American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2025 Annual Council Meeting
Thursday Evening, September 4, 2025, through Saturday, September 6, 2025
Hyatt Regency Salt Lake City Hotel

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 upon adoption by the Council.

Asynchronous testimony will open on Thursday, August 7 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2025 resolutions will be posted on the Council engagED when asynchronous testimony opens. 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 of the resolution 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, AACEM, 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 hearings in Salt Lake City. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. All comments should be addressed to the Reference Committee Chair or the Council Speaker. **Please do not direct any communications to another member, including anyone who has posted comments before you, with whom you may or may not agree.** Proper decorum is expected within the asynchronous testimony platform as well as the in-person Reference Committee hearings during the Council meeting.

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, August 25. 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, August 29 and will be the starting point for the live Reference Committee hearings during the Council meeting in Salt Lake City on Friday, September 5.

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, Council officer candidates, and the resolutions. Additional documents may be added over the next several days, so please check again if what you need is not currently available.

We are looking forward to seeing everyone in Salt Lake City!

Your Council Officers,

Melissa W. Costello, MD, FACEP
Speaker

Michael J. McCrea, MD, FACEP
Vice Speaker

American College of Emergency Physicians®
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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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2025 Council Meeting
Reference Committees

Reference Committee A – Governance, Membership, & Academic Affairs
Resolutions 21-40

Susanne J. Spano, MD, FACEP (CA) – Chair
Shayne M. Gue, MD, FACEP (FL)
Torree M. McGowan, MD, FACEP (GS)
Diane Paratore, MD, MEd, MBA, FACEP (MI)
Michael D. Smith, MD, MBA, CPE, FACEP (LA)
Carol Wright Becker, MD, MBA, FACEP (WV)

Amanda Pairitz-Campo
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 41-60

Erik Blutinger, MD, MSc, FACEP (NY) – Chair
Brett H. Cannon, MD, JD, MBA, FACEP (GA)
Carrie de Moor, MD, FACEP (TX)
Comfort A. Orebayo, DO (CA)
George RJ Sontag, MD, FACEP (OH)
James C. Mitchiner, MD, MPH, FACEP (MI)

Brianna Hanson, MPH
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 61-80

Angela P. Cornelius, MD, FACEP (TX) – Chair
Greg Gafni-Pappas, DO, FACEP (MI)
Puneet Gupta, MD, FACEP (CA)
Amanda Irish, MD, MPH, MS (IA)
Jeffrey F. Linzer, MD, FACEP (GA)
Aaron Snyder, MD (NM)

Travis Schulz, MLS, AHIP
George Solomon, MHS, FP-C, CCP-C, TP-C

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2025 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Melissa W. Costello, MD, FACEP *Alabama Chapter*	
2	Commendation for Terry Fulmer, PhD, RN, FAAN, and the John A. Hartford Foundation *Kevin Biese, MD, MAT, FACEP* *Jonathan Fisher, MD, MPH, FACEP* *Geriatric Emergency Medicine Section*	
3	Commendation for Gene Scruggs *Douglas Char, MD, FACEP* *Kelly Gray-Eurom, MD, MMM, FACEP* *Chad Kessler, MD, MHPE, FACEP* *Chadd Kraus, DO, DrPH, CPE, FACEP* *James D. Thompson, MD, FACEP*	
4	Commendation for Michael Lemanski, MD, FACEP *Jordan Celeste, MD, FACEP* *Nicholas Cozzi, MD, MBA, FACEP* *B. Bryan Graham, MD, FACEP* *Alexa Golden, MD* *Brian Hiestand, MD, FACEP* *J. Mark Meredith, III, MD, FACEP* *John Proctor, MD, FACEP* *James L. Shoemaker, MD, FACEP*	
5	Commendation for Shelly Lyford and West Health *Kevin Biese, MD, MAT, FACEP* *Jonathan Fisher, MD, MPH, FACEP* *Geriatric Emergency Medicine Section*	
6	Commendation for Aisha T. Terry, MD, MPH, FACEP *District of Columbia Chapter*	
7	Commendation for Richard E. Wolfe, MD, FACEP *Jonathan Fisher, MD, MPH, FACEP* *Nicholas J. Jouriles, MD, FACEP* *Massachusetts College of Emergency Physicians*	
8	In Memory of James B. Broselow, MD *Marc Auerbach, MD* *Corrie E. Chumpitazi, MD, MS, FACEP* *Marianne Gausche-Hill, MD, FACEP* *Charles Macias, MD, FACEP* *Katherine E. Remick, MD, FACEP* *Mohsen Saidinejad, MD, MS, MBA, FACEP* *Sandra M. Schneider, MD, FACEP*	
9	In Memory of Vinod K. Chettur, MD *Pennsylvania College of Emergency Physicians*	

Resolution #	Subject/Submitted by	Reference Committee
10	In Memory of Conklin, MD, FACEP *Alaska Chapter*	
11	In Memory of Gregory L. Henry, MD, FACEP *Michigan College of Emergency Physicians*	
12	In Memory of Richard T. Hostelley, MD, FACEP *Pennsylvania College of Emergency Physicians*	
13	In Memory of Frank J. Jehle, Jr, MD, MPH, FACEP, FAAP *Massachusetts College of Emergency Physician s*	
14	In Memory of Roger B. Lim, MD *North Carolina College of Emergency Physicians*	
15	In Memory of Lidio W. Medina, MD *Pennsylvania College of Emergency Physicians*	
16	In Memory of Joseph Moellman, MD *Ohio Chapter*	
17	In Memory of Frank S. Orth, DO, FACEP *Ohio Chapter*	
18	In Memory of Janice E. Reisinger, MBA, CAE *Pennsylvania College of Emergency Physicians*	
19	In Memory of Ronald D. Stewart, MD, FACEP, FAEMS *Pennsylvania College of Emergency Physicians* *EMS-Prehospital Care Section*	
20	In Memory of Todd Thomas, CPC, CCS-P *Elijah Berg, MD, FACEP* *David Friedenson, MD, FACEP* *Edward Gaines, JD, CCP* *Michael Granovsky, MD, CPC, FACEP* *David A. McKenzie, CAE* *Rebecca B. Parker, MD, FACEP*	
21	Distinguished ACEP Fellow Recognition - Bylaws Amendment *Jeffrey Feden, MD, FACEP* *Nicole Veitinger, DO, FACEP* *Membership Committee* *Board of Directors*	A
22	International ACEP Fellow Recognition - Bylaws Amendment *International Emergency Medicine Committee* *International Emergency Medicine Section* *Board of Directors*	A
23	Councillor Allocations for Sections of Membership - CSR Amendment *Council Steering Committee*	A
24	Procedures for Addressing Charges of Ethical Violations & Other Misconduct - College Manual Amendment *Ethics Committee* *Board of Directors*	A

Resolution #	Subject/Submitted by	Reference Committee
25	Protecting Section Integrity and Member Engagement in ACEP *AAWEP Section* *Young Physicians Section*	
26	Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in EM *Christopher L. Smith, MD, FACEP* *Jessica J. Wall, MD, MPH, MSCE, FACEP* *Aine Yore, MD, FACEP* *California Chapter* *District of Columbia Chapter* *Washington Chapter* *Access, Belonging, & Community Section*	A
27	Upholding Equal Access to Care in EM Amidst Political Challenges *Michael J. Bresler, MD, FACEP* *Gus M. Garmel, MD, FACEP* *Nicole E. Exeni McAmis, MD* *Colorado Chapter* *Montana Chapter*	A
28	Establish a College-Wide Mentorship Program *Access, Belonging, and Community Committee*	A
29	Promote Equal Access in Leadership *Access, Belonging, and Community Committee*	A
30	Development of Research Grant Funding Opportunities Exclusively for ACEP Members as a Membership Benefit *Illinois Chapter*	A
31	Evaluate the Quality and Member Support for ACEP's Association with an Open Access Journal *Joshua J. Davis, MD* *Kenneth Frumkin, MD, PhD, FACEP*	A
32	Transparency in Vendor and Speaker Communication Restrictions at Scientific Assembly *California Chapter*	A
33	Emergency Medicine Public Education *Pennsylvania College of Emergency Physicians*	A
34	Recognition of Public Media as a Public Health Necessity *District of Columbia Chapter*	A
35	Appropriate Representation in the Review Committee for Combined EM Residency Programs *James Humble, MD, FACEP* *Joseph D. Lykins, MD* *Daniel Martin, MD, MBA, FACEP* *Vinay Mikkilineni, MD* *Travis Olives, MD, MPH, FACEP* *Katherine Ren, DO* *Delaware Chapter* *Illinois College of Emergency Physicians* *Dual Training Section* *Observation Medicine Section* *Pediatric Emergency Medicine Section*	A

Resolution #	Subject/Submitted by	Reference Committee
36	Reaffirming Support for 3-Year and 4-Year Emergency Medicine Residency Program Accreditation *California Chapter* *Young Physician Section*	A
37	Support for Funding Resident Training Away from Home Institutions *International Section* *Maryland Chapter*	A
38	Inclusion of ACEP Leadership Roles as Approved Practice Improvement Activities for ABEM Certification *Jamila Goldsmith, MD, FACEP* *Alexandra N. Thran, MD, FACEP* *Vermont Chapter* *Locum Tenens Section*	A
39	Support Board Certification as an Exemption for State Mandated CME Topics *New Mexico Chapter* *Michigan College of Emergency Physicians*	A
40	Support Ongoing Education on Implicit Bias and Structural Inequity *Access, Belonging, & Community* Section	A
41	Advocate for No-Fault Medical Liability Reform and Redefinition of Negligence in Health Care *Michigan College of Emergency Physicians*	B
42	Occurrence-Based Malpractice Coverage for All Emergency Physicians *Jeffrey D. Anderson, MD, FACEP* *Sean Vanlandingham, MD, MBA, FACEP* *Alabama Chapter*	B
43	Support for Eliminating Physician Non-Compete Clauses in Contracts *Pennsylvania College of Emergency Physicians* *Emergency Medicine Workforce Section*	B
44	Advocating for National Leadership on Workplace Violence in Health Care through the AMA *Illinois College of Emergency Physicians*	B
45	Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies *California Chapter* *New Jersey Chapter* *American Association of Women Emergency Physicians Section* *Young Physicians Section*	B
46	Support for Full Preservation of Medicaid *Abbas Husain, MD, FACEP* *District of Columbia Chapter* *American Association of Women Emergency Physicians Section* *Wellness Section*	B

