abstracts:


2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Kristin Bond McCabe-Kline, MD, FACEP

**Question #1:** What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?

Ensuring patients have access to emergency physicians 24/7/365 has always been a fundamental premise of the College. ACEP’s strategy regarding workforce, scope of practice, and sustainability has been developed with the patient at the center of the conversation. The challenge of workforce has led to many crucial conversations over the last two years during which time we have seen circumstances that many emergency physicians never thought possible.

ACEP has taken an evidence-based approach to the issue of workforce leveraging analysis of recent data as well as historical trends to engage members across our specialty to work toward solutions that will improve our practices and benefit our patients. As emergency medicine has evolved, the revision of emergency medicine training programs to include greater exposure to specific areas of practice and refine expectations for procedural competency were inevitable. ACEP has taken a proactive approach to addressing potential revisions to emergency medicine training relying on facts to direct this important work for our medical students, residents, and fellows. The geographical mismatch of emergency medicine board certified physicians in urban vs. rural areas is another key component of the workforce conversation. ACEP’s strategy to change paradigms around the practice of emergency medicine occurring in any setting where acute unscheduled care is delivered rather than simply within the four walls of emergency departments will be key to improving access in historically hard to penetrate areas.

Similarly, scope of practice is an essential part of the workforce conversation and ACEP has again taken an evidence-based approach to addressing scope of practice. ACEP acknowledges that the incorporation of physician assistants and nurse practitioners into the practice of emergency medicine has the potential to benefit emergency medicine physicians and our patients. However, the value of preserving the role of the emergency physician as the leader for the clinical care team must be demonstrated by leveraging data surrounding emergency physician utilization of resources and clinical outcomes translating into lower cost/higher quality of care for our patients.

When addressing the sustainability of the College, the question is primarily one of relevancy. ACEP’s strategic plan was crafted with incredible inclusion, wisdom, and commitment to address the needs of our members and the patients we serve. The College will continue to grow and learn as we have for the last fifty years by adjusting to the changing landscape of emergency physicians’ mental, physical, emotional, and spiritual health as well as the increasingly complex health care system our patients are expected to navigate. Just as there will always be a need for emergency physicians, there will always be a need for a collective voice of emergency physicians. The sustainability of the College has always been a directive as we strive to be relevant to our members by meeting their needs, advocating for them and their patients, as well as creating new opportunities to learn and grow as individuals in a greater community of emergency physicians.

**Question #2:** Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?

Every element of ACEP’s well thought out strategic plan is key to serving our members and specialty. Rather than selecting only two topics, I would like to amalgamate these five issues that comprise the strategic plan into two top priorities to be addressed: 1) the future of emergency medicine and 2) the culture of emergency medicine.

Emergency medicine is a specialty that emerged when selfless and brave physicians dedicated their careers to patients with unmet needs who had been relegated to backdoors and basements. The infrastructure of the health care system as it existed at that time was unable to accommodate patients outside of regular business hours and the rigid paradigms of the time. Without a secured path forward, the founders of our specialty blazed a trail under harsh conditions to emerge as the true safety net for patients; the most trusted and depended upon specialty in the house of medicine.

On a grand scale, emergency physicians have transformed emergency departments into the front doors of hospitals and key access points throughout the community via free standing sites. On a granular level, emergency physicians have done basic things like tape tongue depressors together to create nose clamps and sophisticated things like leveraging ultrasound equipment...
we observed being utilized by others to expedite our ability to provide patients with immediate results while they remain under our constant care. The strategic plan item of **Innovation** is essential to the **future of emergency medicine.** As emergency physicians, we are well positioned to identify the gaps in care where the system has failed our patients, embrace opportunities to better meet their needs as our patients become increasingly complex, and reimagine the delivery of our unique skillset in service to our patients.

We find ourselves on this journey at the very same time that health care is shifting from a fee for service/transactional model to a population health/outcomes-based model. The manner in which care is compensated and the way in which quality of care is measured are critical to our specialty, making **Advocacy** essential to the **future of emergency medicine.** ACEP must be at the table, leading discussions around reimbursement models, speaking to the value of the care we provide, and helping to develop metrics that support evidence-based practices that translate into the best possible outcomes for our patients. **Advocacy** on behalf of our members is key to preserving our reputation as fierce patient advocates as these efforts ultimately support access to emergency medicine board certified physicians.

In order to aggressively pursue the best **future of emergency medicine,** we must foster a healthy **culture of emergency medicine.**

As emergency physicians, we are subjected to the harshest of circumstances and held to the highest of standards. This reality can undermine even the most resilient emergency physicians. While providing individual resources for emergency physicians to foster wellness, ACEP must step up to provide solutions for systems level issues that undermine the positive mindset, physical health, and connectivity to others necessary for emergency physicians to thrive. The strategic plan item of **Career Fulfillment** focused emergency physicians feeling appreciated, free to explore a variety of career options based on constraints of their circumstances that shift throughout their careers, and fully supported when things are less than ideal, is essential to building and maintaining a healthy **culture of emergency medicine.** Providing opportunities for **Career Fulfillment** should highlight diversity as ACEP has members with a variety of interests, pursuits, backgrounds, and practice environments. Personal acknowledgement of the value of every individual member of ACEP, the milestones of our careers, and opportunities for growth and mentorship as part of a greater community of emergency physicians are outlined in the **Engagement and Trust** item of the strategic plan. When emergency physicians engage with one another in meaningful College activities, there is a level of mutual support that is unparalleled in other emergency medicine forums making ACEP a vital force for resiliency, healing, and wellness for emergency physicians.

Both the **future of emergency medicine** and the **culture of emergency medicine** cannot be optimized without appropriate infrastructure making **Resources and Accountability** an essential component of addressing all other areas of the strategic plan. The data driven approach the College is taking to address the **future of emergency medicine** requires project management and analytics resources. There are also resources needed to ensure the infrastructure to support the **culture of emergency medicine** is sufficient to provide busy emergency physicians with the access and communication tools and platforms to keep us connected.

The **future of emergency medicine** is bright with innovation and advocacy efforts that highlight the importance of the value and contribution of emergency physicians in service to our patients. The **culture of emergency medicine** is being restored as we learn to address systems level issues that affect us collectively and individually, care for ourselves and one another, and discover opportunities for growth on our journeys as emergency medicine physicians.

**Question #3: What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?**

Rather than ranking the many potentially divisive issues amongst emergency medicine physicians, the more important question would be, “What are we doing to create a collaborative culture within the College that fosters a greater sense of trust?” The lack of connectivity emergency physicians experienced during the COVID-19 pandemic created isolation that further depersonalized many of our interactions and fostered a binary approach to many sensitive conversations that had historically been more nuanced. When emergency medicine physicians focus on the things that divide us with ultimatums, we lose sight of our synergistic ability to accomplish great things together despite differing points of view. The understanding that we are all well intentioned, doing our best to serve our patients, communities, and one another, is the most essential rule of engagement for our growth and progress as emergency medicine physicians who are part of the College. Divisive issues do not have the power to divide emergency physicians when the culture supports diversity, inclusion, and tolerance. Addressing the issue of culture will allow the College to address any divisive issue facing emergency physicians with temperance.
CANDIDATE DATA SHEET

Kristin Bond McCabe-Kline, MD, FACEP

Contact Information
91 Island Estates Parkway
Palm Coast, FL
32137

Mobile Phone: (386) 283-2326
E-Mail: kmccabemd@gmail.com

Current(*) and Past Professional Position(s)
*VP/Chief Medical Information Officer, AdventHealth Central Florida Division
*EMS Medical Director, Flagler County/City of Palm Coast/City of Flagler Beach
*Chief Medical Officer, WaterSafe
*Medical Director, Flagler Technical College EMT Training Program
*Medical Director, AllCare Medical Transport
Vice President/Regional Operations Coordinator/Shareholder, Emergency Medicine Professionals
Regional Market Medical Director, AdventHealth Central Florida Division North Region
Chief of Staff, AdventHealth Palm Coast
Interim Department of Medicine Chair, AdventHealth Palm Coast
Medical Director, AdventHealth Palm Coast
Medical Director, AdventHealth New Smyrna Beach
Medical Director, 2010-2014, Stroke Program, Bert Fish Medical Center
Medical Director, Stuart F. Meyer Hospice House
Associate Medical Director, Greenville Health System Behavioral Annex (Psychiatric Hold Unit)
Shareholder, Carolina Emergency Medicine Physicians Association

Education (include internships and residency information)
Advocate Christ Medical Center Emergency Medicine Residency Program
Program Director: Robert Harwood, M.D.

M.D. University of Texas Medical School, San Antonio, Texas, 1998-2002
Top 20% of Graduating Class

B.A. Rice University, Houston, Texas, 1994-96 (Major: English)
Rice University President’s Honor Roll
University of Michigan, Ann Arbor, Michigan, 1992-94, 1996
University of Michigan Class Honors

Harvard University, Cambridge, Massachusetts, Summer 1993

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM Subspecialty Certified in EMS 2021
ABEM Specialty Certified in 2007 and recertified in 2017

Professional Societies
ACEP
FCEP
FAEMSMD
National ACEP Activities – List your most significant accomplishments

Faculty, Emergency Medicine Group Academy, American College of Emergency Physicians, 2021-present
Councillor, American College of Emergency Physicians, 2013-present
Council Steering Committee, American College of Emergency Physicians, 2020-present
Candidate Forum Subcommittee of the Council Steering Committee, American College of Emergency Physicians, 2021

Annual Meeting Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Chair, Council Reference Committee B 2018, American College of Emergency Physicians
Council Reference Committee B 2015, American College of Emergency Physicians
Quality & Patient Safety Committee, 2020-present, American College of Emergency Physicians
Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee, 2020-present, American College of Emergency Physicians
Reimbursement Committee, 2019-present, American College of Emergency Physicians
Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force, 2021-present, American College of Emergency Physicians and EDPMA
Emergency Medicine Practice Committee, 2017-present, American College of Emergency Physicians
Best Practices for Incidental Findings in the Emergency Department National Working Group, 2021-present, Selected representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American College of Radiology
Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care Workers Subcommittee of the Emergency Medicine Practice Committee, 2020-2021, American College of Emergency Physicians
Award Selection Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section, 2021, American College of Emergency Physicians
Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee, 2019-2020, American College of Emergency Physicians
Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
EMS Committee, 2017-present, American College of Emergency Physicians
Democratic Group Practice Section, 2016-present, American College of Emergency Physicians
Emergency Medical Services-Prehospital Care Section, 2016-present, American College of Emergency Physicians
Freestanding Emergency Centers Section, 2016-present, American College of Emergency Physicians
Well Being Committee, 2016-2017, American College of Emergency Physicians
Physician Representative, 2013 Rand Corporation Study US Value of Emergency Medicine

ACEP Chapter Activities – List your most significant accomplishments

Immediate Past President, Florida College of Emergency Physicians, 2021-present
President, Florida College of Emergency Physicians, 2019-2021
Served Two Consecutive Terms (1 of 3 people to have done so over 50 years)
Completed Executive Search/Transitioned CEO and Organizational Restructure
Revised Bylaws
Established Women in Medicine Committee
Established Florida EM Physician Owned Corporation Consortium
President Elect, Florida College of Emergency Physicians, 2018-2019
Vice President, Florida College of Emergency Physicians, 2017-2018
Treasurer, Florida College of Emergency Physicians, 2016-2017
Bylaws Task Force, Florida College of Emergency Physicians 2020
Executive Committee, Florida College of Emergency Physicians, 2016-present
Finance Committee, Florida College of Emergency Physicians, 2016-present
Board of Directors, Florida College of Emergency Physicians, 2013-present
Women in Emergency Medicine Committee, Florida College of Emergency Physicians, 2019-present
Florida EM Physician Owned Corporation Consortium, Florida College of Emergency Physicians, 2019-present
Government Affairs Committee, Florida College of Emergency Physicians, 2013-present
Medical Economics Committee, Florida College of Emergency Physicians, 2013-present
Pediatrics Committee, Florida College of Emergency Physicians, 2013-present
EMS Committee, Florida College of Emergency Physicians, 2013-present
Readmissions Stakeholder Summit Panelist, 2017, Florida Hospital Association
Florida Office of Insurance Regulation and Insurance Consumer Advocate, Emergency
Medical Transportation Work Group, 2016-2017
Faculty/Panel Moderator, FCEP Emergency Medicine Payment Reform Summit, 2017-2019

Practice Profile

Total hours devoted to emergency medicine practice per year: 2,500 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 5% Research 0% Teaching 10% Administration 85%

Other: __________% Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

EMS Medical Director primarily for government agencies located within Flagler County, Florida. Previously worked for an independent group and successfully doubled the size of the group in terms of number of ED visits per year as well as number of shareholders/employees during my tenure.

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.)

Please see Current and Past Professional Positions noted above.

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>

I worked very part time as an independent contractor for Abbason and Associates, an entity contracted with the Florida Department of Health Medical Licensing Board to provide case reviews to opine upon standard of care from 2010-2020. During that time, I never provided oral or written evidence under oath, at trial, or in an affidavit or deposition.
CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Kristin Bond McCabe-Kline, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

   Employer: AdventHealth
   Address: 900 Hope Way
            Altamonte Springs, FL 32714
   Position Held: Chief Medical Information Officer, Central Florida Division
   Type of Organization: Health System

   Employer: Flagler County Fire Rescue
   Address: 1769 E. Moody Blvd.
            Bunnell, FL 32110
   Position Held: EMS Medical Director
   Type of Organization: Government EMS Agency

   Employer: City of Palm Coast Fire & Rescue
   Address: 1250 Belle Terre Pkwy
            Palm Coast, FL 32164
   Position Held: EMS Medical Director
   Type of Organization: Government EMS Agency

   Employer: Flagler Beach Fire Department
   Address: 320 S. Flagler Ave.
            Flagler Beach, FL 32136
   Position Held: EMS Medical Director
   Type of Organization: Government EMS Agency

   Employer: AllCare Medical Transport
   Address: 4751 E. Moody Blvd.
            Bunnell, FL 32110
   Position Held: Medical Director
   Type of Organization: Non-Emergent Transport Company
2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.