Resolution #	Subject/Submitted by	Reference Committee
47	Protecting Medicaid Disproportionate Share Hospital (DSH) Payments to Preserve Emergency Care Access *District of Columbia Chapter*	B
48	Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA *Scott H. Pasichow MD, MPH, FACEP* *New Jersey Chapter* *American Association of Women Emergency Physicians Section* *Young Physicians Section*	B
49	Support for EMTALA Reform to Ensure Timely Access to Definitive Care *Joshua Davis, MD* *John F. McMaster, MD, FACEP*	B
50	Emergency Department Staffing Transparency *Louisiana Chapter* *Maine Chapter* *New Jersey Chapter* *Pennsylvania College of Emergency Physicians*	B
51	Supporting Board Certified Physicians in Every Emergency Department *Kansas Chapter*	B
52	Investigation of State Licensure Requirement for Hospital Administrators *Gary Gaddis, MD, PhD, FACEP* *Sonya Naganathan, MD, MPH, FACEP*	B
53	Prior Authorization Reform to Reduce Delays in Care and Emergency Department Burden *Kansas Chapter*	B
54	Reassessment and Potential Restructuring of the HCAHPS Survey and Its Role in Medicare Reimbursement *Nevada Chapter*	B
55	Reduce Non-Beneficial Regulation by The Joint Commission and other Health Care Regulatory Bodies *Michigan College of Emergency Physicians*	B
56	Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions *Michigan College of Emergency Physicians* *New Mexico Chapter*	B
57	Repeal Certificate of Need Laws to Expand Access and Improve Patient Care *Michigan College of Emergency Physicians*	B
58	Role of EDs in Interactions with U.S. Immigration and Customs Enforcement *Michael J. Bresler, MD, FACEP* *Nicole E. Exeni McAmis, MD* *Gus M. Garmel, MD, FACEP* *California Chapter* *Colorado Chapter* *Montana Chapter* *Ohio Chapter*	B

Resolution #	Subject/Submitted by	Reference Committee
59	Support Interstate Telemedicine Practice for Physicians with Permanent Licensure *Michigan College of Emergency Physicians* *New Mexico Chapter*	B
60	Tele-Emergency Medicine Oversight of Non-Board-Certified/Board-Eligible Emergency Medicine EDs *Minnesota Chapter*	B
61	Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers *Juliana Chang, MD* *Gayle Galletta, MD, FACEP* *Hillary Irons, MD, FACEP* *Emily Sbiroli, MD, FACEP* *Tushara Surapanemi, MD* *Massachusetts College of Emergency Physicians*	C
62	Promoting Environmental Sustainability and Waste Reduction in the ED *Kansas Chapter*	C
63	Addressing Bullying in the ED – Role of Emergency Physicians in Identification and Intervention *Michael J. Bresler, MD, FACEP* *Gus M. Garmel, MD, FACEP* *Nicole E. Exeni McAmis, MD* *Colorado Chapter* *Montana Chapter*	C
64	Endorsement of Electronic Discharge Instructions for Patients with Electronic Medical Records *Juliana Chang, MD, NY ACEP* *Gayle Galletta, MD, FACEP, MA ACEP* *Hillary Irons, MD, FACEP, MA ACEP* *Tushara Surapaneni, MD, CT ACEP* *Massachusetts College of Emergency Physicians* *New Jersey Chapter*	C
65	Emergency Physicians and Collaborative Practice Agreements *Louisiana Chapter* *Maine Chapter* *New Jersey Chapter*	C
66	Endorsing a Realistic Door-to-Doctor Standard *Sean Vanlandingham, MD, MBA, FACEP* *Alabama Chapter*	C
67	Forensic Programs in Trauma Centers *Forensic Medicine Section* *Illinois College of Emergency Physicians*	C
68	Integrating Firearm Safety Counseling into Emergency Medicine Education and Practice *Halleh Akbarnia, MD, MPH, FACEP* *Kristen Donaldson, MD, MPH, FACEP* *Illinois College of Emergency Physicians*	C

Resolution #	Subject/Submitted by	Reference Committee
69	Investigating Best Practices and Policy Solutions for Direct Communication When Referring Patients to the ED *Kansas Chapter*	C
70	Mandated Reporting of ED Violence *Colorado Chapter* *District of Columbia Chapter* *New York Chapter* *North Carolina College of Emergency Physicians* *Wellness Section*	C
71	Maintenance of Malpractice Tail Coverage in the Setting of Employer Bankruptcy *Louisiana Chapter* *New Mexico Chapter* *Pennsylvania College of Emergency Physicians* *Texas College of Emergency Physicians* *Vermont Chapter* *Emergency Medicine Workforce Section*	C
72	Naloxone Access and Education in Public Schools *Stephen H. Anderson MD, FACEP* *John Bibb, MD, FACEP* *Nida Degesys, MD, FACEP* *Ramnik Dhaliwal, MD, JD* *Alicia Gonzalez, MD, FACEP* *Alexis LaPietra, DO, FACEP* *Aimee Moulin, MD, FACEP* *Evan Schwarz, MD, FACEP* *Donald Stader, MD, FACEP* *Jessica Wall, MD, MPH, FACEP* *Scott Weiner, MD, FACEP* *California Chapter* *Missouri Chapter* *New Mexico Chapter* *Toxicology Section* *Pain Management & Addiction Medicine Section*	C
73	Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation *Stephen Anderson, MD, FACEP* *John Bibb, MD, FACEP* *Christine Collins, MD, FACEP* *Fred Dennis, MD, MBA, FACEP* *Anthony Furiato, DO, EJD, FACEP* *California Chapter* *Pain Management & Addiction Medicine Section*	C
74	Necessary Facility-Provided Medications from Emergency Departments *Pennsylvania College of Emergency Physicians* *Medical Directors Section* *Quality Improvement & Patient Safety Section* *Rural Emergency Medicine Section*	C

Resolution #	Subject/Submitted by	Reference Committee
75	Protecting the Term "Emergency Department" in Critical Access Hospitals *Louisiana Chapter* *Maine Chapter* *New Jersey Chapter* *Vermont Chapter*	C
76	Protection and National Standardization of Transgender Care in Emergency Medicine *Puneet Gupta, MD, FACEP* *Scott Pasichow, MD, FACEP* *California Chapter* *New Jersey Chapter* *Social Emergency Medicine Section*	C
77	Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation *New York Chapter* *North Carolina College of Emergency Physicians* *Ohio Chapter* *Texas College of Emergency Physicians*	C
78	Standardized Emergency Medicine Post-Graduate Training for Advanced Practice Providers *Gregory Gafni-Pappas, MD, FACEP* *Antony Hsu, MD, FACEP* *James Mitchiner, MD, FACEP*	C
79	Standards for the Safe and Appropriate Transport of Patients to Psychiatric Facilities *Pennsylvania College of Emergency Physicians*	C
80	Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding *Michigan College of Emergency Physicians*	C
	Late Resolutions	
81	In Memory of Joshua Alinger, MD *Illinois College of Emergency Physicians*	
82	In Memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired) *Texas College of Emergency Physicians*	
83	In Memory of Elizabeth B. Jones, MD, FACEP *Texas College of Emergency Physicians*	
84	In Memory of Brian Wai Lin, MD *California Chapter*	
85	In Memory of Forest Daniel McCoig, MD *Virginia Chapter*	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(25)

SUBMITTED BY: Alabama Chapter

SUBJECT: Commendation for Melissa Wysong Costello, MD, FACEP

WHEREAS, Melissa Wysong Costello, MD, FACEP, has served the American College of Emergency Physicians with dignity, distinction, and dedication as Council Vice Speaker 2021-2023 and Council Speaker 2023-25; and

WHEREAS, Dr. Costello represented the Council at Board of Directors' meetings during her term as Vice Speaker and Speaker and provided thoughtful discourse and comments on a variety of issues; and

WHEREAS, Dr. Costello gracefully led the Council during debate of contentious issues with respect and courtesy; and

WHEREAS, Dr. Costello diligently devoted significant amounts of time, creativity, humor, and enthusiasm to her duties as a Council officer; and

WHEREAS, Dr. Costello welcomed and encouraged the participation of new councillors and alternate councillors on Council committees and is respected for her integrity, objectivity, and mentorship that she provided to numerous councillors across all chapters of the College; and

WHEREAS, Dr. Costello has demonstrated a long history of service to the Council including serving on the Tellers, Credentials, & Elections Committee 2010-2017, and as committee chair 2013-2017; and

WHEREAS, Dr. Costello has maintained an active presence in the Alabama Chapter and served on the Board of Directors 2008-2014 and as President 2014-2015; and

WHEREAS, Dr. Costello has shown exemplary leadership and outstanding service with her participation on several committees and task forces of the College; and

WHEREAS; Dr. Costello is a visionary and influential leader with a distinguished career in emergency medicine as a clinician, mentor, and advocate for the specialty; and

WHEREAS, Dr. Costello will continue to be involved and committed to the cause and mission of ACEP and the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Melissa Wysong Costello, MD, FACEP, for her service as Council Vice Speaker and Council Speaker and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 2(25)

SUBMITTED BY: Kevin Biese, MD, MAT, FACEP
Jonathan Fisher, MD, MPH, FACEP
Geriatric Emergency Medicine Section

SUBJECT: Commendation for Terry Fulmer, PhD, RN, FAAN, and the John A. Hartford Foundation

WHEREAS, The United States is experiencing a demographic shift with a growing population of older adults, many of whom require emergency care at higher rates than the general population; and

WHEREAS, Older adults often face complex and unique medical challenges when seeking emergency care, including multiple chronic conditions, cognitive impairments, and social vulnerabilities; and

WHEREAS, The Age-Friendly Health Systems movement, based on the "4Ms" framework—What Matters, Medication, Mentation, and Mobility—provides a structured approach to delivering evidence-based, person-centered care to older adults; and

WHEREAS, The John A. Hartford Foundation and its President, Terry Fulmer, PhD, RN, FAAN, are dedicated to advancing age-friendly health care across all settings, including emergency departments; and

WHEREAS, The John A. Hartford Foundation and its President Terry Fulmer, PhD, RN, FAAN, have partnered with ACEP on age-friendly emergency care, including an important CMS quality measure that addresses geriatric boarding, and are also long-time supporters of the Geriatric Emergency Department Accreditation Program; and

WHEREAS, Through strategic investments, visionary leadership, and partnership with ACEP, the John A. Hartford Foundation has supported the integration of age-friendly principles into emergency care environments, enhancing the safety, quality, and dignity of care for older adults; therefore be it

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest appreciation to the John A. Hartford Foundation and its President, Terry Fulmer, PhD, RN, FAAN, for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 3(25)

SUBMITTED BY: Douglas M. Char, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Chad Kessler, MD, MHPE, FACEP
Chadd Kraus, DO, DrPH, CPE, FACEP
James D. Thompson, MD, FACEP

SUBJECT: Commendation for Gene Scruggs

WHEREAS, Gene Scruggs served the American College of Emergency Physicians (ACEP) with distinction and dedication through his many roles in ACEP's Technology Services/Information Technology Department; and

WHEREAS, Mr. Scruggs retired from ACEP effective April 1, 2025, after 37 years as a valued and respected staff member; and

WHEREAS, Mr. Scruggs played a critical role in the evolution of ACEP's technology systems and services providing invaluable knowledge and expertise; and

WHEREAS, Mr. Scruggs assisted with guiding ACEP through several major overhauls of membership systems, the website, and multiple other technology platforms, systems, and software; and

WHEREAS, Mr. Scruggs was instrumental in identifying and implementing process improvements for councillor credentialing and updated software for electronic voting on resolutions and conducting the elections during the Council meeting; and

WHEREAS, Mr. Scruggs was a resource to the Council Tellers, Credentials, & Elections Committee; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Gene Scruggs for his outstanding service and commitment to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for his extraordinary contributions.