Organization: Florida College of Emergency Physicians
Address: 3717 S. Conway Rd.
Orlando, FL  32812
Type of Organization: Florida State Chapter of ACEP
Leadership Position: Immediate Past President
Term of Service: August 2021- August 2022

Organization: WaterSafe, Inc.
Address: 14 Audubon Lane
Flagler Beach, FL  32136
Type of Organization: Non-Profit (501C3) promoting water safety and providing no cost swim lessons
Leadership Position: Chief Medical Officer
Term of Service: 2016-present (Co-Founder), ongoing

3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe:

My husband is an optometrist who works for an ophthalmology practice, Tomoka Eye Associates.

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ NO
4. If YES, Please Describe:

No. He is not officially “on call” as he is not privileged at any hospitals but he does take calls from emergency medicine physicians all hours of the day and night and sees many ED patients in follow up in his clinic regardless of their ability to pay.

7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Kristin B. McCabe-Kline, MD

6/15/22
Dear ACEP Council,

The Florida College of Emergency Physicians (FCEP) is honored to endorse our colleague Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT as a candidate for the national ACEP Board of Directors. On the state level, Dr. McCabe-Kline has held every leadership position within our chapter. While serving an extended 2-year term as FCEP President, she led the chapter and staff through transitions in executive leadership – and also navigated a global pandemic. She has been among distinguished faculty for FCEP education programs, and most recently continued to be actively engaged as our chapter’s Immediate Past President.

Kris has further proven her commitment to the college through active engagement on national level. She represents our chapter on the ACEP council, where she also serves on the Steering Committee as well as the Candidate Forum subcommittee. She serves on multiple national ACEP committees including Reimbursement, Emergency Medicine Practice, EMS, and Quality & Patient Safety. She is also a member of multiple ACEP sections (Democratic Group Practice, EMS-Prehospital Care, and Freestanding Emergency Centers), as well as a member of ACEP’s 911 Legislative Network.

Dr. McCabe-Kline’s distinguished professional career further demonstrates her passion for the specialty, specifically with regards to emergency medical services, quality management, legislative advocacy, and physician wellness. Dr. McCabe-Kline has recently been appointed Chief Medical Information Officer for one of the largest non-profit health systems in the nation and is the Chief Medical Officer of Watersafe, Inc., a nonprofit organization created to mitigate preventable injury or death in and around water. She also serves as the EMS Medical Director for multiple EMS agencies and fire departments in Flagler County where she developed and implemented a Community Paramedicine program to improve collaboration across the continuum of care focused on patient safety, system efficiencies, and appropriate utilization of resources. She maintains membership in multiple professional associations and specialty medical societies; has authored articles in local, state, and national publications; and has received many awards in recognition of her outstanding leadership and service – including being named the 2019 Humanitarian of the Year by the AdventHealth Palm Coast Foundation.

Kristin is clearly highly motivated to serve, and she is well-qualified. She would be an invaluable member of the ACEP board. Her intellect and leadership acumen, enhanced by her poise and eloquence, are the exact type of attributes that the college requires to continue navigating through such challenging times. FCEP is pleased to support Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT as a candidate for the national ACEP Board of Directors.

Sincerely,

Damian Caraballo, MD, FACEP
President
Florida College of Emergency Physicians
Kristin B. McCabe-Kline, MD, FACEP

Dear Colleagues,

Thank you for your commitment to our patients, specialty, and one another. I am incredibly humbled to be part of such a unique and impactful specialty that exhibits selfless service to patients, exceptional ability to meet patients where they are, and attracts amazing physicians like you. I would very much appreciate the opportunity to serve you as a member of the ACEP Board of Directors.

Our specialty was founded based on the unmet needs of our patients where emergency physicians were brave enough to step into the gap to meet the needs, show the value to achieve reimbursement, and while continuing to innovate. We are well positioned to identify areas of opportunity where the system has failed our patients, embrace opportunities to meet their needs, and reinagine the delivery of our unique skillset in service to patients.

The compensation of care and measurement of quality are critical to our specialty, particularly as we move from a fee for service to value based structures. ACEP must be at the table, leading discussions around reimbursement models, speaking to the value of the care we provide, and developing metrics that support evidence-based practices translating to the best outcomes for our patients. Advocacy on behalf of our members is key to preserving our reputation as fierce patient advocates.

As emergency physicians, we are subjected to the harshest of circumstances and held to the highest of standards which can undermine even the most resilient emergency physicians. While providing individual resources for emergency physicians to foster wellness, ACEP must step up to provide solutions for systems level issues that undermine the positive mindset, physical health, and connectivity to others necessary for emergency physicians to thrive.

The future of emergency medicine is bright with innovation and advocacy efforts that highlight the importance of the value and contribution of emergency physicians in service to our patients. The culture of emergency medicine is being restored as we learn to address systems level issues that affect us collectively and individually, care for ourselves and one another, and discover opportunities for growth on our journeys as emergency medicine physicians.

Thank you for your leadership in ACEP, your chapters, sections, and committees, and, most importantly, your own communities. I look forward to continuing to serve our leaders and members. Your vote would be very much appreciated.

Sincerely,

Kristin B. McCabe-Kline, MD, FACEP
Globally, emergency physicians transformed emergency departments into front doors of hospitals and key access points throughout the community via free standing sites. Granularly, emergency physicians leveraged ultrasound equipment we saw utilized by others to provide patients with immediate results while under our constant bedside care. Innovation is essential to the future of emergency medicine. As emergency physicians, we are well positioned to identify gaps in care where the system has failed our patients, embrace opportunities to meet their needs, and reimagine the delivery of our unique skillset in service to patients.

The compensation of care and measurement of quality are critical to our specialty, making Advocacy essential to the future of emergency medicine. ACEP must be at the table, leading discussions around reimbursement models, speaking to the value of the care we provide, and developing metrics that support evidence-based practices translating to the best outcomes for our patients. Advocacy on behalf of our members is key to preserving our reputation as fierce patient advocates.

As emergency physicians, we are subjected to the harshest of circumstances and held to the highest of standards which can undermine even the most resilient emergency physicians. While providing individual resources for emergency physicians to foster wellness, ACEP must step up to provide solutions for systems level issues that undermine the positive mindset, physical health, and connectivity to others necessary for emergency physicians to thrive.

Career fulfillment where emergency physicians feel appreciated, free to explore a variety of career options, and fully supported when things are less than ideal, is essential to maintaining a healthy culture of emergency medicine. Providing opportunities for career fulfillment should highlight diversity as ACEP has members with a variety of interests, pursuits, backgrounds, and practice environments. Engagement and trust highlights the value of every individual member of ACEP, milestones of our careers, and opportunities for growth and mentorship as part of a greater community of emergency physicians. When we engage with one another in meaningful College activities, there is a level of mutual support that positions ACEP as a vital force for wellness for emergency physicians.

The future of emergency medicine is bright with innovation and advocacy efforts that highlight the importance of the value and contribution of emergency physicians in service to our patients. The culture of emergency medicine is being restored as we learn to address systems level issues that affect us collectively and individually, care for ourselves and one another, and discover opportunities for growth on our journeys as emergency medicine physicians.
As submitted to the ACEP Nominating Committee on behalf of the FCEP Board of Directors - March 6, 2022.

The Florida College of Emergency Physicians (FCEP) is honored to nominate our colleague Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT as a candidate for the national ACEP Board of Directors. On the state level, Dr. McCabe-Kline has held every leadership position within our chapter. While serving an extended 2-year term as FCEP President, she led the chapter and staff through transitions in executive leadership – and also navigated a global pandemic. She has been among distinguished faculty for FCEP education programs, and she continues to be actively engaged as our chapter’s Immediate Past President.

Dr. McCabe-Kline has further proven her commitment to the college through active engagement on national level. She represents our chapter on the ACEP council, where she also serves on the Steering Committee as well as the Candidate Forum subcommittee. She serves on multiple national ACEP committees including Reimbursement, Emergency Medicine Practice, EMS, and Quality & Patient Safety. She is also a member of multiple ACEP sections (Democratic Group Practice, EMS-Prehospital Care, and Freestanding Emergency Centers), as well as a member of ACEP’s 911 Legislative Network.

Dr. McCabe-Kline’s distinguished professional career further demonstrates her passion for the specialty, specifically with regards to emergency medical services, quality management, legislative advocacy, and physician wellness. Dr. McCabe-Kline has recently been appointed Chief Medical Information Officer for one of the largest non-profit health systems in the nation and is the Chief Medical Officer of Watersafe, Inc., a nonprofit organization created to mitigate preventable injury or death in and around water. She also serves as the EMS Medical Director for multiple EMS agencies and fire departments in Flagler County where she developed and implemented a Community Paramedicine program to improve collaboration across the continuum of care focused on patient safety, system efficiencies, and appropriate utilization of resources. She maintains membership in multiple professional associations and specialty medical societies; has authored articles in local, state, and national publications; and has received many awards in recognition of her outstanding leadership and service – including being named the 2019 Humanitarian of the Year by the AdventHealth Palm Coast Foundation.

Dr. McCabe-Kline is clearly highly motivated to serve, and she is well-qualified. She would be an invaluable member of the ACEP Board. Her intellect and leadership acumen, enhanced by her poise and eloquence, are the exact type of attributes that the college requires to continue navigating through such challenging times. FCEP is pleased to support Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT as a candidate for the national ACEP Board of Directors.
Kristin Bond McCabe-Kline, MD, FACEP, FAAEM, FACHT
91 Island Estates Pkwy
Palm Coast, FL
32137
Cell (386) 283-2326
kmccabemd@gmail.com

EMERGENCY MEDICINE RESIDENCY TRAINING

Advocate Christ Medical Center Emergency Medicine Residency Program
Program Director: Robert Harwood, M.D.

EDUCATION

M.D. University of Texas Medical School, San Antonio, Texas, 1998-2002
Top 20% of Graduating Class

B.A. Rice University, Houston, Texas, 1994-96 (Major: English)
Rice University President’s Honor Roll

University of Michigan, Ann Arbor, Michigan, 1992-94, 1996
University of Michigan Class Honors

Harvard University, Cambridge, Massachusetts, Summer 1993

PROFESSIONAL WORK EXPERIENCE

Vice President/Chief Medical Information Officer, AdventHealth Central Florida Division
Altamonte Springs, Florida (10/14-present)
Chief Medical Information Officer rep of the AdventHealth Central Florida Division responsible for more than 50% of the corporation and reports directly to the AdventHealth Corporate Chief Medical Information Officer. Evaluates a variety of clinical path

Vice President/Regional Operations Coordinator, Emergency Medicine Professionals
Volusia/Flagler Counties, Florida (5/17-11/24)
Regional Operations Coordinator specifically works with the Emergency Medicine Professionals Executive Committee and Board of Directors to support corporate operations and development as well as corporate management and Emergency Department/Hospital throughput. The Regional Operations Coordinator serves to provide high level communication to the AdventCare Health System Central Florida Region North Division Administrations as well as working on health care process improvement and care delivery innovation with AdventHealth Corporate Administration.
Chief of Staff, Florida Hospital Flagler (Now AdventHealth Palm Coast)
   Palm Coast, Florida (1/16-12/18)
Participating in expansion of capacity from 99 to 150 patients including observation unit following new construction, sole hospital in Flagler County, with thriving Interventional Cardiology program, Orthopedic Center of Excellence, Cancer Center, and Robotic Surgery program. Initiating improved hospital wide throughput utilizing LEAN methodologies. Rolling out hospital wide Just Culture education and responsible for ensuring medical staff compliance. Completed Bylaws revision. Awarded the “2016 Florida Hospital Mission Award” while serving as Chief of Staff.

Flagler County Fire Rescue Emergency Medicine Services Medical Director,
   Bunnell, Florida (8/14-present)
City of Palm Coast Emergency Medicine Services Medical Director,
   Palm Coast, Florida (8/14-present)
Flagler County Sheriff’s Department Medical Director,
   Bunnell Florida (8/14-present)
City of Flagler Beach Emergency Medical Services Medical Director,
   Flagler Beach, Florida (10/14-present)
Providing medical direction for all EMS agencies in Flagler County including ongoing work group of Field Training Officers to continually keep guidelines up to date. Oversight of Flagler County Fire Rescue Fire Flight program. Initiated monthly QA meetings utilizing technology to achieve 100% participation of all medics. Work with Flagler County Emergency Manager, Chiefs of all First Responder agencies as well as AdventHealth Palm Coast administration to perform periodic disaster drills. Oversight of SWAT Medic program in coordination with the Sheriff’s Department. Developed a Community Paramedicine program for Flagler County Fire Rescue. Empowered all first responders to initiate treatment with intranasal Narcan when appropriate. Coordinated “Leave Behind Narcan” program for first responders during the opioid epidemic. Awarded “Flagler County Health Professional of the Year 2015”.

Flagler Technical College EMT Training Program Medical Director
   Palm Coast, Florida (7/18-present)
Providing medical direction for all EMT program instructors and oversight of all EMT students. Responsible for adherence of the program to state statute and coordination of field training with local EMS agencies as well as in hospital clinical training at AdventHealth Palm Coast. Proctor of final clearing exam upon completion of the classroom and clinical training assuring proficiency to graduate the EMT course.

AllCare Medical Transport Medical Director
   Flagler County, Florida (4/21-present)
Assisted this medical transport company in becoming a BLS transport entity and an ALS entity throughout 2021 including adherence of the program to state statute and coordination of certification and clearing processes to provide community standards for medical transport and competencies beyond state requirements. Providing medical direction and oversight of quality assurance programming.

Daytona International Speedway
   Daytona Beach, Florida (1/15-5/18)
Attending Physician serving as “99” or trackside physician as well as providing physician services at the Infield Care Center for participants, crew members, employees, and fans. Provided pre-hospital care on scene and during transport for Kyle Busch post crash February 21, 2015.
Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)  
*Palm Coast, Florida (1/16)*

**Assistant Medical Director,** Served in this role to help transition the new Medical Director into his position as well as launching two projects that had been in process for the past year: Emergency Department Improvement Team (ongoing LEAN team to continually address reduction of waste in ED processes) and introduction of Tele-Neurology including Stroke LEAN event.

**Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)**  
*Palm Coast, Florida (4/14-12/15)*

**Medical Director** 30+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Transitioned this new contract as an employee of Emergency Medicine Professionals. Decrease in LWBS from 14% to 1% with Press Ganey scores improved from 70th %tile to 90th %tile.

Bert Fish Medical Center Emergency Department (Now Advent Health New Smyrna)  
*New Smyrna Beach, Florida (1/12-3/14)*

**Medical Director** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals. BFMC ED awarded “Innovation of the Year in Patient Care” by the Florida Hospital Association in 2012 for implementation of multiple initiatives to improve patient focused care with an emphasis on quality and safety.

Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)  
*New Smyrna Beach, Florida (4/11-12/11)*

**Attending Physician** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals.

Florida Hospital Fish Memorial Emergency Department (Now AdventHealth Fish)  
*Orange City, Florida (1/11-3/11)*

**Attending Physician** 30+ Bed ED with Cardiology, Pulmonology, Surgery, Gastroenterology, Orthopedic, Gyn, ENT, Psychiatry, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals. VOTED INTO PARTNERSHIP IN APRIL 2011 AFTER MINIMUM PREREQUISITE 18 MONTH PERIOD.

Florida Hospital DeLand Emergency Department (Now AdventHealth DeLand)  
*DeLand, Florida (10/10-12/10)*

**Attending Physician** 25+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Ob/Gyn, Psychiatric, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals.

Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)  
*New Smyrna Beach, Florida (8/09-7/10)*

**Attending Physician** 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals.
**Carolina Emergency Medicine Physician Association, Partner, Director ED Operations**  
*Greenville, South Carolina (7/05-6/07 and 1/08-6/10)*

**Attending Physician** rotating in four facilities of the Greenville Hospital System.

**Greenville Memorial Hospital** *(Greenville)*: Level I Trauma Center with 90,000 ED visits annually. 50+ Bed ED including Critical Care, Intermediate Care, Pediatric, Cardiac Care, and Fast Track Areas.

**Allen Bennett Memorial Hospital** *(Greer)*: 30,000 ED visits annually in this 25+ Bed ED with Ob/Gyn, Cardiology, Orthopedic, Gastroenterology, and General Surgery specialty service availability on site.

**Hillcrest Memorial Hospital** *(Simpsonville)*: 25,000 ED visits annually in this 20+ Bed ED with Orthopedic and General Surgery specialty service availability on site.

**North Greenville Hospital** *(Travelers Rest)*: 10,000 ED visits annually in this 10+ Bed ED with no specialty services on site.

*VOTED INTO PARTNERSHIP IN 2007 AFTER MINIMUM PREREQUISITE 2 YEAR PERIOD.*

**DIRECTOR OF ED OPERATIONS**- Including patient experience, Press Ganey orientation and ongoing coaching of physicians, all patient complaints/concerns, facilitating transitions of care.

**MEDICAL DIRECTOR, GREENVILLE MEMORIAL HOSPITAL BEHAVIORAL ANNEX**- Provided clinical policy oversight, process improvement, and coordination with hospital employed Advanced Practice Clinicians for care of patients awaiting placement at inpatient psychiatric facilities.

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**Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)**  
*New Smyrna Beach, Florida (1/07-2/08)*

**Attending Physician** 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, and Nephrology specialty service availability on site. Employed by Emergency Medicine Professionals.

**Stuart F. Meyer Hospice House**  
*Palm Coast, Florida (8/07-12/07)*

**Associate Medical Director** 8 Bed inpatient Hospice unit providing patient care and facilitating the Interdisciplinary Team involving administration, nursing and patient care staff, social workers, and clergy. Responsible for developing plans of care for terminally ill patients facing imminent expiration, as well as providing inpatient care for those enrolled in the Home Hospice program requiring symptom management or respite care.

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**Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)**  
*Palm Coast, Florida (5/07-11/07)*

**Attending Physician** Level II Facility with 50,000 visits annually. 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, Pediatric, and Nephrology specialty service availability on site.

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**Advocate Christ Medical Center, Emergency Department**  
*Oak Lawn, Illinois (6/02-6/05)*

**Resident Physician** in Level I Trauma Center with 82,000 ED visits annually. 50+ Bed ED including Critical Care, General Care, Pediatric, Cardiac Care, and Fast Track Areas. Rotations outside of the Emergency Department include Ultrasound, MICU, PICU, Trauma Surgery, General Surgery, Pediatrics, Orthopedics, Obstetrics/Gynecology, Oral Surgery, EMS, and Radiology.

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**Henry Ford Health System, Center for Clinical Effectiveness**  
*Detroit, Michigan (10/97-6/98)*

**Administrative Assistant** and **Data Analyst** working on several outcomes-based research projects and grant applications (including NIH). Worked under the Director of Cardiovascular Informatics to coordinate computer programmers and outside consultants to develop a new computer-based cardiovascular information system for electronic charting in the hospital/clinic as well as formation of a queryable database.

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**St. Joseph Mercy Health System, McPherson Hospital, Emergency Department**  
*Ann Arbor/Howell, Michigan (8/96-10/97)*

**Unit Clerk** in the Emergency Department coordinating inter-departmental services and patient care including hospitalizations and transfers to outlying facilities.
LICENSURE
State of Florida April 11, 2007 - present
State of South Carolina March 4, 2005 - present
State of Illinois June 24, 2002 – July 31, 2005

CERTIFICATIONS
Emergency Medicine Initial EMS Subspecialty Board Certification 2021
Emergency Medicine Board Recertification 2017
Emergency Medicine ConCert Exam September 15, 2016 Pass
ACEP Directors Academy Graduate
Phase I November 2011
Phase II May 2012
Phase III November 2012
Phase IV August 2015
FCEP Leadership Academy June 2012 - July 2013
Emergency Medicine Initial Board Certification December 6, 2007
Written Examination November 8, 2006 Pass
Oral Examination October 22, 2007 Pass
Diplomate of the National Board of Medical Examiners
USMLE Step 1 Passed May 26, 2000
USMLE Step 2 Passed July 2, 2001
USMLE Step 3 Passed April 14, 2004

PROFESSIONAL ACTIVITIES

EMPros Physician Leader Representative to the Emergency Department Practice Management Association (EDPMA), 2018-2021
Councillor, American College of Emergency Physicians, 2013-present
Council Steering Committee, 2020-present, American College of Emergency Physicians
Candidate Forum Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Annual Meeting Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Chair, Council Reference Committee B 2018, American College of Emergency Physicians
Council Reference Committee B 2015, American College of Emergency Physicians
Quality & Patient Safety Committee, 2020-present, American College of Emergency Physicians
Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee, 2020-present, American College of Emergency Physicians
Reimbursement Committee, 2019-present, American College of Emergency Physicians
Chair, Reimbursement Committee Working Group 1, 2021-present, American College of Emergency Physicians
Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force, 2021-present, American College of Emergency Physicians and Emergency Department Practice Management Association

Emergency Medicine Practice Committee, 2017-present, American College of Emergency Physicians

Best Practices for Incidental Findings in the Emergency Department National Working Group, 2021-present, Selected representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American College of Radiology

Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care Workers Subcommittee of the Emergency Medicine Practice Committee, 2020-2021, American College of Emergency Physicians

Award Selection Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians

Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section, 2021, American College of Emergency Physicians

Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee, 2019-2020, American College of Emergency Physicians

Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians

EMS Committee, 2017-present, American College of Emergency Physicians

Democratic Group Practice Section, 2016-present, American College of Emergency Physicians

Emergency Medical Services-Prehospital Care Section, 2016-present, American College of Emergency Physicians

Freestanding Emergency Centers Section, 2016-present, American College of Emergency Physicians

Well Being Committee, 2016-2017, American College of Emergency Physicians

Women in Emergency Medicine Committee, Florida College of Emergency Physicians, 2019-present

Florida EM Physician Owned Corporation Consortium, Florida College of Emergency Physicians, 2019-present

Government Affairs Committee, Florida College of Emergency Physicians, 2013-present

Medical Economics Committee, Florida College of Emergency Physicians, 2013-present

Pediatrics Committee, Florida College of Emergency Physicians, 2013-present

EMS Committee, Florida College of Emergency Physicians, 2013-present

Chair, American Heart Association Go Red for Women Luncheon, 2018

Readmissions Stakeholder Summit Panelist, 2017, Florida Hospital Association


Faculty/Panel Moderator, FCEP Emergency Medicine Payment Reform Summit, 2017-2019

Immediate Past President, Florida College of Emergency Physicians, 2021-present
President, Florida College of Emergency Physicians, 2019-2021
   Served Two Consecutive Terms (1 of 3 people to have done so over 50 years)
   Completed Executive Search/Transitioned CEO and Organizational Restructure
   Revised Bylaws
   Established Women in Medicine Committee
   Established Florida EM Physician Owned Corporation Consortium

President Elect, Florida College of Emergency Physicians, 2018-2019
Vice President, Florida College of Emergency Physicians, 2017-2018
Treasurer, Florida College of Emergency Physicians, 2016-2017
Bylaws Task Force, Florida College of Emergency Physicians 2020
Executive Committee, Florida College of Emergency Physicians, 2016-present
Finance Committee, Florida College of Emergency Physicians, 2016-present
Board of Directors, Florida College of Emergency Physicians, 2013-present
Flagler Technical College EMT Advisory Board of Directors, 2018-present
AdventHealth Corporate Emergency Department Reimagine Design Group, 2021-present
AdventHealth Central Florida Division Clinically Integrated Network Board of Managers, 2021-present
AdventHealth Corporate Transitions of Care Steering Committee, 2020-present
AdventHealth Corporate Transitions of Care Clinical Workstream Committee, 2020-present
AdventHealth Corporate Change Coalition Steering Committee, 2021-present
AdventHealth Corporate Cross Clinical Advisory Council, 2020-present
Co-Chair, AdventHealth Corporate Cross Clinical Advisory Council Emergency Medicine Rapid Decision Group, 2020-present
Co-Chair AdventHealth ED/Imaging Subject Matter Expert (SME) Working Group, 2020-present
AdventHealth Corporate Formulary & Therapeutics Critical Care and Emergency Medicine Clinical Advisory Committee, 2020-present
AdventHealth Corporate Aunt Bertha Steering Committee, 2021-present
AdventHealth Corporate Epic Advanced Care Planning Working Group, 2020-present
AdventHealth Corporate Epic Opioid Working Group, 2020-present
AdventHealth Corporate COVID-19 Vaccination Planning Taskforce, 2020-present
AdventHealth Corporate COVID-19 Open Door Task Force, Emergency Medicine, 2020
AdventHealth Corporate Clinical Response to COVID-19 Contributing Author, Emergency Medicine, 2020
AdventHealth Central Florida Division COVID-19 Workstream Task Force, 2020-present
Co-Chair, AdventHealth Corporate ED Clinical Reliability Council, 2019-present
AdventHealth Corporate PAMA/CDSM Committee, 2019-present
AdventHealth Central Florida Division Cardiovascular Institute Heart Failure Steering Committee, 2021-present
Co-Chair, AdventHealth Central Florida Division North Region ED Governance Council, 2019-present
Co-Chair, AdventHealth Central Florida Division North Region ED/Hospitalist Governance Council, 2018-present
AdventHealth Central Florida Division North Physician Champion Orthopedics, 2020-present
AdventHealth Central Florida Division North Physician Champion Neurosciences, 2020-present
AdventHealth Central Florida Division North Readmissions Committee, 2018-present
AdventHealth Central Florida Division North Region Transfer Committee, 2018-present
AdventHealth Central Florida Division North Opioid Stewardship Committee, 2018-present
AdventHealth Central Florida Division North Region ED/Radiology Council, 2017-present
AdventHealth Central Florida Division North Region CHF Committee, 2017-2021
AdventHealth Central Florida Division North Region Stroke Committee, 2017-present
AdventHealth Central Florida Division North Region Pediatric Quality Committee, 2017-present
Flagler County Open Arm Recovery Services (OARS) Visionary Committee, 2020-present
Chief Medical Officer, WaterSafe (501C3), 2019-present
Executive Committee Member, WaterSafe (501C3), 2019-present
Board of Directors, WaterSafe (501C3), 2019-present
Co-Founder, WaterSafe, 2016-present
Vice President, Emergency Medicine Professionals, 2017-2021
Executive Committee Member, Emergency Medicine Professionals, 2011-2021
Board of Directors, Emergency Medicine Professionals, 2011-2021
Partner/Shareholder, Emergency Medicine Professionals, 2010-2021
ED Throughput Council, AdventHealth Daytona Beach, 2017-present
ED Throughput Council, AdventHealth Fish Memorial, 2017-present
ED Throughput Council, AdventHealth Deland, 2017-present
ED Throughput Council, AdventHealth Palm Coast, 2014-present
ED Throughput Council, AdventHealth New Smyrna Beach, 2012-2014, 2017-present
Board of Directors, Florida Hospital Flagler 1/16-12/18
Chief of Staff, Florida Hospital Flagler 1/16-12/18
Revised Bylaws
AHS Florida Regional Strategic Physician Leadership Development Program, 2013-2014
Baker Act Interagency Committee, 2012-2016 Volusia and Flagler Counties
Physician Representative, 2013 Rand Corporation Study US Value of Emergency Medicine
Chief of Staff Elect, Florida Hospital Flagler 2015
Interim Chair Department of Medicine, Florida Hospital Flagler 2015
Vice Chief of Staff, Florida Hospital Flagler 2014
Hospital/Physician Strategy Committee, 2014-2016, Florida Hospital Flagler
Medical Executive Committee Member, 2014-2019, Florida Hospital Flagler
Medical Director, 2014-2016, Florida Hospital Flagler Emergency Department
Performance Improvement Committee, 2014-2019, Florida Hospital Flagler
Peer Review Committee, 2014-2019, Florida Hospital Flagler
Biomedical Ethics Committee, 2014-2019, Florida Hospital Flagler
Patient Safety Committee, 2014-2019 Florida Hospital Flagler
Medical Records and Utilization Review Committee, 2014-2018, Florida Hospital Flagler
Emergency Management Committee, 2014-2018, Florida Hospital Flagler
Readmissions Committee, 2014-2018, Florida Hospital Flagler
Care Transitions Committee, 2014-2018, Florida Hospital Flagler
Cardiology Committee, 2016-2018, Florida Hospital Flagler
Stroke Committee, 2014-present, Florida Hospital Flagler
Critical Care Committee, 2016-2018, Florida Hospital Flagler
Pharmacy and Therapeutics Committee, 2016-2018, Florida Hospital Flagler
Community Relations Committee, 2014-2018, Florida Hospital Flagler
Medical Executive Committee Member, 2013, Bert Fish Medical Center
Chair, Peer Review Committee, 2013, Bert Fish Medical Center
Medical Director, 2011-2014, Bert Fish Medical Center Emergency Department
Physician Director, 2010-2014, Stroke Program, Bert Fish Medical Center
Expert Witness, 2010-2020, Abbason & Associates contracted with Florida DOH
Judge, Florida College of Emergency Physicians Annual Case Presentation Competition
Judge, Florida College of Emergency Physicians Annual Simulation Wars Competition
Director of Emergency Department Operations, Carolina Emergency Medicine
Associate Director, Greenville Memorial Hospital Emergency Department Behavioral Annex
(Psychiatric care holding facility within ED for patients awaiting inpatient psychiatric placement.)
Candidate Selection Committee Member, Carolina Emergency Medicine, 2005-2009
Board of Directors, Carolina Emergency Medicine Physicians Association, 2007-2009
Member, Advocate Christ Emergency Medicine Department Journal Club, 2002-2005
Mentor, Advocate Christ Emergency Medicine Residency Mentorship Program, 2003-2005
Member, Advocate Christ Emergency Medicine Residency Selection Committee, 2003-2005