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American College of Emergency Physicians®
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RESOLUTION: 4(25)

SUBMITTED BY: Jordan Celeste, MD, FACEP
Nicholas Cozzi, MD, MBA, FACEP
B. Bryan Graham, MD, FACEP
Alexa Golden, MD
Brian Hiestand, MD, FACEP
J. Mark Meredith, III, MD, FACEP
John Proctor, MD, FACEP
James L. Shoemaker, MD, FACEP

SUBJECT: Commendation for Michael J. Lemanski, MD, FACEP

WHEREAS, Michael J. Lemanski, MD, FACEP, served as ACEP's Alternate Advisor to the Current Procedural Terminology (CPT) Editorial Panel from November 2016 to June 2025, attending quarterly CPT meetings and participating in work groups and similar special project meetings; and

WHEREAS, Dr. Lemanski was appointed and served two terms on the CPT Assistant Editorial Advisory Board, providing both specialized expertise and broad professional perspective regarding the proper application of CPT codes; and

WHEREAS, Dr. Lemanski represented emergency medicine through the once-in-a-generation changes to the documentation guidelines that determine Evaluation and Management (E/M) code levels of service, not only helping to shape the modifications themselves, but also helping the emergency medicine community understand them all; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Michael J. Lemanski, MD, FACEP, for his outstanding dedication and contributions on behalf of the specialty of emergency medicine and to the CPT Editorial Panel.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
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RESOLUTION: 5(25)

SUBMITTED BY: Kevin Biese, MD, MAT, FACEP
Jonathan Fisher, MD, MPH, FACEP
Geriatric Emergency Medicine Section

SUBJECT: Commendation for Shelly Lyford and West Health

WHEREAS, The aging population in the United States is growing rapidly, with adults aged 65 and older representing one of the fastest-growing segments of the population; and

WHEREAS, Older adults visit the emergency department (ED) at disproportionally higher rates compared to younger adults; and

WHEREAS, Older adults often face complex and unique medical challenges when seeking emergency care, including multiple chronic conditions, cognitive impairments, and social vulnerabilities; and

WHEREAS, West Health, a family of nonprofit, nonpartisan organizations founded by Gary and Mary West and led by CEO Shelley Lyford, has demonstrated an unwavering commitment to improving the healthcare system for older Americans; and

WHEREAS, West Health has partnered with ACEP to promote and advance the quality and accessibility of emergency care for older adults through generous financial and technical support for ACEP's Geriatric Emergency Department Accreditation program and other initiatives; and

WHEREAS, The Geriatric Emergency Department Accreditation has recently reached several milestones and continues to change the face of emergency care for older adults; therefore be it

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest appreciation to West Health and its CEO Shelley Lyford for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

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RESOLUTION: 6(25)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Commendation for Aisha T. Terry, MD, MPH, FACEP

WHEREAS, Aisha T. Terry, MD, MPH, FACEP, has demonstrated unwavering dedication to the advancement of emergency medicine and to the mission of the American College of Emergency Physicians throughout her distinguished career; and

WHEREAS, Dr. Terry served with distinction as the President of the DC Chapter of ACEP and went on to make history as the first African American physician to serve as President of National ACEP (2023-2024), setting a precedent and inspiring a generation of underrepresented physicians in the specialty; and

WHEREAS, During her tenure as national ACEP President, Dr. Terry championed workforce well-being, the expansion of emergency physician leadership pathways, and systemic reforms aimed at reducing emergency department boarding, and improving conditions for emergency care teams nationwide; and

WHEREAS, Dr. Terry serves as an Associate Professor of Emergency Medicine and Health Policy at The George Washington University School of Medicine and the Milken Institute School of Public Health, where she continues to educate and mentor future leaders in medicine and public health; and

WHEREAS, Dr. Terry is the founder and CEO of the Minority Women in Science Foundation, a nonprofit committed to advancing science and medicine careers for women from underrepresented backgrounds, reflecting her broader commitment to diversity, equity, and inclusion; and

WHEREAS, Dr. Terry has served in numerous national leadership roles within ACEP, including positions on the Board of Directors, and is widely recognized for her visionary leadership, collaborative spirit, and deep commitment to mentorship; and

WHEREAS, Dr. Terry's contributions to policy, education, advocacy, and clinical care continue to shape the future of emergency medicine, and her efforts have earned national recognition across the fields of health policy and academic medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Aisha T. Terry, MD, MPH, FACEP, for her exceptional leadership, enduring contributions to the specialty of emergency medicine, and her unwavering dedication to the mission and values of ACEP and the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 7(25)

SUBMITTED BY: Jonathan Fisher, MD, MPH, FACEP
Nicholas J. Jouriles, MD, FACEP
Massachusetts College of Emergency Physicians

SUBJECT: Commendation for Richard E. Wolfe, MD, FACEP

WHEREAS, Richard E. Wolfe, MD, FACEP, has been a long-standing member of ACEP and a former member and chair of ACEP's Program Committee, and he helped shape *Scientific Assembly* and education within ACEP and the specialty; and

WHEREAS, Dr. Wolfe founded not one but two emergency medicine residencies and has been instrumental in the training of hundreds of residents and mentoring emergency physicians during his career; and

WHEREAS, Dr. Wolfe has edited several key textbooks, authored over a hundred articles and papers, and spent countless hours lecturing, all in the advancement of emergency medicine; and

WHEREAS, Dr. Wolfe's academic expertise has been instrumental in developing and establishing the specialty of emergency medicine; and

WHEREAS, Dr. Wolfe is stepping down as Chief of Emergency Medicine at Beth Israel Deaconess Medical Center (BIDMC) after 26 years of service; therefore it be

RESOLVED, That the American College of Emergency Physicians commends Richard E. Wolfe, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 8(25)

SUBMITTED BY: Marc Auerbach, MD
Corrie E. Chumpitazi, MD, MS, FACEP
Marianne Gausche-Hill, MD, FACEP
Charles Macias, MD, FACEP
Katherine E. Remick, MD, FACEP
Mohsen Saidinejad, MD, MS, MBA, FACEP
Sandra M. Schneider, MD, FACEP

SUBJECT: In Memory of James B. Broselow, MD

WHEREAS, The specialty of emergency medicine and prehospital emergency medical services lost a compassionate physician, leading innovator, dedicated educator, and colleague in James B. Broselow, MD, who died on February 20, 2025, at the age of 82; and

WHEREAS, Dr. Broselow grew up in Franklinville, NJ, the son of a family doctor and jazz vocalist and he was a high school quarterback and all-round athlete; and

WHEREAS, Dr. Broselow graduated from Dartmouth College in 1965 with a degree in economics and then attended New Jersey College of Medicine and Dentistry where he received his medical degree in 1969; and

WHEREAS, Dr. Broselow practiced as a board-certified family physician in Frankenmuth, MI before transitioning to emergency medicine; and

WHEREAS, Dr. Broselow was married to his hometown sweetheart, Mildred “Millie” Ella Taylor, and delighted in his daughter Sabrina Moser, her husband Marc, and grandsons Wolfgang James and Leopold Roland; and

WHEREAS, Dr. Broselow practiced at Lincoln County Hospital, Cleveland Memorial, and Catawba Valley Medicine Center before retiring from clinical practice in 2006 to devote himself to visionary and entrepreneurial endeavors; and

WHEREAS, Dr. Broselow revolutionized pediatric emergency medicine with the creation of the Broselow Tape, developed in 1985 with Robert Luten, MD, of the University of Florida College of Medicine; and

WHEREAS, The Broselow Tape color-coded system saved millions of lives through the use of a stress-reducing system that is widely used around the world; and

WHEREAS, Dr. Broselow continued to work on paradigm-shifting optimizations to enhance safety right up to the time of his passing; and

WHEREAS, Dr. Broselow was an exceptional clinician, peer, and consummate innovator; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by James B. Broselow, MD, as one of the leaders in advancing pediatric emergency care, pediatric readiness, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James B. Broselow, MD, his wife Millie, his family, and his friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of North Carolina and the United States.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 9(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Vinod K. Chettur, MD

WHEREAS, The specialty of emergency nedicine lost an exceptional physician when Vinod K. Chettur, MD, passed away on March 21, 2025 at the age of 56 after a year-long battle with colon cancer and complications related to his treatment; and

WHEREAS, Dr. Chettur graduated from the University of Illinois in 1990 where he studied biochemistry; and

WHEREAS, Dr. Chettur graduated from the Loyola University of Chicago Stritch School of Medicine in 1996; and

WHEREAS, Dr. Chettur completed residency training at Ascension Saint Vincent in Indianapolis, IN; and

WHEREAS, Dr. Chettur was employed at Logansport Hospital in Indiana for two years; and

WHEREAS, Dr. Chettur returned to Pennsylvania to work within the UPMC Health System from 2003-2024 at 13 hospitals and also worked at Washington Hospital from 2002-2008; and

WHEREAS, Dr. Chettur made a huge impression on everyone who met him; and

WHEREAS, Dr. Chettur came to work every day with a smile and terrific attitude, and everyone knew it was going to be a great day because he was there; and

WHEREAS, Dr. Chettur had an incredible sense of humor that helped him through his suffering; and

WHEREAS, Dr. Chettur loved being an emergency physician and served as his whole family's "on-call" physician; and

WHEREAS, Dr. Chettur grew up in State College, PA and was a lifelong Penn State fan and sports enthusiast; and

WHEREAS, Dr. Chettur enjoyed traveling, cooking, fine dining, the Steelers, Da Bears, the Cubs, the White Sox, and spending time with family and friends; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Vinod K. Chettur, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his mother Jayanthi Menon, his father Govindan Chettur, his sister Rema Makhija, and his nephew Aran our heartfelt gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 10(25)

SUBMITTED BY: Alaska Chapter

SUBJECT: In Memory of Terry A. Conklin, MD, FACEP

WHEREAS, With the passing of Terry A. Conklin, MD, FACEP, on June 24, 2024, emergency medicine lost an irreplaceable member of the Alaska Chapter of American College of Emergency Physicians, a valuable leader, teacher, and beloved friend in the field of emergency medicine; and

WHEREAS, Dr. Conklin discovered his love of medicine while serving as a Combat Field Medical Specialist with the United States Army in the Republic of Panama from October 1990 until June 1992; and

WHEREAS, Dr. Conklin received his bachelor's degree in Natural Science from Lewis-Clark State College and medical degree from the University of Washington, completed his residency at Resurrection Emergency Medicine in Chicago, IL, was board certified in emergency medicine by the American Board of Emergency Medicine, and was a Fellow of ACEP; and

WHEREAS, Dr. Conklin served as an important member of the Foundation Health Partners Medical Staff since July 8, 2010, when he came to Fairbanks Memorial Hospital as an emergency physician with Golden Heart Emergency Physicians (GHEP); and

WHEREAS, Dr. Conklin provided strong leadership for GHEP serving as president from 2023 until his death; and

WHEREAS, Dr. Conklin served on the Peer Review Committee/Professional Practice Evaluation Committee from 2017 until his death; and

WHEREAS, Dr. Conklin served as a member of the Bylaws Committee from 2015-2018 and he also served various roles on the Medical Executive Committee/Leadership Council including: Secretary/Treasurer 2015-2016; Vice Chief of Staff 2017-2018; Chief of Staff 2019-2021 where his role was crucial in establishing a professional, cohesive, collaborative relationship between the medical staff, administration, and the hospital board through the pandemic; and past Chief of Staff 2022-2023; and

WHEREAS, Dr. Conklin served as Medical Director for the University of Alaska Fairbanks Paramedic Academy from 2015 until his death; and

WHEREAS, Dr. Conklin believed that the only thing better than being an emergency physician was spending time with his beloved family; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognizes the outstanding dedication and contribution of Terry A. Conklin, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Alaska Chapter extends to the family of Terry A. Conklin, MD, FACEP, his colleagues, partners, former residents, and all friends our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Alaska, where his impact will be felt for generations to come.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 11(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Gregory L. Henry, MD, FACEP

WHEREAS, As William Shakespeare said in *As You Like It*, "All the world's a stage, and all the men and women merely players. They have their exits and their entrances; And one man in his time plays many parts;" and

WHEREAS, With the passing of Gregory L. Henry, MD, FACEP on November 26, 2024, a veritable giant in the world of emergency medicine, the American College of Emergency Physicians (ACEP) and the Michigan College of Emergency Physicians (MCEP) lost a beloved clinician, leader, educator, orator, advocate, curmudgeon, scholar, musician, philosopher, and friend; and

WHEREAS, Dr. Henry received his undergraduate degree in 1969 and his medical degree in 1973, both from the University of Michigan, and then practiced as a clinical emergency physician for 38 years, including serving 21 years as Chief of the Department of Emergency Medicine at Oakwood Hospital – Beyer Center in Ypsilanti, Michigan; and

WHEREAS, Dr. Henry served academically as a Clinical Professor in the Department of Emergency Medicine at the University of Michigan Medical School in Ann Arbor, Michigan; and

WHEREAS, Dr. Henry became one of the first American Board of Emergency Medicine Diplomates in 1981 and one of the first Fellows of the American College of Emergency Physicians in 1982; and

WHEREAS, Dr. Henry joined ACEP in 1976 and remained actively engaged in both MCEP and ACEP for the rest of his life; and

WHEREAS, Dr. Henry served on the MCEP Board of Directors from 1985-1990, including serving as Treasurer from 1988-1990; and

WHEREAS, Dr. Henry served on the ACEP Board of Directors from 1989-1997, including a year as President of ACEP from 1995-1996; and

WHEREAS, Dr. Henry was recognized for his contributions to the field of emergency medicine throughout his career, including as recipient of the MCEP Ronald L. Krome Meritorious Service Award in 1997, the ACEP John G. Wiegenstein Award for Leadership in 1998, and the MCEP John G. Rupke, MD, Lifetime Achievement Award in 2010; and

WHEREAS, In addition to clinical, societal, and educational contributions to emergency medicine, Dr. Henry was internationally known as an expert in patient safety and risk management; and

WHEREAS, More than anything, as a gifted storyteller with a unique ability to command an audience, teaching was Dr. Henry's passion, and his love for emergency medicine was reflected in the energy and enthusiasm that he brought to every presentation he made and the many unforgettable aphorisms we remember him for; and

WHEREAS, Dr. Henry brought a scholar's love for the arts to his life, often quoting Shakespearean and Latin texts, as well as entertaining music lovers as the percussionist in his jazz band, The Emergitones; and

WHEREAS, Dr. Henry had a long and distinguished career and life as an invaluable resource, mentor, and friend, and as such, will be dearly missed; and

WHEREAS, Reflecting on a lifetime of contributions to emergency medicine, *si monumentum requiris, circumspice*; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the lifetime of service that Gregory L. Henry, MD, FACEP gave to the specialty of emergency medicine, generations of emergency physicians, and the patients we serve as a clinician, educator, leader, orator, advocate, and scholar; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Henry, MD, FACEP, especially his wife Margene, his three children, and his two grandchildren, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, the United States, and the world, where his impact will be felt for generations to come.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 12(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Richard T. Hostelley, MD, FACEP

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Richard T. "Dick" Hostelley, MD, FACEP, passed away, on December 1, 2024, at the age of 80; and

WHEREAS, Dr. Hostelley was born in Philadelphia in 1944; and

WHEREAS, Dr. Hostelley graduated from Dickinson College in 1965 with majors in biology and chemistry; and

WHEREAS, Dr. Hostelley graduated from Temple Medical School in 1969; and

WHEREAS, Dr. Hostelley served as a board-certified emergency physician at Holy Redeemer Hospital and later Jeanes Hospital; and

WHEREAS, Dr. Hostelley retired from practicing medicine in 2024 to pursue his love of traveling, gardening, and N gauge trains; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Richard T. Hostelley, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Linda of 49 years, his sister Bissie Miller, and numerous nieces and nephews gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 13(25)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Frank J. Jehle, Jr, MD, MPH, FACEP, FAAP

WHEREAS, The American College of Emergency Physicians mourns the passing of Frank J. Jehle, Jr, MD, MPH, FACEP, FAAP, who died on April 28, 2025; and

WHEREAS, Dr. Jehle graduated from Wayne State University School of Medicine in 1965, completed a residency in pediatrics at the Children's Hospital of Michigan, earned a Master of Public Health degree from Harvard University, served in the United States Navy, and ran a large solo pediatric primary care practice in Rhode Island for 15 years; and

WHEREAS, Dr. Jehle transitioned to pediatric emergency medicine in 1988 by completing a residency in emergency medicine at UMass Chan School of Medicine, followed by a pediatric emergency medicine fellowship at Rhode Island Hospital; and

WHEREAS, Dr. Jehle joined the newly created Division of Pediatric Emergency Medicine at UMass Memorial in 1992 and served faithfully until his retirement in 2019; and

WHEREAS, Dr. Jehle devoted his career to the compassionate care of children in the Pediatric Emergency Department at the UMass Memorial Children's Medical Center, and to the education of innumerable medical students, pediatric, and emergency medicine residents; and

WHEREAS, Dr. Jehle was beloved for his generosity and warmth, known for hand-packed treats for young patients and thoughtful birthday and holiday cards, Sunday "coffee rounds" for the entire team, and his ever-present kindness in always feeding the residents and medical students on shift to ensure those he taught were also cared for in body and spirit; and

WHEREAS, Dr. Jehle's distinguished career was marked by numerous teaching awards from the Departments of Pediatrics and Emergency Medicine at UMass, and the UMass Memorial Children's Medical Center, and his influence endures through an annual resident-given faculty award in his name, as well as the redesign of the UMass Pediatric Emergency Department, which was named in his honor and displays his portrait; and

WHEREAS, Dr. Jehle's career earned him the reputation and admiration among all who worked with him and nurses and other staff have described him as "the greatest doctor of all time" and physicians reverently refer to him as "a legend;" and

WHEREAS, Dr. Jehle was a longstanding member of ACEP from 1988 through 2021, embodying the values of the specialty and contributing meaningfully to its growth through clinical service, education, and mentorship; therefore be it

RESOLVED, That the American College of Emergency Physicians extends its deepest sympathy to the family, friends, and colleagues of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP; and be it further

RESOLVED, That ACEP gratefully acknowledges and honors the legacy of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP, a physician of extraordinary compassion, wisdom, and integrity that touched innumerable live, whose wisdom will be passed down for generations and made lasting contributions to the field of pediatric emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 14(25)

SUBMITTED BY: North Carolina College of Emergency Physicians

SUBJECT: In Memory of Roger B. Lim, MD

WHEREAS, Roger B. Lim, MD, dedicated his life to the service of others, serving as a beacon of hope and healing for patients in their most critical moments; and

WHEREAS, Dr. Lim was a proud partner of Mountain Emergency Physicians for his entire post-residency career; and

WHEREAS, Dr. Lim's kindness and compassion was felt by his colleagues, co-workers, and patients with every encounter; and

WHEREAS, Outside of the hospital, Dr. Lim was a devoted husband and father to his wife, April, and their two children, Ian and Gabriel; and

WHEREAS, His unexpected passing has deeply impacted colleagues, patients, and the broader emergency medical community, leaving behind a legacy of expertise, compassion, and resilience; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the legacy of Roger B. Lim, MD, and recognizes his extraordinary contributions to emergency medicine, his dedication to the countless lives he saved, and the compassion that defined his practice; and be it further

RESOLVED, That the American College of Emergency Physicians extends our deepest sympathies to the family, friends, and colleagues and remembers the profound impact Roger B. Lim, MD, made and his memory will continue to inspire all who follow in his footsteps.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 15(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Lidio W. Medina, MD

WHEREAS, The specialty of emergency medicine lost an exceptional physician when Lidio W. Medina, MD, passed away on November 14, 2024, at the age of 83; and

WHEREAS, Dr. Medina was born in Villeta, Paraguay, and lived most of his young life in Argentina before moving to the United States; and

WHEREAS, Dr. Medina played soccer professionally in South America before attending medical school; and

WHEREAS, Dr. Medina completed his Internal Medicine residency at Grace Hospital in Detroit in 1973; and

WHEREAS, Dr. Medina immediately started working in emergency departments following his training; and

WHEREAS, Dr. Medina worked as a permanent nocturnist for the next 38 years; and

WHEREAS, Dr. Medina worked at four different hospital systems including St. Joseph Hospital, Detroit, MI 1973-1981; William Beaumont Hospital, Troy, MI 1981-1986; York Hospital, York, PA 1986-2004; and Heart of Lancaster Hospital, Lititz, PA 2004-2011; and

WHEREAS, Dr. Medina's career as an emergency physician impacted countless lives; and

WHEREAS, Dr. Medina loved teaching residents and training the next generation of physicians; and

WHEREAS, Dr. Medina's other interests included playing tennis, which he did up to five days a week even into his mid-70s, watching soccer, and traveling with his wife and family; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Lidio W. Medina, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Patricia of 53 years, his son Jim (wife Stacie), and daughter Michelle Medina-Smuck (husband Darryl), as well as his numerous grandchildren, gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 16(25)