PROFESSIONAL ORGANIZATIONS
Fellow of the American College of Emergency Physicians
Fellow of the American Academy of Emergency Medicine
Founding Fellow of the American College of Healthcare Trustees
Member of the American College of Health Care Executives
Member of the American College of Health Care Executives Physician Forum
Member of the National Association of EMS Physicians
Member of the Florida College of Emergency Physicians
Member of the Florida Association of EMS Medical Directors
Member of the American Medical Association
Member of the Florida Medical Association
AWARDS

**ACEP Speaker’s Award for Outstanding Service**, 2019-2021
**Humanitarian of the Year**, AdventHealth Palm Coast Foundation, 2019
**ACEP President’s Award for Outstanding Service**, 2018-2019
**Physician of the Quarter**, Florida Hospital Flagler, 2017
**“Top Doctor” Award**, Daytona Beach News Journal, 2016
**Mission Leadership Award**, Florida Hospital Flagler, 2016
**Dedication to Community Service Award**, WaterSafe 2016
**Health Professional of the Year**, Flagler County 2015

PUBLICATIONS


Dr. Kristin McCabe-Kline and Dr. Charles Duva. PHYSICIANS: Medical billing law is rebounding on Volusia, Flagler emergency medical staff. Daytona Beach News-Journal August 21, 2019.


PRESENTATIONS

One Voice for Volusia. December 2020
Volusia County Florida, Virtual Event.
Flagler Cares Coalition: Opioid Use Disorders. November 2020
Flagler County Florida, Virtual Event.

Emergency Medicine Vision 2030. October 2020

Protecting Access to Medicare Act / Appropriate Use Criteria. October 2020
AdventHealth Central Florida Division North Region CMO Roundtable, Virtual Event.
AdventHealth Central Florida Division North Region CEO Roundtable, Virtual Event.

Regional AdventHealth Opioid Initiatives Presentation. September 2020
Leadership Daytona Class XL Program/Daytona Regional Chamber of Commerce, Virtual Event.

Preparing for the Next Pandemic: Information Flow. September 2020
American College of Emergency Physicians Webinar Series, Virtual Event.

Florida Emergency Medicine Town Hall. August 2020
Symposium by the Sea, Florida College of Emergency Physicians Conference, Virtual Event.

Statewide Effort to Prepare for the COVID-19 Surge in Florida. April 2020
FMEDA Quality Advocacy Coalition Stakeholders Virtual Meeting.

Opioid Epidemic Impact and Solutions. August 2019
Keeping Hope: Overdose Awareness & Remembrance Day, Daytona Beach, Florida.

Florida Emergency Medicine Town Hall. August 2019
Symposium by the Sea, Florida College of Emergency Physicians Annual Conference, Boca Raton, Florida.

Fearless and Focused. February 2019
Flagler Professional Women's Council Luncheon Presentation, Palm Coast, Florida.

Emergency Medicine Innovators Summit Panelist Moderator. February 2019
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

Statewide Effort to Avoid Hospital Readmissions Panelist. October 2018
FMEDA Quality Advocacy Coalition Stakeholders Workshop, Orlando, Florida.

Emergency Medicine Payment Reform Summit Panelist Moderator. February 2018
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

EMS Wellness: Where are we? December 2017
FCEP/Emergency Medicine Learning Resource Center Webinar.
Emergency Medicine Innovators Summit Panelist Moderator. February 2017
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

Work Life Balance. September 2016
FCEP Life after Residency Conference Faculty, Gainesville, Florida.

Optimizing Transitioning of Patients from the Emergency Department. April 2014
Flagler County Emergency Nurses Association Meeting, Palm Coast, Florida.

Pre-Hospital Education for Stroke Alert and STEMI Alert. December 2013
Volusia County EMS and Fire/Rescue CE, BFMC, New Smyrna Beach, Florida.

Juggling Personal and Professional Life. September 2013
FCEP Life after Residency Conference Faculty, Orlando, Florida.

Trauma in Pregnancy Case Presentation and Follow-Up. April 2004
Joint ACMC Trauma Surgery/Emergency Department Conference, Oak Lawn, Illinois.

Pediatric Head Trauma. November 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Pulmonary Embolism Case Presentation and Follow-Up. July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Testicular Cancer Case Presentation and Follow-Up. July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Caring for Caregivers. May 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

PROFESSIONAL REFERENCES
Available Upon Request.

PERSONAL ACTIVITIES

Member, Santa Maria del Mar Catholic Church
Member, St. Brendan Catholic School Parent Teacher Organization
Vice President, Belles Artistic Swimming Team (501C3)
Board of Directors, Belles Artistic Swimming Team (501C3)
Certified Judge and Coach, USA Artistic Swimming Association
Sustaining Member, Junior League of Daytona Beach, Florida
Former Member, Junior League of Greenville, South Carolina
2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Henry Z. Pitzele, MD, FACEP

**Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?**

The subjects of workforce and scope are intertwined, and the College is attacking them both on several fronts. The approach to the projected workforce oversupply has been further honed in the past year, but is still a multifactorial attack on both supply and demand.

I wholeheartedly approve of the supply-side efforts to raise the bar for new residency entrance; I am not usually a patient man, but in this case, slow and steady look like a winning strategy—getting everyone in the EM tent on the same page regarding residency requirements was worth doing right, and it looks like the RRC-EM will likely respect the ACEP-built consensus on new residency criteria. I think we can be even stronger in our stance against corporate-backed residency proliferation; many of the large companies still don’t seem to believe that there is a problem with indefinitely increasing resident production (and to them, there isn’t one!), and we don’t need to be as nice to them as we have been in presenting our case.

Finally, on supply, I applaud our efforts and investments on fomenting the redistribution of our workforce; data continues to come out showing a lack of EP’s practicing rurally. This not only worsens the global supply/demand mismatch, but fuels the (government/payor/NPP) argument that there aren’t enough ER docs, and that we should be upping our residency production. Spending resources in developing and testing new strategies, especially funding and payment models (increased reimbursement for REH physicians, exploration of a fire department funding model) could make downstream gains—both for our workforce and for the underserved rural populations.

On the flipside, I vehemently disagree with the prediction that the market will correct oversupply – i.e., that less medical students will apply to EM, and residency slots will go unfilled, forcing programs to close. They won’t. Even with this year’s shocking prelim NRMP underfills (in itself a statement showing how much work we have to do to regain confidence in the future of the specialty), most of those slots were eventually filled up by the apparently near-infinite worldwide demand for EM residency slots. We will still be producing record numbers of ER docs—they just will be drawing from a different part of the qualifications curve. We badly need to keep working on all of the other supply-side fixes, because the oversupply problem won’t go away by itself.

The demand side fixes are much more complicated—expanding the scope of EM is still a murky future, and we haven’t yet fully defined what we want to do on that front. And while we are fighting NPP independent practice on the legislative front (nationally and on the state level), and have taken superb and unprecedented stances on defining supervision levels (with the 2022 ACEP policy on NPP supervision, and the work by the ED accreditation task force to publicize these standards), the true number of de facto unsupervised NPP interactions is near-impossible to track or research; even the superb recent workforce paper by Gettel et al admits that this number is not represented in their conclusions (and would be very difficult to obtain). My opinion of our supply-side strategies are much less rosy than our efforts on the demand side—please see my answer to question 3 for more detail on why.

**Question #2: Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?**

For me, the most important of the College’s missions has always been advocacy. Within the Advocacy pillar of the strategic plan, several of the strategies resonate with me, specifically the plans to standardize advocacy strategies across the federal, state, and workplace levels. To that end, a few of us in the State Legislative/Regulatory Committee have begun a project which we think will help meet these goals—a dashboard of the most common legislative hurdles faced by all of us. Each ACEP member will (once we are up and running) be able to look at this dashboard and see how each state has handled the most common legislative issues (medicaid, NPP scope, unfunded mandates, etc); if one of us has had a winning strategy, others won’t have to reinvent the wheel—they’ll be able to reach out to the stakeholders in the Chapter that has done well, and use some of those strategies themselves. We think that this will not only help us meet our legislative goals, but will help unify the College when members see all of the work that is being done on their behalf.
Secondly, I want to highlight the final strut in the Advocacy pillar—that of creating awareness around the business of EM. I feel very strongly that the interests of the major EM corporations do not align with the interests of the front line EP, and I want ACEP to be very clear, to one and all, that the mission of the College is to better the working lives of those front line docs. I am quite proud of what the College has done already this year, not just the act of adopting the strategic plan to reaffirm our mission to support individual EP’s, but on this particular objective of creating awareness of the interests of business. In one of the most important months of ACEP’s recent history, we filed an amicus brief supporting AAEM’s lawsuit about the corporate practice of medicine, the Board came out with a statement about private equity in EM, and we wrote a letter to the FTC/DOJ perfectly and succinctly summarizing how corporate interests are eroding the specialty and negatively affecting both docs and patients. I can’t really express what a MJolnir-esque blow these three back-to-back events had—not just to EM as a specialty, but to me personally; they showed in the most public way, to our members and to those watching outside that ACEP is here for us, not for an industry enriched by our blood and sweat. The College represents us. Now, do I feel like these three momentous events mean that our work on this issue is done? Absolutely not! It’s merely a starting point—and a very encouraging one—and it means that, if we continue in this vein, and keep making change, this College can and will be the unifying force through which together, Emergency Physicians can make the next phase of EM a place in which we truly look forward to working.

**Question #3:** What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?

The most divisive issue in EM right now is the status of nonphysician practitioners (NPP) within the specialty. I think it’s become pretty clear that the steeply increasing utilization of NPP’s in EM is pushing the demand side of the workforce issue—that is, that there is an ever-decreasing demand for EM physicians, since so many charts are being picked up and managed by NPP’s. This is not a controversial conclusion—the controversy lies in what we want to do about it.

There is a segment of our membership who feels that every patient should be seen by an EP, every time—we’ve seen recent Council resolutions stating this, and they received significant support. Perhaps the supporters of this model (the model of zero independent disposition, and 100% prospective, in-person direct supervision of NPP’s) believe in the improved quality of care, perhaps they are acting in a protectionist stance toward our specialty, or perhaps some of both. To be clear, I am one of these people.

There is another large segment of EP’s who do want NPP’s to have some autonomy; to support models of care such as “oversight” (where the EP was uninvolved but available) or asynchronous chart review. Support for these models is not just made up of immense corporations, to whom any revenue-generating provider is equal as long as they have a low hourly rate and high PG scores, but also made up of EP’s from small- and medium-sized groups, whose practices and incomes are bolstered from this model of care. The supporters of some amount of NPP autonomy are not a small segment of EP’s or of our membership, and I do understand their point as well.

I’m leaving out the contested middle ground of offsite vs. onsite supervision of NPP’s; the argument made for this is one of literal EP availability in rural areas. This is not a winnable argument by either side, yet, although I hope that with ACEP’s ongoing efforts to bolster rural EP presence, it soon will be. But leaving the rural issue aside, we still have to come together as a specialty and decide precisely how we want to incorporate NPP’s into our practices going forward, knowing that an unerringly protectionist stance is going to cost us significantly in the short term. So our first and most important step is going to be clearly establishing how we, as a College, feel about this issue, so that we can go forward stongly and in a unified manner to support it,
Henry Z. Pitzele, MD, FACEP

Contact Information
617 S. Loomis
Chicago, IL 60607
Phone: (312) 523-6080
E-Mail: pitzele@gmail.com

Current and Past Professional Position(s)
Attending Physician (full time), Jesse Brown VA Medical Center, Chicago (2007-present)
  Deputy Section Chief of Emergency Medicine 2007-2012
  Section Chief of Emergency Medicine 2012-2015
Attending Physician (part time) Advocate Illinois Masonic Medical Center, Chicago (2010-present)
Attending Physician (part time) Mesa View Regional Medical Center, Mesquite NV (2011-present)
Attending Physician, Mercy Hospital, Chicago (full time 2003-2007, part time 2007-2010)

Education (include internships and residency information)
Univ. of Illinois at Chicago, Emergency Medicine residency 2000-2003
Univ. of Illinois at Chicago College of Medicine:
  MD 2000

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM 2004, 2014
Clinical Informatics 2022

Professional Societies
ACEP, AAEM, ICEP (Illinois Chapter)

National ACEP Activities – List your most significant accomplishments
State Legislative/Regulatory Committee 2021-22—led several subcommittees

ACEP Chapter Activities – List your most significant accomplishments
ICEP president 2020-22
ICEP Board of Directors 2015-2022
ICEP EMBRi Written Board Review Course, course and committee chair 2012-2019

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 95 %  Research ____ %  Teaching ____%  Administration 5 %
  Other: ___________________________ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Full time in tertiary VA teaching hospital. Moonlighting 1-2 times per month at an urban Level I trauma center (also an EM residency program site), as well as at a rural CAH in Nevada.
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.)

**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 CONFLICT OF INTEREST DISCLOSURE STATEMENT

Henry Z. Pitzele, MD, FACEP

1. Employment – List current employers with addresses, position held, and type of organization.

   Employer: US Dept of Veterans Affairs—Jesse Brown VAMC
   Address: 820 S. Damen
   Position Held: Attending Physician
   Type of Organization: VA Hospital

   Employer: Advocate Medical Group—Advocate Illinois Masonic Hospital
   Address: 836 W. Wellington
   Position Held: Attending Physician—part-time/moonlighting
   Type of Organization: Regional medical group

   Employer: American Physician Partners (Mesa View Regional Hospital)
   Address: 5121 Maryland Way #300
   Position Held: Attending Physician—part-time/moonlighting
   Type of Organization: National CMG

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.

   Organization: Illinois College of Emergency Physicians
   Address: 2001 Butterfield Rd, Esplanade 1, Suite 320
   Position Held: Board member, various officer positions including president
   Term of Service: 7 years (2015-2022)
3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

Candidate Conflict of Interest Disclosure Statement
I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Henry Pitzele

Date

6/20/2022
The Illinois College of Emergency Physicians wholeheartedly endorses Dr. Henry Pitzele as a candidate for the ACEP Board of Directors.

Dr. Pitzele has been a strong and constant presence at ICEP for the past two decades. He began his service mainly fulfilling our mission of education, starting as a lecturer in our written board review course, then eventually taking over as Course Director and Chair of that committee. He moved into a leadership position on the Board of Directors, and eventually served in leadership positions within the Board, serving as President from 2020-21 and Past President the following year.

Dr. Pitzele’s year as President began just as the pandemic was shutting down the country, and many of the functions of the Chapter were put in jeopardy by the same stroke. However, during his tenure (and with the tireless and expert help of the staff), ICEP was able to successfully pivot operations, advocacy, and educational programs into a virtual stance, and the organization actually came out of the pandemic on better financial footing than it had before the shutdown.

Throughout his time with the ICEP Board, Henry was a strong advocate for the well-being and advancement of frontline emergency physicians. He has consistently been unafraid to speak loudly when business or government actors seek to encroach on the rights of the practicing emergency doctor, and to work strongly to minimize and manage conflicts of interest. He continues to steadfastly represent our interests by advocating with legislators at the state and national level.

Dr. Pitzele is the voice we need in the ACEP Board, one we can count on to continually promote the betterment of the individual Emergency Physician, even in the face of powerful organizations whose interests lie counter to ours. We can count on him to consider strategies which may run counter to entrenched thinking, and we can count on him to further the movement to improve communication and transparency within the College. We look forward to working with Dr. Pitzele to move our organization into the stance required to support EP’s in our important work during the transformative next decade.

Jason Kegg, MD, FACEP
President
Henry Z. Pitzele, MD, FACEP

This is a humbling time to be an ER doctor.

It seems like every day, pieces are being chipped away from the bedrock that holds us up—pieces like autonomy, self-governance, respect within our institution and community, and acknowledgment of the importance of our hard and ceaseless work. We feel unseen, especially by those higher up in our business structures, and within the government who sets the rules for payment. We see the instability this causes to our colleagues, and to ourselves, and it often doesn’t seem like a winnable fight.

Now, more than ever, we need the College to be our avatar—an institution that will remain focused on one thing: collectively acting to make the working lives of frontline EP’s better. And throughout the past year, ACEP has been moving towards this focus; representing our interests to the FTC/DOJ in their early healthcare antitrust work, and supporting our colleagues (not our competition) at AAEM in their legal opposition to the corporate practice of medicine.

Just because the College has moved in the right direction does not mean it’s time to hang back. Quite the opposite! Now is our chance to continue this movement to centralize the College on representing practicing emergency physicians. It’s the time to come out even stronger on things like Workforce, especially on the supply-side issues of establishing quality/safety over business interests in creating new residency slots, and the demand-side issue of guaranteeing the EP as the medical decisionmaker in every ED visit.

It’s time to invest in communications. Our outward-facing communications need to become more personalized, and more pervasive online—especially now, when we have so much value to convey to members who have left us, or who have never joined. Our inward-facing communications also need attention; we need to take the superb efforts like Workforce Minute (which have improved transparency and publicized ongoing College efforts), and expand them—our members need to know how much is happening on their behalf, and we need to meet them where they ingest this information. And most of all, we need to design the next incarnation of ACEP’s digital home to actually connect our members with each other, so that we realize that we’re all alike, and all fighting the same fight—we can’t cede this ever-more-important function of community to Facebook. We are none of us alone in this field, and when even one of our members feels that they are, I consider it a loss.

This is also the perfect time to aggressively pursue the financial future of the College, and we must have leadership who is not grounded in the status quo. In addition to stabilizing our membership numbers, our overall business model currently rests heavily on CME and its concomitant sponsorship by the pharma and EM staffing industries. Whether or not you think this is an ethically appropriate way to make money (I don’t, particularly), it is certainly a model with a bleak future—people are buying less and less live CME, and the industries that function symbiotically to sponsor CME are matching their decreased spend—we need to look for a different way to support ourselves, and our leadership can’t be stuck in a concept that has worked for the past few decades, but which won’t work in the next few.

I’m proud to be an ACEP member, and never more so than in the past year. Now is our opportunity to tilt the ship even more in towards representing the working EP, and through that, create the building blocks to ensure that the College will flourish in future.
we’re not there yet

the College has started to move towards exclusively representing the front-line EP, but we still have a lot more work to do

we need leadership who is unafraid to challenge corporate power and status-quo positions in order to address our most important issues, chief among them being Workforce

together, we can build the College into the next level of success

Pitzele for ACEP Board

platform· bio· support· information @pitzele.com
HENRY ZOLTAN PITZELE, MD

Work Experience
11/11-present  Attending physician, Department of Emergency Medicine, Mesa View Regional Hospital, Mesquite NV (part-time/moonlighting)
8/10-present  Attending physician, Department of Emergency Medicine, Advocate Illinois Masonic Medical Center, Chicago (Level I Trauma Center—part-time/moonlighting)
3/16-12/18  Attending physician, Department of Emergency Medicine, Advocate Trinity Hospital, Chicago (Part-time/moonlighting)
6/03-7/10  Attending physician, Department of Emergency Medicine, Mercy Hospital and Medical Center, Chicago (Full-time 2003-2007, part-time 2007-2010)
11/02-6/03  Attending physician at UIC O’Hare Medical Clinic, part-time

Educational Experience
2000-2003  University of Illinois at Chicago Emergency Medicine Residency
Chief Resident at Mercy Hospital and Medical Center
1996-2000  University of Illinois at Chicago College of Medicine
Graduated top quartile of class
1992-1996  University of Chicago
BA in Economics with General Honors

Publications

Awards
Award of Teaching Excellence, UIC Internal Medicine Residency, 2011-2012
Oral Presentations
Lecturer, UIC Internal Medicine Residency Noon Conference (2-3 times per year) 2007-present
Lecturer, American Academy of Emergency Medicine Scientific Assembly, San Diego 2012
Lecturer, Third Dutch North Sea Emergency Medicine Conference, Netherlands, June 2009
Lecturer, American College of Emergency Physicians Scientific Assembly, Chicago 2008
Lecturer, American College of Emergency Physicians Spring Congress (New Speaker's Forum), Las Vegas 2006

Leadership Experience
Illinois College of Emergency Physicians (Illinois Chapter of ACEP)
  President, 2020-2021
  Secretary/Treasurer 2019-2020
  Board of Directors, 2015-2021
  Chair, Written Board Review Course committee, Illinois College of Emergency Physicians 2012-2019
Medical Director (Section Chief) Emergency Medicine, Jesse Brown VAMC 2012-2015
Lead Physician for Emergency Medicine, VA Great Lakes Health Care System 2012-2015
Jesse Brown VAMC LEAN Steering Committee 2014-2015
Chair, ED Committee at Jesse Brown VAMC 2012-2015
Site Director, Medical Student Rotation in EM at Jesse Brown VAMC, 2007-2013

Hospital Committees
Peer Review (2014-present)
Inpatient Flow (2012-2015)
Utilization Management (2012-2015)
Emergency Management (2012-2015)
Medical Executive Council (2012-2015)
CPR (2012-2015)
Clinical Products and Resources (2012-2015)

Certifications
BLS, ACLS, ATLS
LEAN Green Belt
AMIA 10x10

Professional Organizations
Associate Professor, Department of Emergency Medicine, University of Illinois at Chicago, 2014-present (Clinical Assistant Professor 2003-2014)
Fellow, American College of Emergency Physicians, 2006-present
Board Certified in Emergency Medicine, American Board of Emergency Medicine, 2004 and 2014
Board Certified in Clinical Informatics 2022

pillez@gmail.com
617 S. Loomis, Chicago IL 60607
cell (312) 523-6080
2022 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Ryan A. Stanton. MD, FACEP

**Question #1: What is your view of ACEP’s strategy regarding workforce, scope of practice, and College sustainability?**

This question really involves three separate and unique challenges facing our college and our members.

Regarding workforce, we are facing a problem that many if not most never thought we would see, more physician supply than demand. It has also uncovered the realities around the sheer number of factors, players, and interests. ACEP has done a fantastic job taking the bold step to investigate the problem and bringing forward as a challenge to our members and profession. It has also been key to engage various stakeholders around workforce development including those that may be seen as “part of the problem”. I personally see this as an opportunity to not only reflect on how we got to this point in the evolution of EM, but also to look forward to the opportunities within and around EM to tap into the skills and talents of emergency physicians. It was not long ago that others in the house of medicine and beyond did not feel like we had the expertise and skill set to perform RSI or bedside ultrasound. It was through the vision and advocacy of leaders in our field that we have grown from an idea to combat immediate and unscheduled care to a growing specialty. Though the workforce numbers pose a real challenge, we must also use this as an opportunity to build the future of EM and the opportunities for our physicians.

Scope of practice has been an ongoing challenge, especially on the state level. We have seen wins and setbacks over the years. The core to this problem is when systems and employers put profits over patients. There is clearly an integral role in our system for non-physician practitioners but should NEVER be to replace the role of a physician and the expertise, skill, and training that comes with board certification. The challenge is that we face a balancing act with the value add versus the expansion of scope that puts patients and specialty at risk. I completely support the ongoing stance and vision that EVERY patient should been seen or access to a board-certified emergency physician in the emergency department setting. We realize this is not the case in every setting, especially in rural and austere environments, but we cannot go backwards. We must push forward and continue to raise the bar that is emergency medicine so every person who seeks care can trust that they are receiving the best care possible. I support ongoing advocacy efforts on the federal and state levels to reaffirm the physician led team, fight scope of practice expansion, and further promote patient access to BCEM physicians.

Finally, in an era where almost all professional organizations are seeing diminished growth or member declines, we must evolve with our specialty and our workforce to provide the college that is needed in the years and decades to come. The close relationship and engagement with young physicians, residents, and students has never been more important. Meeting physicians and future physicians “where they are” regarding the services and ROI that can help promote career fulfillment, longevity, and satisfaction. We are the American College of Emergency Physicians and thus, our focus must be on the individual physician and the profession in which we work. Doing so, we are also increasing the care access and level of care that our patients receive. This is clear in the new ACEP strategic plan, repositioning and evolving the college for the physicians of today and into our future. The long term and ongoing focus on physicians, fiscal responsibility, and tailoring the individual return on investment will position us well into the future.

**Question #2: Considering ACEP’s Strategic Plan, what do you consider to be the top two issues and how should they be addressed?**

The strategic plan is all about focusing on the emergency physician and our practice of emergency medicine. The two biggest challenges are unifying a profession in a time of great divide and protecting the profession from those that work to undermine emergency medicine, whether intentional or as a byproduct. We clearly have seen growing divides in this country and more positions that land in the “my way or the highway” realm. We are at a place and time that ACEP leadership has received death threats and frequent calls to take firm stances one way or the other, often both. Our college is blessed with diversity in beliefs and passions. I still remember as a Kentucky councilor when the question was asked among ~500 emergency physician in attendance their political leanings, and the vote was with a handful of 50/50. We need that diversity and those difference in viewpoints, but that also presents the challenge of being the leading voice in EM and how do we best represent our physicians and patients. We must all double-down on listening more, being open to disagreement, and working towards a common ground that can help us move forward. We are all emergency physicians and that is the cornerstone of our work, advocacy, and
opportunity. It is integral that we unite and fight as one voice with a diversity of opinions and viewpoints because we are under attack from many angles. Whether it is scope of practice, moral injury/burnout, entities putting profits over patients, insurance industry games, corporate influences, documentation bloat, or another unrealistic metric that provides no beneficial patient-oriented outcome. The patient care part of EM is the easy part, but we are seeing ever increasing challenges and pressure from outside the treatment room. This is exactly why a strong unified voice through ACEP is integral. Individually, we are vulnerable, together, we are a force that can truly move the needle. The five pillars of the strategic plan are built on the foundation of the emergency physician and how we as a college best advocate, communicate, and provide the best return on investment regarding membership and a fulfilling career in EM.

Question #3: What do you believe is the single most divisive issue in emergency medicine at this time and how would you address it?