SUBMITTED BY: Ohio Chapter

SUBJECT: In Memory of Joseph Moellman, MD

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Joseph Moellman, MD, passed away on February 17, 2025; and

WHEREAS, Joseph Moellman, MD, obtained his MD from the University of Cincinnati in 1992, and was selected to Alpha Omega Alpha, his junior year. He then completed his residency in emergency medicine at the University of Cincinnati, where he also served as Chief Resident; and

WHEREAS, Dr. Moellman was a faculty member at the University of Cincinnati for 28 years where he dedicated his career to advancing emergency medicine through his clinical expertise, research, and commitment to medical education; and

WHEREAS, Dr. Moellman was a nationally known expert in his work in the diagnosis and emergency treatment of acute allergic conditions, angioedema, and anaphylaxis, producing over 50 peer-reviewed publications; and

WHEREAS, Dr. Moellman was perennially recognized as a Top Doc by Cincinnati Magazine and won the 2022 American College of Emergency Physicians, Ohio Chapter, Emergency Physician of the Year Award; and

WHEREAS, Dr. Moellman's passion for teaching and mentorship shaped the next generation of emergency physicians, and his dedication to patient care leaves a lasting legacy; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Joesph Moellman, MD, who dedicated himself to his patients, his trainees, his profession, and his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Ohio College of Emergency Physicians extends to his wife Kim, his sons Josh Moellman and Jordan Moellman, gratitude for his tremendous service as an emergency physician at the University of Cincinnati, as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 17(25)

SUBMITTED BY: Ohio Chapter

SUBJECT: In Memory of Frank S. Orth, DO, FACEP

WHEREAS, The specialty of emergency medicine lost an outstanding clinician and friend when Frank S. Orth, DO, FACEP, passed away on September 18, 2024, at the age of 67; and

WHEREAS, Dr. Orth graduated from Kirksville College of Osteopathic Medicine in June 1983, completing his residency training at Doctors Hospital in Columbus, OH; and

WHEREAS, Dr. Orth worked at multiple central Ohio healthcare organizations, becoming the heart and soul of Immediate Health Associates where over his career he served as CMO, Chairman of the Board, President, and Medical Director; and

WHEREAS, Dr. Orth was an outstanding community leader, serving as the Westerville Fire/EMS Medical Director for over 25 years, as well as medical director to several additional central Ohio EMS agencies; and

WHEREAS, Dr. Orth was a pioneer in prehospital medicine, including directing the Westerville Division of Fire to become the first fire-based EMS system in Ohio to utilize adult CPAP; and

WHEREAS, Dr. Orth was recognized posthumously at the 2025 Ohio Star of Life Awards as Medical Director of the Year Award for his prehospital training and education; and

WHEREAS, Dr. Orth will also be remembered for his humor, adventurous spirit, and numerous hobbies; and

WHEREAS, Dr. Orth was affectionately referred to as an “elite” basketball player and mediocre golfer; and

WHEREAS, Dr. Orth’s legacy of compassion, wisdom, and love will forever remain in the hearts of those who knew him; therefore be it

RESOLVED, That the American College of Emergency Physicians extends to the family of Frank S. Orth DO, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his community and the countless patients that benefited from his care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 18(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Janice E. Reisinger, MBA, CAE

WHEREAS, The Pennsylvania College of Emergency Physicians and the American College of Emergency Physicians lost an exemplary colleague when Janice E. (Jan) Reisinger, MBA, CAE, passed away from a brief but brave battle with pancreatic cancer on Saturday, April 12, 2025, at the age of 60; and

WHEREAS, Jan Reisinger, MBA, CAE, served as the Executive Director for the Pennsylvania College of Emergency Physicians (PACEP) from 2019-2025; and

WHEREAS, Jan was the first independent Executive Director in PACEP's nearly 50-year history; and

WHEREAS, Within just a few years under Jan's guidance, PACEP went from a state of financial peril to one of stability and growth; and

WHEREAS, Jan's superb ability to connect with people helped to foster relationships and expand the PACEP network, significantly increasing exhibitor participation and sponsorships at our annual Scientific Assembly, and maximizing CME credits for both allopathic and osteopathic members; and

WHEREAS, Jan's meticulous planning and execution of the PACEP Scientific Assembly led to record-breaking in-person attendance in 2023, 2024, and 2025; and

WHEREAS, Jan helped forge a partnership with a new lobbying firm, making PACEP much more visible on a state level for advocacy; and

WHEREAS, Jan digitized PACEP's historical records and helped to make the award-winning 50th anniversary documentary film, *Missing Square to Shining Star*, that aired statewide on the Pennsylvania Cable Network (PCN), raising the profile of emergency physicians and the positive impact of PACEP on the health of Pennsylvanians; and

WHEREAS, Jan's impact bridges PACEP and ACEP, extending her impact to the national level; and

WHEREAS, Jan was an active member of the national ACEP Membership Committee from 2021-25; and

WHEREAS, Jan was an active member of the national ACEP National/Chapter Relations Committee from 2023-25; and

WHEREAS, Jan first joined the ACEP Chapter Executives Committee in 2021 and was shortly thereafter selected as the Chair for the May 2023-May 2025 term; and

WHEREAS, Prior to devoting her work to emergency physicians, Jan contributed her talents to the practice of medicine and health care in general, serving in the Pennsylvania Osteopathic Medical Association, the Greater Pennsylvania Chapter of the Alzheimer's Association, and the Pennsylvania Medical Society; and

WHEREAS, Jan held key leadership roles within other health care organizations, including Education Program Manager for the Pennsylvania Medical Society (2018-19); Education and Outreach Coordinator for the Greater Pennsylvania Chapter of the Alzheimer's Association (2016-19); Vice President for Physician Leadership, Education

and Practice Support with the Pennsylvania Medical Society (2014-15); and Executive Director and Vice President for Specialty Society Management Services with the Pennsylvania Medical Society (1999-2015); and

WHEREAS, Jan understood clinical medicine, previously serving as the Director of Marketing and Development and Practice Administrator for PHB Management Co./Beacon Medical Group (Camp Hill, PA), as well as the Practice Administrator for Shepherdstown Family Practice (Mechanicsburg, PA); and

WHEREAS, Outside of medicine, Jan served numerous other organizations equally proficiently, including numerous leadership roles with the Pennsylvania Society for Association Excellence, the American Society of Association Executives, the Juniata County Business and Professional Women's Association of Pennsylvania; and

WHEREAS, Jan also served her community as an active Pennsylvania Interscholastic Athletic Association (PIAA) field hockey official, and as a member and in multiple leadership positions in United States Field Hockey and the Harrisburg Chapter of Field Hockey Officials; and

WHEREAS, Jan acquired both her Bachelor of Arts in Organizational Management and later her Master of Business Administration degrees from Eastern University in St. David's, PA, and obtained Certified Association Executive certification from the American Society of Association Executives in 2013; and

WHEREAS, Her exceptional dedication and unwavering commitment to PACEP and the specialty of emergency medicine has left a profound and lasting impact on our organization; and

WHEREAS, For many within PACEP, Jan was a colleague, a friend, and like family, and her memory and legacy will live on in our organization; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Jan Reisinger, MBA, CAE; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to her husband Greg, her mother Maxine, her sister Ann, and her extended family, as well as countless professional colleagues and personal friends, gratitude for her service to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 19(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
EMS-Prehospital Care Section

SUBJECT: In Memory of Ronald D. Stewart, MD, FACEP, FAEMS

WHEREAS, The specialty of emergency medicine, the Pennsylvania College of Emergency Physicians, the American College of Emergency Physicians, and the world lost a legendary emergency physician when Ronald D. Stewart, MD, FACEP, FAEMS, passed away, on October 21, 2024, at the age of 82; and

WHEREAS, Dr. Stewart was born in Sydney Mines, Nova Scotia in 1942; and

WHEREAS, He graduated from Dalhousie University with his medical degree and took up a rural practice following his graduation; and

WHEREAS, He completed a residency in emergency medicine at the University of Southern California in 1972; and

WHEREAS, He served as the first medical director of the Los Angeles paramedic program; and

WHEREAS, He was a script advisor to TV medical shows and became known as “Doc Hollywood;” and

WHEREAS, His Los Angeles paramedic program and instruction manual were legendary and served as a vital resource for prehospital care in the United States, United Kingdom, and Australia; and

WHEREAS, He was recruited to join the University of Pittsburgh in 1978 where he started the University of Pittsburgh’s emergency medicine residency; and

WHEREAS, He began as the Medical Director of the City of Pittsburgh Department of Public Safety Bureau of EMS and was key to developing Pittsburgh’s emergency medical response system; and

WHEREAS, He founded the Center for Emergency Medicine of Western Pennsylvania to advance emergency care, research, and training; and

WHEREAS, He founded and became the inaugural president of the National Association of EMS Physicians; and

WHEREAS, Dr. Stewart was named a Hero of Emergency Medicine in 2008 by the American College of Emergency Physicians; and

WHEREAS, Dr. Stewart served as Nova Scotia’s Minister of Health from 1993 to 1996. He helped establish Emergency Health Services (EHS), revolutionized paramedic services across the province, and introduced stronger tobacco control; and

WHEREAS, He was recognized with the Companion of the Order of Canada award for his exceptional achievement and service to Canada or humanity and this award is the country’s highest honor and only 500 Canadians have had this honor bestowed upon them; and

WHEREAS, He was also awarded the Order of Nova Scotia and honorary doctorates from three Canadian universities; and

WHEREAS, Dr. Stewart continued to transform and develop emergency medicine over the rest of his career and his contributions to EMS and emergency medicine are immeasurable; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Ronald D. Stewart, MD, FACEP, FAEMS; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his sister Donalda (James) Davis, and his countless friends, colleagues, and students gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 20(25)

SUBMITTED BY: Elijah Berg, MD, FACEP
David Friedenson, MD, FACEP
Edward Gaines, JD, CCP
Michael Granovsky, MD, CPC, FACEP
David A. McKenzie, CAE
Rebecca B. Parker, MD, FACEP

SUBJECT: In Memory of Todd Thomas, CPC, CCS-P

WHEREAS, Todd Thomas, CPC, CCS-P, ACEP honorary member passed away on December 6, 2024; and

WHEREAS, Mr. Thomas served as a combat medic for the Army National Guard, and later an EMT, providing him a medical background that served as his foundational understanding of emergency medical services; and

WHEREAS, Mr. Thomas began his career as an emergency department coder in 1992, working for a small independent ED physician group; and

WHEREAS, Mr. Thomas attended his first ACEP Reimbursement and Coding Conference in 1997 where he impressed the faculty with his insightful questions and comments during the conference; and

WHEREAS, Mr. Thomas Todd joined the ACEP Reimbursement and Coding Conference faculty in 2001 and participated in thirty-one straight offerings of the conference, averaging 12 hours of lectures each time with exceptional speaker scores; and