There are many areas of potential divide in our culture and profession. Whether it is the corporate influence on the practice of medicine, NPP scope expansion, or generational differences, there are countless areas of potential angst and consternation. That being said, the greatest area of divide is definitely within political views and positions. As a college that represents emergency physicians from the full spectrum of ideology and belief, every communication and position must weigh this wide diversity to find the best ground for EM and our patients. Most recently, we have dealt with challenges regarding firearms as well as Roe vs. Wade. As you can expect, many have strong opinions that fall across the board. As we discuss these issues as a college, it is important to advocate for patient access, safety, evidence-based legislation, and against the criminalization of medical practice. At the same time, we must avoid diving into “wedge issues” that serve only to divide and draw battle lines. Unfortunately, when we dig in, we often lose the opportunity for debate and open discussion. As emergency physicians, we must find positive steps forward based on our expertise as the front door of the healthcare system and the safety net for our communities. I have my own strong beliefs on both firearms and Roe vs. Wade, but that does not make me correct nor others incorrect. Our greatest challenge is understanding that we may have vastly different opinions and views, from individuals, to chapters, the national college, and everything in between, but we need to work to find the common ground and positions that can advance emergency medicine, our patients, and our physicians while still understanding the individual rights and beliefs of our members and autonomy of our chapters. This boils down to the fact that we did not make it this far without a strong brain between our ears. We must be willing and able to take the sheer diversity, challenges, and differential we see with our patient presentations and utilize that listening and higher-level cognitive expertise to promote respectful and open discussions, dialogue, and debate. We are weaker when we have no difference in opinion, but also weaker when we tear each other down. We are one college with 40,000 voices and each must be supported.
CANDIDATE DATA SHEET

Ryan A. Stanton MD, FACEP

Contact Information
106 Stonewall Dr.
Nicholasville KY 40356
Phone: 859-948-2560
E-Mail: rstanton@acep.org

Current and Past Professional Position(s)
Emergency Physician- Central Emergency Physicians
ACEP Board of Directors- 2019-Current
ACEP PR/Comms Committee Chair
Host- ACEP Frontline Podcast
ACEP National Spokespersons Network
Medical Director- Lexington Fire/EMS
Medical Director- AMR/NASCAR/SRX/RTI Safety Teams
Medical Director- Lexington Bluegrass Airport
Chief Medical Contributor- WDKY Fox-56 Lexington

Education (include internships and residency information)
East Tennessee State University Quillen College of Medicine 1999-2003
East Tennessee State University Department of Surgery Internship 2003-2004
University of Kentucky Emergency Medicine 2005-2008
MD 2003

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
ABEM Emergency Medical Services 2021-2031

Professional Societies
American College of Emergency Physicians
Kentucky Chapter of the American College of Emergency Physicians
Kentucky Medical Association

National ACEP Activities – List your most significant accomplishments
Board of Directors- 2019-Present
Chair of the PR/Comms Committee
Host of the ACEP Frontline Podcast
ACEP Spokespersons Network
Spokesperson of the Year
9-1-1 Network Member of the Year

ACEP Chapter Activities – List your most significant accomplishments
Past-President
PR Chair
Education Chair
**Practice Profile**

*Total hours devoted to emergency medicine practice per year: 1200 Total Hours/Year*

**Individual % breakdown the following areas of practice. Total = 100%.**

- Direct Patient Care: 100%
- Research: 0%
- Teaching: 0%
- Administration: 0%
- Other: **Do teach students in the department during shifts.**

**Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)**

Single hospital physician owned private group. Community urban 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.)**

Full-time Emergency Physician

**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 | 3 Cases | Plaintiff Expert | 0 Cases |
# CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

**Ryan A. Stanton, 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>Central Emergency Physicians</td>
<td>1740 Nicholasville Rd.</td>
<td>Full-Time Emergency Physician</td>
<td>Private Single Hospital Democratic Group</td>
</tr>
<tr>
<td>Lexington-Fayette Urban County Government</td>
<td>219 E. 3rd St.</td>
<td>Medical Director</td>
<td>City/County Fire/EMS</td>
</tr>
<tr>
<td>Global Medical Response</td>
<td>6363 S Fiddlers Green Circle</td>
<td>Motorsports Medical Director</td>
<td>EMS Event Medicine</td>
</tr>
<tr>
<td>Everyday Medicine LLC</td>
<td>106 Stonewall Dr.</td>
<td>Founder/CEO</td>
<td>Medical Media/Education</td>
</tr>
</tbody>
</table>

2. **Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Emergency Physicians</td>
<td>4950 W. Royal Lane</td>
</tr>
</tbody>
</table>
3. Describe any outside relationships with any person(s) 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, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: EMSConnect Minority Owner and educator. Teleflex educator and clinical consultant.

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:
6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. 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:

8. 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:

9. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Ryan Stanton MD, FACEP  Date  6/27/22
July 18, 2022

ACEP Councillors;

It is with great pleasure the Kentucky Chapter of ACEP (KACEP) and the ACEP Pain Management and Addiction Medicine Section endorse incumbent Dr. Ryan A. Stanton to the American College of Emergency Physician Board of Directors. We have had the pleasure of serving with Ryan over many years. He has shown exemplary state and national involvement in ACEP. Ryan has held many state leadership roles; Councillor, Public Relations Committee Chair, Vice President as well as President of KACEP. He remains an integral member of the state Board of Directors and serves as the Board Liaison for Pain and Addiction Medicine.

Ryan is our “go-to” member for all things public relations. His background in television and radio makes him very comfortable in front of crowds and the camera. He has natural leadership ability and is very charismatic. He serves leadership and medical directorships for many different entities; Lexington Fire/EMS, AMR/NASCAR Safety Team, AirMed International, and Infield Care Team for NASCAR events.

Ryan works clinically in the emergency department and yet always finds time to advocate for emergency medicine with the legislators in Frankfort and Washington. No matter how busy, we know we can always count on Ryan to testify on behalf of emergency physicians throughout the state and nation. He takes every opportunity to promote strategies that manage acute and chronic pain in emergency medicine. He has provided many educational presentations on treatment of patients with opiate addiction.

Ryan always hosts our KACEP EMRA grant awardees at the ACEP Leadership and Advocacy meetings in Washington, DC. He provides our residents a view of the Hill that most would not be able to offer, which has opened many young minds to emergency medicine advocacy and its importance.

Ryan’s curriculum vita illustrates his numerous achievements during his career. He has touched many lives through his medical work, Fire/EMS leadership, media roles, and his young physician mentorships. It is our pleasure to endorse Dr. Ryan Stanton.

Sincerely,

Chris Pergrem, MD, FACEP
President
KY Chapter of ACEP

Donald Stader, MD, FACEP
Chair
Pain Management and Addiction Medicine
Esteemed colleagues and friends,

Three years ago, I stood in front of you and asked for your vote with a vision to change the ways we communicate as a college and double down on our advocacy of emergency physicians. Little did I know that less than 5 months later, the world would shut down as we were impacted by the COVID-19 pandemic. During the subsequent 2.5 years, I have seen a virus impact our country and profession in ways that I could not have imagined. At this point, I feel that so many around this country and beyond can simply be described as…tired.

That is why that message from three years ago is as important if not more important than when I stood before you. We have seen great advances in the way we communicate as a college with growing expertise and resources to your voice and the incredible work you do every day. Our strategic plan has bolded, underlined, and highlighted “emergency physicians” as the reason we exist, and our decisions must center on the advancement, careers, fulfillment, and opportunities of each of you. We know that by being the unified voice and advocacy of emergency physicians that we not only improve the lives of physicians, but advance the care of our patients, and positively impact the acute care landscape in all facets of the system…and beyond.

If you would honor me with the opportunity to continue this adventure, I will absolutely double down with my promise from three years ago. I will continue to fight for the opportunities, communications, advocacy, and specialty that we call home. We will continue to position ACEP as the largest, most powerful, and influential voice for emergency physicians and our patients. That includes advocating and fighting against those that wish to attack, devalue, replace, or diminish the integral work and sacrificial commitments of every emergency physician in this great country. We will support individual physicians as they face adversity and challenges, as well as the largest battles that threaten our profession.

The last three years have forced unprecedented change and unimaginable challenges. However, it has also opened the door for incredible opportunity. It is now that we can shape the emergency medicine specialty of our future and the countless to come. To do so, we must unite as a profession and college, building on the diversity of thought and voices to be the instrument of positive change for our physicians and every patient that turns to us in their time of need.

Finally, I want to say thank you. Thank you for showing continued commitment in the face of countless challenges, to giving a community emergency physician from central Kentucky the opportunity to fight for you. Thank you for dedicating your time and efforts to this college, for the emergency physicians of today, but also those that are to come, we want their opportunities to be as good, if not better than what we have experienced in our careers. Thank you, for the opportunity to continue as a representative of your voice on the ACEP board and for opportunities to come. You are heroes, and though you don’t hear it enough, there are millions among us that have their lives, families, and opportunities because of you and your expertise as an emergency physician.
Together We Grow

You have honored me the last three years with “a seat at the table” to represent you and this wonderful college. As we move forward, I will continue to commit to fight and advocate for every emergency physician to be able to work and prosper in the environment that promotes the greatest career fulfillment, to expand our opportunities, and to defend our profession from those that would in any way threaten our profession and the patients that turn to us in their time of need.
Profile

Board certified emergency physician in Lexington, Kentucky with involvement in community, pre-hospital, and motorsports medicine. Interests in media and public education through internet, podcast, print, and television. Active in leadership with local and national organizations through work with Central Emergency Physicians, KACEP, ACEP, AMR, and NASCAR.

Experience

EMERGENCY PHYSICIAN, CENTRAL EMERGENCY PHYSICIANS, LEXINGTON, KY – 11/2013-PRESENT

Emergency Physician at Baptist Health Lexington

MEDICAL DIRECTOR, LEXINGTON FIRE/EMS LEXINGTON, KY - 3/2013-PRESENT

Medical Director for one of the premier fire departments and EMS services in Kentucky, overseeing the EMS operations for over 48,000 EMS runs annually.

MEDICAL DIRECTOR, AMR/NASCAR SAFETY TEAM – 4/2017-PRESENT

On-track response physician for NASCAR as part of the AMR/NASCAR Safety Team at tracks throughout the country. Named team Medical Director as of 1/1/20.

KENTUCKY/FLORIDA STATE MEDICAL DIRECTOR, AIRMED INTERNATIONAL – 1/2014-PRESENT

Kentucky and Florida state medical director for AirMed International which provides air medical services throughout the world.

EVERYDAY MEDICINE AND ACEP FRONTLINE PODCASTS, 1/2010-PRESENT

Production of two emergency medicine based podcasts. Everyday Medicine in conjunction with Emergency Medicine News and ACEP Frontline with the American College of Emergency Physician
EMS part-owner and educator for EMSConnect. One of four physician educators for this nationwide company.

INFIELD CARE CENTER FOR NASCAR SANCTIONED AND OTHER RACING EVENTS
KENTUCKY SPEEDWAY AND TALLADEGA SUPER SPEEDWAY – 6/2006-4/2017

Medical Services for Kentucky Speedway 2006-2014 and Talladega Super Speedway 2015-2017

"DOCTOR ON CALL" FOR ABC-36, LEXINGTON, KY – 1/2009-12/2016

On-Air physician for weekly "ask the doc" segments, weekly "what's going around" segments, and as needed for health-related interviews.

EMERGENCY PHYSICIAN, MESA/TEAMHEALTH, LEXINGTON, KY -7/2008-7/2014

Emergency Physician and past Medical Director at UK Good Samaritan Hospital in Lexington, KY

ASSISTANT PROFESSOR OF EMERGENCY MEDICINE, UK HEALTHCARE, LEXINGTON, KY – 7/2008-6/2013

Emergency Physician and Assistant Professor for the UK Emergency Medicine Residency Program.

ABC NEWS MEDICAL UNIT INTERN, BOSTON, MA, FALL 2005

Worked with the ABC Medical Unit on story research, composition, interviews and writing for ABCNews.com and ABC News programs under the direction of Dr. Tim Johnson.

WETS-FM 89.5 NATIONAL PUBLIC RADIO PRODUCER, JOHNSON CITY, TN - 10/1996-12/2015

Produced "Everyday Medicine", a weekly segment pertaining to common medical topics focused towards patients and the lay public. Past roles as a board operator and announcer, as well as producer of several programs including "Reel Music" and "Ritmo Latino".


Production assistant duties including camera operation, sound board, editing, story composition, and directing.
Board Certification
American Board of Emergency Medicine, Board Certified, 2009-Present
American Board of Emergency Medicine-, Emergency Medical Services, Board Eligible, 2019-Present
American Board of Emergency Medicine, Board Eligible, 2008-2009

Medical Licensure
Kentucky, 6/26/2008-Active -License #41963
Resident License- 1/2007-6/2008
Alabama, 9/25/2014-Active- License #MD.33740
Tennessee, 4/7/2016-Active- License #54178
Florida, 2017-Active- License #ME.134262
New York, 2018-Active- License #293995-1
Delaware, 2018-Active- License #C1-0012583
Georgia, 2018-Active- License #079785
Pennsylvania, 2018-Active- License #MD465496
Virginia, 2018-Active- License #0101264445
North Carolina, 2018-Active- License #2018-00671
Nevada, 2020-Active- License #19571
Indiana, 12/9/2004-Active- License #01060023A

Residency Training
University of Kentucky, Emergency Medicine, 7/2005-6/2008
Education

ETSU James H. Quillen College of Medicine, Medical Doctor, 8/1999-5/2003

East Tennessee State University, BS- Chemistry, 8/1995-5/1999
Leadership Positions

**Founder/CEO**, Everyday Medicine LLC, 7/2013-Present

**Board of Directors**, American College of Emergency Physicians, 2019-Present

**Medical Director**, AMR/NASCAR Safety Team, 1/2020-Present

**Medical Director**, Lexington Fire/EMS, Lexington-Fayette Urban County Government, 3/2013-Present

**President**, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2013-12/2014

**Chairman of Public Relations Committee**, American College of Emergency Physicians, 10/2014-10/2016

**Assistant Medical Director**, AirMed International, 1/2014-Present

**Director of PR, Media, and Education**, Mesa Medical Group, Lexington, KY, 1/2013-7/2014

**Medical Director**, UK Good Samaritan Emergency Room, University of Kentucky Healthcare, 7/2008-7/2013

**Assistant Medical Director**, Kentucky Motor Speedway Emergency Medical Services, 2010-2013

**President Elect**, KACEP(Kentucky Chapter of the American College of Emergency Physicians), 1/2010-12/2012

**Vice President**, KACEP, 1/2010-12/2012

**Public Relations Committee Chairman**, KACEP, 7/2008-Present

**Vice Chairman UK ED Executive Committee**, UK Healthcare, 1/2010-6/2013

**Counselor**, American College of Emergency Physicians, 10/2011-Present

**PR Committee**, American College of Emergency Physicians, 10/2008-Present

**National Spokesman**, American College of Emergency Physicians, 10/2008-Present

**Medical Operations Subcommittee Member**, UK Good Samaritan Hospital, 2008-2013

**Emergency Medical Advisory Board**, Lexington/Fayette County, KY, 7/2008-Present

**Chief Resident**, UK Healthcare Emergency Medicine, 7/2007-6/2008
Awards/Honors

ACEP 911 Network Member of the Year, American College of Emergency Physicians, 2014

Spokesman of the Year, American College of Emergency Physicians, 2011-2012

Preceptor of the Year, UK Physician Assistant Program, 2010-2011

UK Leadership Legacy Mentor, University of Kentucky, 2011-2012

Gatton School of Business Executive Leadership Program, University of Kentucky, 2009-2010
Publications/Presentations/Talks

Recurring Media Productions
ACEP Frontline Podcast- 10/2015-Present
StantonMD TV Show- 3/2016-9/2018
The Doc is In TV Segment- 2012-Present
   Six television markets around the southeast United States
Chief Medical Contributor- WKYT-TV Lexington- 1/2017-Present
WVLK 97.3FM/590AM- Weekly Medical Contributor and Guest Host(Various Shows)- 2010-Present
American College of Emergency Physicians- Spokesperson- 2008-Present
Everyday Medicine for Physicians Podcast- 1/2010-12/2019
Everyday Medicine Podcast- 1/2006-12/2015

Presentations/Talks
ACEP19- Moderator: SoMe in EM- Denver, CO 10/29/19
Emerald Coast Conference- Mythbusting: EM Medication Myths- Destin, FL 6/3-5/2019
Emerald Coast Conference- Law and Order: EM Medical Malpractice- Destin, FL 6/3-5/2019
Emerald Coast Conference- He Said, She Said: Vaccine Refusals- Destin, FL 6/3-5/2019
Kentucky Hospital Association- KY Statewide Opioid Stewardship- ALTO in EM and Beyond, Multiple Sites in KY 2019
ANC-AHE Annual Conference- State of the Union: Opioids in America- Savannah, GA, 2/20/19
NASCAR Summit 2019- What Can You Actually Do in a Racecar- Concord, NC 1/2019
Kentucky Hospital Association Leadership Academy- Moderator for Opioid Panel Discussion- Louisville, KY, November 2018
PHI Regional Outreach Critical Care Symposium- Sepsis in the EMS Setting- Morehead, KY, November 2018

ACEP18- Becoming Unjaded: The Opioid Epidemic- San Diego, CA, October 2018

ACEP18- Social Media: Collaboration or Litigation- San Diego, CA, October 2018

ACEP18- Mills Memorial Lecture- ACEP Past, Present, and Future- San Diego, CA, October 2018

SEC ACEP- Mythbusting in Emergency Medicine- Destin, FL, June 2018

SEC ACEP- Frontline Live: The Evolution of Medical Education- Destin, FL, June 2018

SEC ACEP- Opioid Epidemic: State of the Union- Destin, FL, June 2018

ACEP Leadership and Advocacy 2018- Advocacy Panel- Washington DC, May 2018

Tennessee ACEP- 2018 Annual Meeting- Opioid Epidemic: State of the Union- Chattanooga, TN, March 2018

NASCAR Summit 2018- AMR/NASCAR Year in Review- Concord, NC, January 2018

NASCAR Summit 2018- The Approach to the Car and Driver- Concord, NC, January 2018

KY ENA State Educational Conference- Surviving Dreamland: The Opioid Crisis, Lexington KY, August 2017

SEC ACEP- Opioids: Why That Didn’t Work, Destin FL, June 2017

SEC ACEP- The Physician Pilot: Keeping the Skies Friendly, Destin FL, June 2017

Ohio ACEP Emergency Medicine Forum- Faces of Physician Leadership, Columbus OH, May 2017

11th Annual Intermountain Brain Injury Conference- Approach to the Acutely Agitated Patient, Johnson City TN, March 2017

11th Annual Intermountain Brain Injury Conference- TBI 101, Johnson City TN, March 2017

ACEP Leadership and Advocacy 2017- Where the Rubber Meets the Road: Emergency Medicine and SoMe, Washington DC, March 2017

TN ACEP Annual Meeting- Narcotics to Narcan: State of the Opioid Union
Address, Chattanooga TN, February 2017

KACEP Medical Director Conference- From IV to IO and In-Between, Louisville KY, November 2016

ACEP16- Rapid Fire: Narcotics to Narcan, Las Vegas NV, October 2016

ACEP16- Rapid Fire: Do Your Patients Know You Care?, Las Vegas NV, October 2016

ACEP16- Feel the Burn: Preventing Burnout in EM, Las Vegas NV, October 2016

CECentral- Opioid Symposium, Narcotics to Narcan: Tackling the Opioid Epidemic, Lexington KY, October 2016

SEC ACEP- Critical Findings for the Community Doc, Destin FL, June 2016

SEC ACEP- Malpractice Minefield, Destin FL, June 2016

TN ACEP- Narcotics to Narcan, Chattanooga TN, March 2016

Can’t Miss Trauma for the Community Physician, SEC ACEP, Destin FL, June 2016

NASCAR Summit- I Will Take CO for an Answer, Concord NC, January 11, 2016

SEC ACEP- Implementing Narcan, Destin FL, June 2015

SEC ACEP- Building a Disaster Plan, Destin FL, June 2015

NASCAR Summit- Metropolis in a Cornfield, Charlotte NC, January 2015

CECentral- Heroin: Old Dog with New Tricks, Lexington KT, October 2014

FACOS Annual Clinical Assembly- Building the Framework for a Disaster, Boston MA, September 2014


SEC ACEP- Opioid Legislation: That Just Happened, Destin FL, June 2014

SEC ACEP- Frequent Flyers: Can We Cut the Sky Miles, Destin FL, June 2014

NASCAR Summit- That Just Happened, Charlotte NC, January 2014

CECentral- The Good, Bad, and Ugly of Substance Abuse, The Frontline of Addiction and Substance Abuse, Lexington KY, August 2013

SEC ACEP- Encephalitis and Meningitis Make My Head Hurt, Destin FL, June 2013

SEC ACEP- Street Drug Abuse, Destin FL, June 2013
SEC ACEP- Opioid Crisis in the US, Destin FL, June 2013
The Faces of Substance Abuse- "KASPER Update Panel", Lexington KY, January 23, 2013
NASCAR Summit- "They Could Be Drunk...Or They Could Be Dying", Concord NC, January 8, 2013
ACEP Spokesman Network- "Prescription Drug Abuse Prevention", Multiple Presentations, 2012
KMA Annual Meeting- "HB1 Update", Louisville KY, September 2012
SEC ACEP Back to Basics- "The Weakest Link", Destin Fl, June 12, 2012
SEC Hot Topics in Emergency Medicine- "Green Tobacco Sickness", Destin FL, June 2011
SEC Hot Topics in Emergency Medicine- “Scan Them Until They Glow: Risks of CT Radiation and Emergency Care”, Destin FL, June 2010
AAEM National Conference Photo Contest- “Purulent Pericardial Effusion”, February 2008

Research Publications
Ryan Stanton, Jeff Schoondyke, Rebecca Copeland, "Papillary Fibroelastoma in the Left Ventricular Wall", Cardiology Review, Volume: Fall 2003,


References

Dr. Mark Spanier, Baptist Health Lexington ED Medical Director, Central Emergency Physicians, 859-260-6180, markspanier1@gmail.com

BC Chad Traylor, Battalion Chief- Lexington Fire/EMS, 859-231-5644, traylorc@lexingtonky.gov

Dr. Chris Doty, Residency Director UK Department of Emergency Medicine, 859-323-5908, chris.doty@uky.edu
The 2022 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**
Rebecca B Parker, MD, 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**
Richard C. Hunt, MD, 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**
Jennifer L Wiler, 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**
Peter M DeBlieux, MD, FACEP

Presented to a member who has made a significant contribution to the educational aspects of emergency medicine.
ACEP HONORS 2022 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

**John A. Rupke Legacy Award**
Louis J. Ling, MD, FACEP

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.

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**Award for Outstanding Contribution in Research**
Deborah B Diercks, MD, MSc, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

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**Award for Outstanding Contribution in Research**
Kevin Ward, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

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**Award for Outstanding Contribution in EMS**
Ronald N. Roth, MD, FACEP

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.

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**Disaster Medical Sciences Award**
Roy L. Alson, MD, PhD, FACEP

Presented to an individual who has made outstanding contributions of national/international significance or impact to the field of disaster medicine.
**ACEP HONORS 2022 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS**

**Community Emergency Medicine Excellence Award**  
Kamara Graham, MD, FACEP  
Presented 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.

**Innovative Change in Practice Management Award**  
Jonathan Rogg, MD, MBA, FACEP  
Presented 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**  
Michael L. Callaham, MD, FACEP  
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**  
Sue Barnhart  
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.

**Diane K. Bollman Chapter Advocate Award**  
Colleen Kochanek, JD  
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.
ACEP HONORS 2022 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Honorary Membership Award
Brad Gruehn
Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award
Margaret Montgomery, RN, MSN
Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award
John "Jack" S. Rozel, MD, MSL, DFAPA
Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award
William Todd Thomas, CPC, CCS-P
Presented to individuals who have rendered outstanding service to the College or the medical profession.

Policy Pioneer Award
Zachary J. Jarou, MD, MBA
Presented to early- and mid-career members who have made outstanding contributions to the College’s health policy and advocacy initiatives.
ACEP HONORS 2022 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

**Council Meritorious Service Award**
James B Aiken, MD, FACEP
Presented to a member who has made consistent contributions to the growth and maturation of the ACEP Council.

**Innovation & Excellence in Behavioral Health & Addiction Medicine Award**
Gail D’Onofrio, MD, FACEP
Presented to an individual who has made a significant contribution in advancing the emergency department care of patients with behavioral health and substance use disorder.

**Public Health Trailblazer Award**
Harrison Alter, MD, FACEP
Presented to an individual who has made a significant contribution in advancing public health care and injury prevention measures locally, statewide, or nationally.

**EM Wellness Center of Excellence Award**
Riverside Community Hospital at UC Riverside
Presented to an emergency medicine group, department, or clinical site that incorporates wellness and resilience on an institutional level and to use the information gathered in the nominations process to understand more about wellness best practices.
2022 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 Councilor.
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
James B Aiken, 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
Scott H Pasichow, MD, MPH

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 Horizon Award
Michael Ruzek, DO, 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.
2022 ACEP COUNCIL AWARDS

**Council Teamwork Award**
Louisiana Chapter ACEP

**Purpose:** Presented to a component body or group of councilors 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.

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**Council Curmudgeon Award**
Marsha D. Ford, 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.

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**Council Champion in Diversity & Inclusion Award**
Ramon W Johnson, 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.
FY 2022-2027 Strategic Plan

1. Career Fulfillment Action Plan
   Goal: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.
   1. Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.
   2. Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients.
   3. Provide resources, roadmaps, education, and networks to assist members in identifying career opportunities and having career fulfillment based on different interests or at different life stages.
   4. Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

2. Advocacy Action Plan
   Goal: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local
   1. Expand and strengthen the role, approach, and impact of state-level advocacy.
   2. Employ a standardized advocacy approach to be more systematic and uniform.
   3. Empower members, through tools and information, to advocate for themselves within their own workplaces, regardless of employment model.
   4. Streamline advocacy content development and delivery to better communicate the importance, limitations, and accomplishments of advocacy efforts.
   5. Identify, test, and adopt new fundraising strategies to support advocacy programs and services.

3. Practice Innovation Action Plan
   Goal: Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.
   1. Using a systematic approach, identify two or three viable career options for emergency physicians that expand the practice of acute, unscheduled care.
   2. Support the implementation of prioritized new high-value practice models.
   3. Develop an institutional framework that will support the creation of innovative models going forward.

4. Member Engagement and Trust Action Plan
   Goal: Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.
   1. Create new leadership development programs that are more accessible, inclusive, and impactful within ACEP and throughout emergency medicine spheres of influence.
   2. Leverage personalization and opportunities for issue/interest-based participation to redefine engagement and to make a member’s connection to ACEP easier to navigate and more personally meaningful.
   3. Make it easier for ACEP members to navigate into leadership positions and engage with ACEP leaders.
   4. Re-imagine the EMRA to ACEP pathway to retain more members upon residency completion.
   5. Develop recognition and rewards to honor in all levels of engagement.
   6. Measure and showcase the diversity and character of ACEP leaders and members.
   7. Enhance ACEP’s brand positioning and communication strategies.

5. Resources and Accountability Action Plan
   Goal: ACEP commits to financially disciplined and modern processes and a culture that aligns sufficient and transparent stewardship of resources to strategic priorities most relevant to members and essential for the future of emergency medicine.
   1. Implement a systematic program evaluation process that considers new and on-going needs, return on investment (including member value), and the College strategic plan.
   2. Invest in overhauling ACEP’s digital infrastructure, processes, and culture to modernize systems and deliver a more personalized, proactive, and responsive experience for members and customers.
   3. Adopt effective project management techniques and data-driven decision-making processes.
   4. Re-examine membership/non-member pricing models and explore other models that would be of interest to more eligible members and still allow us to fulfill our mission.
   5. Develop alternative/non-traditional revenue and in-kind sources and opportunities to achieve our strategic priorities.
   6. Be more transparent and timelier in communicating College policies, operations, and initiatives.
YOUR LEADERSHIP

Finding strategies to reduce physical, verbal, and emotional abuse on ED professionals

YOUR SAFETY

The effect residency-trained, board-certified emergency physician-led care teams have on care quality in the ED

YOUR IMPACT

Analyzing the logistical and financial efficiencies of EM in the rapid evaluation and diagnosis of undifferentiated acute illness and injury

ACEP Councillors have contributed more than $2.5 million since the challenge inception.

Your support fuels our specialty!