WHEREAS, His presentations at the Conference earned him the ACEP Outstanding Speaker of the Year Award in 2010, only the second non-physician to be recognized with the honor at that time; and

WHEREAS, Mr. Thomas received recognition for his volunteer speaking work with the 2015 ACEP Over the Top Award, presenting more hours of educational material with the highest average scores at ACEP meetings than any other speaker; and

WHEREAS, He also provided education on coding to ACEP State Chapters, including twenty years at the Michigan Chapter Straight Talk Reimbursement Conference, ten years for the Massachusetts College of Emergency Physicians, and multiple years as a featured speaker for ACEP chapters in Pennsylvania, Louisiana, Minnesota, Virginia, and the Southeastern Chapters Educational Conference; and

WHEREAS, Mr. Thomas joined the ACEP Coding and Nomenclature Advisory Committee (CNAC) in 2002 and was the primary author of many of the Reimbursement and Coding FAQs found on the ACEP website, including the award winning 2023 Documentation Guidelines FAQ set; and

WHEREAS, Mr. Thomas received the 2022 ACEP Honorary Membership Award in recognition of his 30 years of devotion to the accurate coding and documentation for emergency physician services; and

WHEREAS, Mr. Thomas shared his wisdom, integrity, friendship, and joy with so many; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Todd Thomas, CPC, CCS-P, and extends its deepest sympathies to his family, friends, and colleagues, and gratitude for his commitment and contributions to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2025 Council Meeting
Reference Committee Members

Reference Committee A – Governance, Membership, & Academic Affairs

Resolutions 21-40

Susanne J. Spano, MD, FACEP (CA) – Chair
Shayne M. Gue, MD, FACEP (FL)
Torree M. McGowan, MD, FACEP (GS)
Diane Paratore, MD, MEd, MBA, FACEP (MI)
Michael D. Smith, MD, MBA, CPE, FACEP (LA)
Carol Wright Becker, MD, MBA, FACEP (WV)

Amanda Pairitz-Campo
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 21(25)

SUBMITTED BY: Jeffrey Feden, MD, FACEP
Nicole Veitinger, DO, FACEP
Membership Committee
Board of Directors

SUBJECT: Distinguished ACEP Fellow Recognition

PURPOSE: Amend the Bylaws to establish Distinguished Fellow recognition with objective, points-based criteria for members who have held FACEP status for a minimum of 12 years and demonstrated continued commitment to ACEP and emergency medicine.

FISCAL IMPACT: Budgeted staff resources to establish the recognition process and for ongoing review and acceptance of applications. The Board may determine any application fee(s) as part of the process oversight if the resolution is adopted.

WHEREAS, The Fellow of the American College of Emergency Physicians (FACEP) designation recognizes early-career emergency physicians who demonstrate commitment to the specialty through leadership, education, and service; and

WHEREAS, A significant portion of eligible ACEP members have already achieved the FACEP designation, and applications have plateaued in recent years; and

WHEREAS, There is an opportunity to further recognize long-standing, actively engaged members through a new mid-to-late career designation aligned with recognition frameworks used by other national medical organizations; and

WHEREAS, The proposed "Distinguished Fellow of ACEP" [FACEP(D)] would honor sustained service and contributions in leadership, scholarship, mentorship, clinical excellence, and engagement with ACEP over time; therefore be it

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish a "Distinguished Fellow of ACEP" [FACEP(D)] that is based on objective, points-based criteria and awarded to members who have held FACEP status for a minimum of 12 years and demonstrated continued commitment to ACEP and the specialty of emergency medicine:

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.

Distinguished Fellows of the College shall meet the following criteria:

1. **Have held FACEP status for at least 12 years.**
2. **Maintain certification in emergency medicine 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 a minimum number of points within the following requirements demonstrating evidence of commitment to emergency medicine:**
   - **A. Research and scholarship, as evidenced by grant awards, peer-reviewed publication, or review or authorship of books or other professional resources.**
   - **B. Teaching and mentorship, as evidenced by teaching history, faculty status, student or resident advisement, or residency/fellowship/clerkship leadership.**
   - **C. Service and leadership, as evidenced by leadership within their emergency department, hospital, staffing group, state or local medical societies, community health planning, or other roles which have advanced the field.**
   - **D. Clinical excellence, as evidenced by clinical or industry awards, letters of support from their chair or medical director, or participation in quality, safety, or wellness activities.**
4. **Meet a minimum number of points within the following requirements demonstrating evidence of commitment to ACEP.**
   - **A. Leadership activities, including participation or leadership within ACEP sections, committees, chapters, delegations, advocacy groups, task forces, Member Interest Groups, Board of Directors, or Council.**
   - **B. Education activities, including participation as faculty or course directors in ACEP in-person or virtual educational offerings.**
   - **C. Public awareness activities, including active involvement in ACEP's online communities, media relations or spokesperson network, or promotion of College wins and activities on social media.**
   - **D. Recognitions, including individual receipt of ACEP awards or hospital/employer receipt of ACEP accreditation status.**

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 **or FACEP(D)** 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.

Background

This resolution seeks to amend the Bylaws to establish distinguished fellow recognition with objective, points-based criteria for members who have held FACEP status for a minimum of 12 years and demonstrated continued commitment to ACEP and emergency medicine.

The Membership Committee has had many discussions for the past several years about opportunities to improve and/or expand the FACEP program. Polling of current FACEPs and members eligible for FACEP in the fall of 2023 identified the majority of survey respondents (37%) with the opinion that FACEP status demonstrates their commitment to emergency medicine. Since FACEP is generally viewed as an early career milestone, there is an opportunity for mid/late career recognition in the form of an advanced status as a Distinguished Fellow of ACEP [FACEP(D)]. Creation of FACEP(D) recognizes longstanding and engaged ACEP members and aligns with other organizations that offer "Distinguished" or "Master" level designations.

If this resolution is adopted by the Council, the Membership Committee will work with staff to finalize the qualifying activities and scoring criteria for each category and develop a policy for approval by the Board of Directors.

Note: Resolution 23(25) International ACEP Fellow Recognition also amends Section 1 – Eligibility and Section 2 – Fellow Status. If both resolutions are adopted, the criteria for "Distinguished Fellows" and "International Fellows" will be added alphabetically to Section 1 and FACEP(D) and FACEP(I) will be added in alphabetical order in the first sentence of Section 2.

ACEP Strategic Plan Reference

Career Fulfillment: Focus resources, education, and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.

Fiscal Impact

Budgeted staff resources to establish the recognition process and for ongoing review and acceptance of applications. The Board may determine any application fee(s) as part of the process oversight if the resolution is adopted.

Prior Council Action

Resolution 32(94) Creation of a Master Category of Membership not adopted. The resolution sought to have the Board of Directors appoint an appropriately constituted committee to study methods and criteria for establishing a Masters (or other suitably named) category of College membership to recognize members who have made superior contributions to the specialty of emergency medicine in areas such as research, education, or College activity.

Resolution 10(84) Master of Emergency Medicine Membership Category not adopted. Sought to create a new category of membership who may or may not be Fellows, have been members for 10 continuous years and have rendered distinguished and exemplary service to the College and the medical profession. Masters shall have all rights and privileges of their prior classification of membership and shall be authorized to use the letters "MACEP."

Resolution 9(84) Master of Emergency Medicine Membership Category not adopted. The resolution sought to create a separate category of membership for Fellows on the basis of personal character, positions of honor and influence, eminence in practice or in medical research, or other attainments in science or medicine and having been a member of ACEP for 10 consecutive years are recommended as "Masters" and authorized to use the letters "MACEP."

Prior Board Action

June 2025, discussed the Membership Committee's recommendation to create the Distinguished Fellow recognition and approved cosponsoring the Bylaws amendment for submission to the 2025 Council.

September 2024, discussed potential changes to the FACEP criteria and associated benefits. Supported the Membership Committee continuing to evaluate potential changes to the FACEP criteria and associated benefits and provide recommendations for the Board to consider.

June 2022, discussed potentially expanding FACEP recognition to include a mid-career credential. Supported preserving current FACEP criteria and explore creating FACEP(D) criteria.

Background Information Prepared by: Mollie Pillman, MS, MBA CAE
Associate Executive Director, Member Experience

Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 22(25)

SUBMITTED BY: International Emergency Medicine Committee
International Emergency Medicine Section
Board of Directors

SUBJECT: International ACEP Fellow Recognition

PURPOSE: Amend the Bylaws to establish International Fellow recognition with objective, points-based criteria for members who live and practice outside of the United States.

FISCAL IMPACT: Budgeted staff resources to establish the recognition process and for ongoing review and acceptance of applications. The Board may determine any application fee(s) as part of the process oversight if the resolution is adopted.

WHEREAS, The Fellow of the American College of Emergency Physicians (FACEP) designation recognizes emergency physicians who demonstrate commitment to the specialty through leadership, education, and service; and

WHEREAS, Most international members of ACEP are currently ineligible to meet FACEP criteria; and

WHEREAS, There is desire internationally for recognition of emergency physicians who meet international standards for education and involvement in the specialty; and

WHEREAS, The proposed "International Fellow of ACEP" [FACEP(I)] would honor sustained service and contributions by international members in leadership, scholarship, mentorship, clinical excellence, and engagement with ACEP; therefore be it

RESOLVED, that the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish an "International Fellow of ACEP" [FACEP(I)] and awarded to members who live and practice outside of the United States:

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, **or** 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.

International Fellows of the College shall meet the following criteria:

1. **Be an international member of ACEP for at least three years immediately prior to election.**
2. **Be certified in emergency medicine by an internationally recognized certifying body, or have completed the minimum training standards to practice emergency medicine within their country (if certification is not available).**
3. **Provide a letter of support from an established authority such as their institution medical director, training program director, or emergency medicine society.**
4. **Satisfy at least three of the following individual requirements demonstrating commitment to emergency medicine:**
   - A. **Active involvement in organized medicine, as evidenced by three years of membership or leadership within any local, national, or regional society dedicated to advancing emergency medicine.**
   - B. **Active involvement in local hospital affairs, such as medical staff committees.**
   - C. **Active involvement in the formal training of future emergency medicine physicians.**
   - D. **Active involvement in departmental or governmental administration or affairs.**
   - E. **Active involvement in EMS systems or disaster preparedness planning activities.**
   - F. **Research or scholarly publication in emergency medicine.**
5. **Satisfy at least one of the following individual requirements demonstrating involvement with ACEP:**
   - A. **Active participation in ACEP sections, committees, or other leadership bodies.**
   - B. **Participation in the development, delivery, or promotion of ACEP educational offerings and resources within home country.**
   - C. **Participation in ACEP educational or research activities (such as in-person attendance at ACEP Scientific Assembly meeting(s), scholarly publication in emergency medicine in *Annals of Emergency Medicine* or *JACEP Open*, etc.).**
   - D. **Other contributions to the College.**

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 **or FACEP(I)** 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.

Background

This resolution seeks to amend the Bylaws to establish International Fellow recognition with objective, points-based criteria for members who live and practice outside of the United States.

Currently, international members desiring to become fellows of the College must be board-certified in emergency medicine by a certifying board recognized by the American Board of Emergency Medicine and members who completed training outside of the U.S. must have Educational Commission for Foreign Medical Graduates (ECFMG) certification, having passed the United States Medical Licensing Examination (USMLE), hold an active medical license that meets the certifying board's policy, and completion of a residency in emergency medicine in a country approved by the certifying board.

The International Emergency Medicine Committee has worked to establish criteria to recognize non-U.S. physicians who are unable to apply for FACEP and have standing within their country in working toward recognition of the specialty of emergency medicine, expanding the practice of emergency medicine, or contributing to emergency medicine research and education. Creation of FACEP(I) would recognize those individuals with the added requirement of involvement with or promotion of ACEP internationally.

Currently, there are varying requirements for specializing in emergency medicine around the world, including different levels of training, certification, and recognition by the country's health care system and government. FACEP(I) is not intended to reflect on those requirements or on an individual's effectiveness as a physician in their local environment – rather to acknowledge commitment to the specialty and the College, to further encourage the development and elevation of emergency medicine, and to promote international collaboration and inclusiveness. There are no changes being requested that would alter or diminish current U.S. physician qualification for FACEP or its value to U.S. employers.

Note: Resolution 22(25) Distinguished Fellow Recognition also amends Section 1 – Eligibility and Section 2 – Fellow Status. If both resolutions are adopted, the criteria for "Distinguished Fellows" and "International Fellows" will be added alphabetically to Section 1 and FACEP(D) and FACEP(I) will be added in alphabetical order in the first sentence of Section 2.

ACEP Strategic Plan Reference

Career Fulfillment: Focus resources, education, and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.

Fiscal Impact

Budgeted staff resources to establish the recognition process and for ongoing review and acceptance of applications. The Board may determine any application fee(s) as part of the process oversight if the resolution is adopted.

Prior Council Action

Resolution 11(19) International Member Eligibility for FACEP referred to the Board of Directors. The resolution proposed to amend the Bylaws to clarify the requirements for international members to become an ACEP fellow.

Resolution 8(10) International Honorary Fellow not adopted. The resolution sought to amend the Bylaws to create a new category of fellowship for international members who were current or former International Federation of Emergency Medicine board representatives.

Resolution 10(09) International Fellow not adopted. The resolution proposed to create a new criterion for fellowship for international members.

Prior Board Action

June 2025, discussed the International Emergency Medicine Committee's recommendation to create the International Fellow recognition and approved cosponsoring the Bylaws amendment for submission to the 2025 Council.

June 2020, discussed the Bylaws Committee review of Referred Resolution 11(19) International Member Eligibility for FACEP and approved the recommendation to take no further action on the resolution and retain the current

requirements for fellowship in the Bylaws.

Background Information Prepared by: Mollie Pillman, MS, MBA CAE
Associate Executive Director, Member Experience

Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
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Council Standing Rules Amendment

RESOLUTION: 23(25)

SUBMITTED BY: Council Steering Committee

SUBJECT: Councillor Allocation for Sections of Membership Housekeeping Change

PURPOSE: Amends the Council Standing Rules to clarify that a section must have 100-dues paying members as defined in the Bylaws and eliminate potential confusion regarding "dues paying and complimentary candidate members."

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules.

WHEREAS, The Bylaws – Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) specifies that sections are entitled to one councillor "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.; and

WHEREAS, The Council Standing Rules, Councillor Allocation for Sections of Membership, specifies "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;" and

WHEREAS, The difference in the language can be confusing; therefore be it

RESOLVED, That the Council Standing Rules – Councillor Allocation for Sections of Membership be amended to read:

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~~ **as defined in the Bylaws**. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting...

Background

This resolution amends the Council Standing Rules to clarify that a section must have 100-dues paying members as defined in the Bylaws and eliminate potential confusion regarding "dues paying and complimentary candidate members."

While reviewing councillor allocations for the 2025 Council, a question was raised by staff pertaining to the language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership and the confusion regarding dues-paying and complimentary candidate members. Multiple changes to the Bylaws and the Council Standing Rules over the years have resulted in the language being slightly different regarding councillor allocations for sections.

A subcommittee of the Council Steering Committee reviewed the language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership and although the Bylaws supersede the CSR, there was consensus to simplify the language in the CSR to reflect that a section must have 100 dues-paying members as defined in the Bylaws. The Council Steering Committee discussed the subcommittee's determination at their April 27, 2025, meeting and approved submitting a CSR amendment to the 2025 Council.

ACEP Strategic Plan Reference

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

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

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. This Council Standing Rules resolution made comprehensive housekeeping changes throughout the document including non-substantive updated language to the Councillor Allocation for Sections of Membership.

Amended Resolution 6(99) Council Standing Rules adopted. This resolution revised the Council Standing Rules based on the streamlined Bylaws and stipulated that future changes to the Council Standing Rules can only be made through submission of resolutions to the Council. *Note: Changes to the Council Standing Rules prior to 2000 were proposed by the Council Steering Committee and approved by the Council at the next annual meeting.*

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

October 1997, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of December 31 each year.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted. This Bylaws amendment specified that sections must have 100 dues-paying members as of December 31 of the preceding year.

September 1992, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 1(90) Voting Privilege for Section Councillors adopted. This Bylaws amendment granted voting privileges to section councillors.

September 1990, approved the Council Standing Rules with the addition of one non-voting councillor for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 11(89) Councillor Allotment for Sections of Membership adopted. This resolution allocated one councillor per section without the right to vote.

Substitute Resolution 13(88) Sections of Membership adopted. This resolution established sections of membership.

Prior Board Action

The Board does not approve changes to the Council Standing Rules.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted.

Note: Prior to 1993 the Board of Directors did not take action on Bylaws amendments.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual Amendment

RESOLUTION: 24(25)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Procedures for Addressing Charges of Ethical Violations and Other Misconduct

PURPOSE: Amend by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues.

FISCAL IMPACT: Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

WHEREAS, A review by legal counsel and a subcommittee comprised of members of the Ethics Committee determined that providing additional clarification of the procedures would be beneficial in future disciplinary action determinations; and

WHEREAS, The ACEP Board of Directors approved a revision to the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* at its meeting in April 2025; and

WHEREAS, Approval by the ACEP Council is required to include the revised document in the College Manual; therefore be it

RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to read:

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

A. Definitions

1. ACEP means the American College of Emergency Physicians.
2. *Code of Ethics* means the *Code of Ethics for 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 **with no conflicts of interest in each pending matter** – 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~~ **an** 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~~ **any protected health information** 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~~ **their** name disclosed to the ACEP Executive Director~~,~~ **and** 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. **Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:**
   a. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that t~~**T**he **charges and conduct set forth in the** complaint**, as alleged by the complainant,** ~~is frivolous, inconsequential, or~~ do~~es~~ 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 t~~**T**he 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 **after membership on the Ethics Complaint Review Panel has been confirmed;** or
   c. ~~Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that t~~**T**he 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 **and that has been screened for conflicts of interest;** 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. T~~the Ethics Complaint Review Panel or the Bylaws Committee**, as appropriate,** will review the President's ~~action~~ **recommendation to reject the complaint**. The President's action can be overturned by a majority vote of the applicable ACEP review body **or adopted by the 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. ~~[w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Ethics Complaint Review Panel:~~]~~

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 **or web 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 r~~**R**enders 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~~[w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Bylaws Committee:

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 **or web 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 r~~**R**enders 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~~ **The respondent may request a hearing to appeal the disciplinary decision or the sanction imposed. 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, audio~~tape~~, **recording,** or video~~tape~~ **recording** at the expense of the requesting party. **A copy of any such record must be provided to the Executive Director.**
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~~ **impractical** 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. **Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings.** 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.

      Private censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards but appears to be a minor isolated incident. The member's actions are not egregious in nature but fall outside of acceptable conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for single ethical violations in the course of a single legal case.

      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**, disclosure of which shall be subject to the discretion of the Executive Director**.

      Public censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and demonstrates a pattern of unethical behavior or a single example of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for multiple ethical violations in the course of a single legal case.

   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**, disclosure of which shall be subject to the discretion of the Executive Director**. 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.

Suspension is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations across more than one legal case.

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**, disclosure of which shall be subject to the discretion of the Executive Director**. 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.

Expulsion is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct to a degree warranting discipline beyond the suspension available under I.1.b. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations over multiple legal cases.

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~~ **The** letter shall specify the name of the member or former member who is the subject of the request. The Executive Director ~~shall~~ **may** 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. **If a non-member makes a request for information about disciplinary actions against a member who has received private censure, the Executive Director shall inform the individual that no published announcement of disciplinary action is available but shall not indicate or confirm that a private censure has been imposed.**

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~~ **a disciplinary** 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~~ **review** 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~~ **their** ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

Background

This resolution amends by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues.

ACEP established procedures in 1997 by which its members may initiate complaints against fellow members for violations of ACEP's *Code of Ethics for Emergency Physicians* ("*Code of Ethics"*). These procedures have been revised several times, most recently in 2020.

The 2020 Council and the Board of Directors adopted a Bylaws amendment to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual. A companion College Manual resolution was also adopted by the Council and the Board of Directors.

The Ethics Committee was assigned an objective for the 2024-25 committee year to revise the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to incorporate the new Board of Directors vice president officer positions and provide additional guidance to future Board Hearing Panels in their determination of disciplinary action. The Board of Directors reviewed the Ethics Committee's proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" in April 2025 and approved submitting the College Manual resolution to the 2025 Council.

ACEP Strategic Plan Reference

Career Fulfillment: Develop and implement ongoing, two-way systems to identify the issues that hinder career satisfaction and meaningfully demonstrate to members that we hear them.

Fiscal Impact

Budgeted committee and staff resources to update the College Manual and to review ethics complaints and other disciplinary charges.

Prior Council Action

Resolution 15(20) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues.

Resolution 14(20) Ethics Procedures – Bylaws Amendment adopted. Amended the Bylaws to permit a designated body appointed by the Board of Directors to render a decision regarding disciplinary action as stated in the College Manual.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the ethics procedures in the College Manual. The changes addressed the timeliness of filing allegations, clarifications of aspects of the process, ensuring that deadlines are reasonable in light of process and review requirements, a respondent's membership status during the pendency of an ethics complaint, and clarifications of the scope and disclosure of disciplinary actions.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to deadlines and provided mechanisms in the event that the number of Board recusals impacts the Board's ability to act on ethics complaints.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to due process and the hearing procedures.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes related to the categories of sanctions and clarifying when disclosure of such sanctions may be appropriate or necessary.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes included enhancements related to communications, responsibilities, timelines, and voting.

Resolution 5(99) College Manual adopted and included the "Procedures for Addressing Ethics and Other Disciplinary Charges." The resolution established the College Manual and defined the method for amending it.