Help your state reach 100% and go gold!
Find out more at emfoundation.org/ccmap

Meet EMF staff at the MCC Lobby Level South to make your donation or visit emfoundation.org
Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

and

Grassroots Advocacy

September 2022
NEMPAC celebrates more than 40 years of success in 2022. 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 of importance to the specialty that ACEP can influence in Congress, our goal is to raise more than $1 million annually. For the past ten years, this goal has been closely met and, in some years, exceeded, despite challenges that continue to confront the specialty.

Just like the NEMPAC Board of Trustees 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 our 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. The past two years and election cycle have been particularly challenging as our nation faced the greatest public health crisis in decades and increasing political partisanship and volatility. Despite many challenges, NEMPAC remains strong and continues to play a critical role in ACEP’s federal advocacy efforts.

NEMPAC serves a vital role in advancing ACEP’s legislative agenda and in broadening emergency medicine’s visibility with Congress. 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. NEMPAC remains the 4th largest medical specialty PAC in the nation.

The Council Challenge has been in place for more than 25 years. Councilors collectively contribute more than $250,000 annually to NEMPAC, which is one-quarter of our total raised annually.

2022 Election Cycle

In the 2022 election cycle, the NEMPAC Board of Trustees adopted the following strategies:
• Identify and assist candidates and incumbents who support ACEP’s mission, vision, and values.
• Support candidates in both major political parties who will work to advance ACEP’s issues or can influence positions important to the specialty of emergency medicine.
• Identify “Champions” of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits.
• Pursue and fund independent expenditure campaigns as warranted with hard dollars.
• Authorize a minimum contribution ($1000) to Senators and Representatives from the states and districts of members of the ACEP Board of Directors and the NEMPAC Board of Trustees. This strategy is designed to enhance the contacts between these two Boards and their Congressional representatives by giving the Board members the opportunity to attend virtual and local events for their Members of Congress.
• Prioritize check deliveries and attendance at in person and virtual fundraisers by ACEP members ACEP leaders, Chapter leaders, and NEMPAC VIP Donors.

The NEMPAC candidate budget is developed and approved by the NEMPAC Board of Trustees with guidance of ACEP staff. It is subject to modifications as the election cycle progresses and the congressional agenda takes shape. The budget is consistently evaluated by and has been modified throughout this election cycle to reflect NEMPAC’s fundraising efforts in 2021 and 2022. The budget was also amended to reflect the results of the 2020 census which altered the landscape as some states gained or lost congressional seats and incumbents were pitted against each other or decided to retire or run for other offices.

Evaluation Criteria

Candidates and incumbents who receive NEMPAC support are expected to exhibit behavior and actions consistent with the mission, vision and values of the American College of Emergency Physicians and uphold the principles of our
democratic process and orderly governance. NEMPAC supported candidates should affirm science, evidence and fact in their words and actions.

The integrity and character of the candidate will be assessed on an ongoing basis and NEMPAC may consider ceasing contributions to a candidate or committee if credible, specific, and serious allegations about the candidate’s behavior arise. NEMPAC also continues our commitment to inclusiveness and respect for diversity.

2022 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.

The NEMPAC 2022 Guidelines and a complete list of candidates supported are available on the NEMPAC website and by request from ACEP staff.

**NEMPAC 2022 Election Cycle Highlights**

Amount Raised in 2021: $852,295  
Amount Raised in 2022 as of 8/24: $500,366  
Donations to Candidates: $1,272,500 donated to candidates, leadership committees, party committees, and independent expenditures/SuperPACs.  
Party Breakdown: $685,000 (54%) to Democrats and $587,500 (46%) to Republicans  
Total Number of Candidates Supported: 163  
House Candidates Supported: 137 – 129 incumbents/8 open seat/challenger candidates  
Senate Candidates Supported: 26 – 25 Incumbents/1 open seat candidate  
Physician/Dentists Supported: 25 physician/dentist candidates/six emergency physician candidates including ACEP members Dr. Thran in the Vermont Senate race and Dr. Baumlin in the PA Senate race.  
See the NEMPAC website for specifics.

We carried over $634,445 from the previous election cycle, so have a balance of $455,419 as of August 24.

**Other Highlights:**

Co-host of the “House Call on the Mall” event with DCCC and NRCC and multiple physician specialty organizations – donated $15K to both party committees to have access to party leaders.

Spearheading efforts to elect and re-elect more physicians to congress. Hosted events for emergency physicians Rep. Raul Ruiz (D-CA), Dr. Richard McCormick (R-GA), and other physician candidates including Sen. Bill Cassidy (R-LA), Rep. Brad Wenstrup (R-OH), Rep. Ami Bera (D-CA), Rep. Kim Schrier (D-WA), Rep. Larry Bucshon (R-IN) and new candidates Dr. Yadira Caraveo (D-CO) and Dr. Kermit Jones (D-CA) with the physician PAC community;

Lead donor of the Healthcare Freedom SuperPAC organized in 2022 to help elect republican physicians, run by former and current physician members of congress including Drs. Roe, Harris, Burgess and Wenstrup – NEMPAC is one of the first donors at $25,000.

Donating to the House Majority PAC ($25,000) to support endangered democrat members of congress with our giving currently targeted to Rep. Kim Schrier, MD (D-WA) and Rep. Susan Wild (D-PA) – both NEMPAC champions.

Educating ACEP members about running for office and physicians currently in office through articles in ACEPNow, monthly NEMPAC Pulse newsletter and on the ACEP/NEMPAC website. Developing a 2022 NEMPAC Election Report for distribution in March of 2023 as an insert in ACEPNow.

Co-host annually of the Physician PAC Forum and the Specialty Physician Candidate Forum.
Developed a GOTV site for ACEP members.

Staff and ACEP member attended more than 700 fundraisers and meet and greets to date in the 2022 election cycle with about 15% attended virtually or in person by ACEP members. 20 percent of these events were hosted or co-hosted by NEMPAC/ACEP. Each event is an opportunity to discuss the concerns of emergency medicine and legislative solutions.

We continued the Distinguished Speakers Series for VIP donors (Give a Shift and above) with special guests in 2022 including Sen. Maggie Hassan (D-NH), Rep. Fred Upton (R-MI), and Rep. Kim Schrier, MD (D-WA). Past guests included Ways and Means Chairman Richard Neal (D-MA), Sen. Shelly Moore Capito (R-WV), Rep. Raul Ruiz, MD, FACEP (D-CA), election expert and political pundit, Nathan Gonzales, Sen. Bill Cassidy (R-LA), and Rep. Raja Krishnamoorthi (D-IL).

2022 Dine-arounds at LAC22: Sen. Tim Kaine (D-VA), Rep. Larry Bucshon, MD (R-IN), Rep. Ami Bera, MD (D-CA) special guest at the NEMPAC VIP reception. Other events where individual ACEP members attended were for Sen. Marsha Blackburn (R-TN), Sen. Gary Peters (D-MI), Sen. John Thune (R-SD), and a virtual event for Rep. Marianette Miller Meeks, MD (R-IA).


We developed and are distributing a 2022 NEMPAC Candidate Questionnaire for screening new candidates in the 2022 elections. This tool along with collaboration with state chapter leaders, helps the NEMPAC Board and staff evaluate viable candidates. To date, we are supporting 10 new candidates, five of whom are physicians.

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 6,000.

We have a robust ACEP Advocacy Action Center where you can find active action alerts, information about your legislators and access to the ACEP 911 Weekly Update.

LAC21 resulted in in 324 emergency physicians from 44 states participating in 287 conference call meetings with federal legislators and/or their healthcare staff, with 30 percent held with members of Congress. We covered 199 House offices and 88 Senate offices.

LAC22 resulted in 294 participants from 41 states participating in 255 in person and virtual meetings with federal legislators and their healthcare staff with 30 percent with Members or senior-level staff. We covered 170 House offices and 85 Senate offices. Note the House of Representatives was not in session during LAC22.

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.
2022 Member of the Year
John Corker, MD, FACEP
In recognition for his outstanding efforts to engage with policymakers and the public on behalf of emergency physicians and patients. Dr. Corker leads by example. As Immediate Past Chair of the YPS Section and Liaison to the ACEP Council, he encourages his colleagues to incorporate advocacy into their practice and everyday life to protect and advance the future of the specialty. His advocacy is encouraging, empathetic and motivating, to young physicians dealing with workforce pressures, COVID-19 stressors, and life milestones encountered in their first years out of residency. His thoughtful awareness and commentary through social media have encouraged many young and emerging leaders in emergency medicine. Such outreach has been his nature since medical school, when he and three fellow students created Radio Rounds, a podcast that eventually inspired EMRA*Cast and ACEP YPS’s newest webcast venture: EM LIFERS. He also serves on the Federal Government Affairs and Strategic Planning committees at ACEP.

You can join the 911 Network here: 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.
The Emergency Medicine Residents’ Association (EMRA) is proud to be ACEP’s oldest and strongest partner. As the EMRA president, I am honored to present EMRA’s annual report to the ACEP Council in celebration of our mission to help our joint members become the best doctors and leaders while advancing the specialty at large.

We are thrilled to welcome as of March our new Executive Director Kris Williams, CAE. She previously worked at ACEP and brings more than 20 years’ experience in association management.

EMRA is also putting the finishing touches on its triennial strategic plan and will roll that out during ACEP22. We are working to refocus the organization in the wake of exceptional growth in members, programming, and engagement over the last several years.

Thank you for your support of EMRA’s mission to be the voice of emergency medicine trainees and shape the future of our amazing specialty.

President
Angela Cai, MD, MBA

Emergency Medicine Residents’ Association Annual Report 2022
EMRA's resources provide meaningful and tangible ways to serve and connect with our 19,000 members. With a free EMRA/ACEP member kit filled with our most popular printed guides, these books stay with you through your career starting as a medical student exploring the specialty to an alumni member connecting with an organization that supported them in their training. Our publications also allow us to financially sustain our mission-driven work through diversified revenue sources.

I use our bedside guides on every single shift with the MobilEM app which gives instant, searchable access to the Antibiotic Guide, PressorDex, and more. EMRA continuously updates these resources in print and in-app to ensure our members in training stay up to date.

We are also continuing and enhancing our non-clinical educational offerings. ACEP and EMRA launched an online, asynchronous, clinically-focused business curriculum. The first module, Billing & Coding, launched in ACEP’s Online Learning Center in Summer 2022 with the formation of other modules slated to be complete in summer 2023.
EMRA helps you become the **BEST LEADER** you can be.

EMRA aims to cultivate lifelong leaders who will shape the future of EM. This is the area in which the partnership between EMRA and ACEP thrives through opportunities, mentorship, and pipelines to our specialty’s leaders in ACEP.

This year, EMRA appointed more than 60 liaisons to ACEP committees, sections, and task forces. We announced an objective to work with all ACEP Chapters to build a pipeline of leaders from across the country. This pipeline is designed to increase engagement among EM physicians in training. Our members care about issues that are often adjudicated at the state level and getting a foothold at the chapter level is a great entry point into ACEP and EM advocacy.

The annual EMRA/ACEP Leadership Academy had 69 graduates. EMRA committees offer leadership opportunities for 100+ trainees across 20 committees, including new subcommittees for Rural EM and Climate Change. We have improved our application questions and data collection to prioritize diversity of experiences and alignment with EMRA’s mission. Our committee leaders host their business meetings and provide programming virtually throughout the year as well as at ACEP SA and collaborate with ACEP Committees. Some of the highlights include:

- **Informatics workshops** by EMRA Technology, Telehealth, and Informatics Committee and ACEP Informatics Section
- **EMRA MedWAR at ACEP21** featuring faculty from ACEP Wilderness Section and EMS and Disaster Committees
- **EMRA/ACEP DEI mentorship program**

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**239 programs with 100% membership**

**20 committees**

**225+ meetings, webinars, publications**

**4,986 members of EMRA’s 20 committees**

- Medical students
- Residents
- Fellows

**104 funded national leadership opportunities for members**

**114 Leadership Academy fellows**

**69 graduates and 45 currently in the program**

**33 categories of awards, scholarships, and grants**

- Scholarships
- Leadership
- Professional excellence
With record Representative Council engagement this past year, EMRA passed the following resolutions, addressing:

- Workplace Violence and Resident Safety in the Emergency Department
- Amendment to EMRA’s Family and Medical Leave Policy
- Restrictive Covenants & Non-Competes
- Corporate Practice of Medicine
- Equitable Occupational Protection Measures for Emergency Medicine Trainees
- State Medical Licensure Questions Regarding Mental Health
- Funeral and Bereavement Leave for Medical Students and Physicians
- Resolving contradictions in EMRA Policy Compendium Related to NPPs, Supervision, and Telemedicine
- Clarifying Residency Applicant Competitiveness through Transparent SLOEs
- Emergency Medicine to Support Evidence-Based Policy Reforms of the

Criminal Justice System
- Equitable Health Care for Incarcerated Patients
- A unionization resolution was referred to the Board of Directors, and in response, EMRA convened a Resident Unionization Task Force, including representation from all EM resident organizations

The EMRA/ACEP YPS Health Policy Primer 2022 delivered timely education on the history of contract management groups and case studies of identifying problems and creating solutions at multiple levels of government from local to federal, regulatory (featuring ACEP DC Staff) to legislative. We closed with a conversation with Dr. Arvind Venkat, ACEP Board, on running for office.

EMRA released a workforce statement to advance our members’ voice and provide education on the following topics: Residency program growth and training standards, nonphysician providers, rural EM, expanding the scope of EM, and the corporate practice of medicine. We also participated in the Multiorganizational Taskforce Recommendations to the ACGME.

We are prioritizing recruiting the best and brightest to EM as EM bound medical students face increased uncertainty about the workforce. We are acknowledging their uncertainty while promoting positive messaging about the specialty.

- Our dedicated Medical Student Council of 25 members has provided outreach to 220+ EMIGs.
- Preference signaling: We supported the specialty’s participation and are developing supporting resources.
- We connected with more than 300 medical students through our medical student forums and residency fairs.
- The EMRA Diversity and Inclusion Committee has been mentoring and teaching HBCU medical students since 2019 to strengthen the pipeline to EM.