Amended Resolution 4(99) Streamlining Bylaws adopted. The resolution simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College Manual.

Amended Resolution 1(97) Code of Ethics for Emergency Physicians Bylaws amendment adopted. The resolution codified ACEP's Code of Ethics for Emergency Physicians in the Bylaws.

Prior Board Action

April 2025, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting the College Manual resolution to the 2025 Council.

Resolution 15(20) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

Resolution 14(20) Ethics Procedures – Bylaws Amendment adopted.

June 2020, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting Bylaws and College Manual resolutions to the 2020 Council.

June 2019, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2019 Council. (The resolution was subsequently withdrawn based on comments received from the Bylaws Committee.)

December 2018, discussed revising the Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to create a more efficient review process.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2013, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2013 Council.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct College Manual resolution adopted.

April 2010, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and approved submitting a College Manual resolution to the 2010 Council.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2007, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and requested additional changes to be reviewed and approved by the Board. Approved submitting a College Manual resolution to the 2007 Council.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Resolution 5(99) College Manual adopted.

Amended Resolution 4(99) Streamlining Bylaws adopted.

August 1998, approved the Procedures for Addressing Ethics Charges.

Amended Resolution 1(97) Code of Ethics for Emergency Physicians Bylaws amendment adopted.

July 1997, approved submitting the "Code of Ethics for Emergency Physicians" Bylaws amendment to the 1997 Council.

June 1997, approved the "Code of Ethics for Emergency Physicians."

Background Information Prepared by: Laura Lang, JD
General Counsel

Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2024 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 25(25)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Protecting Section Integrity and Member Engagement in ACEP

PURPOSE: Amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Sections within ACEP are essential for fostering community, professional development, and focused advocacy among emergency physicians with shared interests and identities; and

WHEREAS, Section dissolution should be undertaken only with substantial justification and transparency, in order to preserve the diversity and engagement of ACEP's membership; and

WHEREAS, In the current politically volatile environment, ACEP must safeguard against external political pressures that could unduly influence internal decisions, including the potential dissolution of sections; and

WHEREAS, The perception or reality of politically motivated section closures may significantly diminish trust in ACEP governance and decrease member participation; therefore be it

RESOLVED, That the Board of Directors amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors.

Background

This resolution seeks to raise the threshold for the Board of Directors to suspend or revoke a section charter from a majority vote to a two-thirds vote.

There are currently 40 sections of membership with approximately 24,000 unique members and total section membership of more than 33,000 members (some members belong to more than one section). Sections provide an opportunity for members to network with other members who share common areas of interest in the diverse areas of emergency medicine or life stages. Section members have the opportunity to cultivate ideas and develop programs to improve the care of emergency patients worldwide.

ACEP's "Policy on Sections of Membership" provides guidance on many issues pertaining to sections, including establishing a section, maintenance of a section, and section charter probation, suspension, and revocation. The policy stipulates that a 2/3 vote of the Board is required to establish a section; however, only a majority vote of the Board is required to suspend or revoke a charter based on the following criteria:

1. The actions of the section are deemed to be in conflict with the Bylaws or the Policy on Sections of Membership.
2. The section fails to comply with all the requirements of the Bylaws, the Policy on Sections of Membership, the individual Section's Operational Guidelines, the online communities Terms of Use, or with any other requirement of the College.

3. The actions of the section are determined not to be in accordance with the goals, objectives, or in the best interest of the College.

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.

Prior Council Action

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

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

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. This Council Standing Rules resolution made comprehensive housekeeping changes throughout the document including non-substantive updated language to the Councillor Allocation for Sections of Membership.

Amended Resolution 6(99) Council Standing Rules adopted. This resolution revised the Council Standing Rules based on the streamlined Bylaws and stipulated that future changes to the Council Standing Rules can only be made through submission of resolutions to the Council. *Note: Changes to the Council Standing Rules prior to 2000 were proposed by the Council Steering Committee and approved by the Council at the next annual meeting.*

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

October 1997, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of December 31 each year.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted. This Bylaws amendment specified that sections must have 100 dues-paying members as of December 31 of the preceding year.

September 1992, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 1(90) Voting Privilege for Section Councillors adopted. This Bylaws amendment granted voting privileges to section councillors.

September 1990, approved the Council Standing Rules with the addition of one non-voting councillor for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 11(89) Councillor Allotment for Sections of Membership adopted. This resolution allocated one councillor per section without the right to vote.

Substitute Resolution 13(88) Sections of Membership adopted. This resolution established sections of membership.

Prior Board Action

June 2024, approved the revised "Policy on Sections of Membership;" revised and approved June 2022, June 2017, April 2008, June 2002, July 2001, June 1996, October 1993, June 1992, January 1992, and May 1990; originally approved January 1989.

Note: Prior to 1993 the Board of Directors did not take action on Bylaws amendments adopted by the Council.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 26(25)

SUBMITTED BY: Christopher L. Smith, MD, FACEP
Jessica J. Wall, MD, MPH, MSCE, FACEP
Aine Yore, MD, FACEP
California Chapter
District of Columbia Chapter
Washington Chapter
Access, Belonging, & Community Section

SUBJECT: Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in Emergency Medicine

PURPOSE: Reaffirm ACEP's commitment to the core principles of DEI by reaffirming the previous policy statement supporting DEI.

FISCAL IMPACT: No additional funding is required for ACEP to reaffirm its current policy statement.

WHEREAS, The American College of Emergency Physicians (ACEP) has a longstanding history of supporting diversity, equity, and inclusion (DEI) initiatives [1, 2, 3, 4, 5, 6] as integral to the mission of advancing the highest quality of emergency care; and

WHEREAS, The College approved a policy statement supporting the principles inherent within DEI in September 2024; and

WHEREAS, The principles of DEI are essential to ensuring equitable access to emergency care, addressing health disparities, and supporting the well-being and professional development of a diverse emergency medicine workforce; and

WHEREAS, ACEPs Access, Belonging, and Community (ABC) Section (formerly the Diversity, Inclusion, and Health Equity Section) and the Access, Belonging, and Community (ABC) Committee (formerly the Diversity, Equity, and Inclusion Committee) have demonstrated exemplary leadership in advancing DEI initiatives, developing resources, and promoting awareness throughout the College and the broader emergency medicine community; and

WHEREAS, Recent actions at the federal and state levels threaten to undermine DEI initiatives critical to fostering inclusive, equitable, and culturally competent health care environments; therefore be it

RESOLVED, That ACEP reaffirm its commitment to the core principles of diversity, equity, and inclusion, recognizing their fundamental role in promoting patient-centered care, health equity, and a thriving, representative workforce by reaffirming its previous policy statement supporting diversity, equity, and inclusion as essential to the College's mission and the practice of emergency medicine.

Resolution References

[1]2021 ACEP Policy Statement: Cultural Awareness and Emergency Care
[2]2023 ACEP Policy Statement: Workforce Diversity in Health Care Settings
[3]2021 ACEP Policy Statement: Non-Discrimination and Harassment
[4]2021 ACEP Policy Statement: Implicit Bias and Awareness Training
[5]2022 ACEP Policy Statement: Caring for Transgender and Gender Diverse Patients in the Emergency Department
[6]2023 ACEP Policy Statement: Appropriate Use of Race in Research

Background

This resolution calls for ACEP to reaffirm its commitment to the core principles of diversity, equity, and inclusion by reaffirming the previous policy statement "Diversity, Equity, and Inclusion" approved by the Board of Directors in September 2024.

ACEP has a longstanding commitment to the principles of diversity, equity, and inclusion (DEI) as integral to its mission and to advancing emergency medicine. ACEP has demonstrated consistent support for DEI through Council and Board actions, policy statements, and national leadership in multi-organization efforts such as the All-EM DEI Vision Statement. Recent developments at the state and federal level have introduced new challenges that may hinder the continuation of DEI initiatives in health care and academic settings.

Internally, ACEP's work on DEI initiatives have been championed by the Access, Belonging, & Community (formerly DEI) Committee and the Access, Belonging, & Community (formerly DIHE) Section. The committee and section have worked to raise awareness, develop tools and resources, and guide integration of DEI principles across the College's strategies. Recognizing the deep importance of intentional language, ACEP's recent updates to its committee and section nomenclature reflect a broader shift away from the term "DEI" toward a more inclusive and active framing – Access, Belonging, & Community (ABC) – emphasizing inclusion as a lived experience rather than a topic of discussion. The scope of their efforts often extends beyond traditional definitions and addresses health disparities and equal access to care across all communities and reflects a holistic approach to achieving health equity in emergency medicine. Reaffirming DEI principles aligns with ACEP's values. The principles of diversity, equity, and inclusion are foundational to ensuring equitable access to care, supporting a thriving emergency medicine workforce, and addressing health disparities that affect patient outcomes.

Background References

1. Cohen, A. J., Sheldon, L. K., Van Decker, W. A., et al. (2022). *Perceptions of Diversity, Equity, and Inclusion in an Urban Emergency Department Patient Population*. **Journal of Patient Experience**, 9, 23743735221130807.
2. Estrellado, M., Shah, M. M., Thomas, A., et al. (2021). *An Intensive Approach to Improving Diversity, Equity, and Inclusion in an Academic Emergency Department*. **Western Journal of Emergency Medicine**, 22(6), 1325–1333.
3. *ACEP Now Why Diversity, Equity, and Inclusion Matter in Medical Education* August 2024
4. ACEP *Statement on a Diverse Emergency Physician Workforce* April 2024

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.

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

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

No additional funding is required for ACEP to reaffirm its current policy statement.

Prior Council Action

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted. Directed ACEP to support and encourage evaluation for social determinants of health and advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

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.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. 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 26(20) 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 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College (position statements, adopted resolutions, task forces) through the lens of health equity and provide a biennial assessment of the work of the College pertaining to health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation 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

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the policy statement "Appropriate Use of Race in Research."

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted.

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with 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.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Tony Vellucci, CNE, CDE
Associate Executive Director, Emergency Medicine Foundation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole E. Exeni McAmis, MD
Colorado Chapter
Montana Chapter

SUBJECT: Upholding Equal Access to Care in Emergency Medicine Amidst Political Challenges

PURPOSE: 1) Reaffirm commitment to promoting and maintaining equal access to care in the ED, ensuring that all patients and staff are treated with respect, dignity, and fairness; 2) Advocate for implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; 3) Support continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; 4) Support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and 5) Call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Diversity, equity, and inclusion (DEI) are fundamental to providing high-quality, patient-centered care in the emergency department (ED), ensuring that all individuals, regardless of their race, ethnicity, gender, sexual orientation, or socioeconomic background, receive respectful, equitable, and culturally competent care[1]; and

WHEREAS, The current political climate has led to increased polarization and challenges to DEI initiatives in healthcare, which may undermine efforts to promote inclusive environments and equitable access to care in the ED[2]; and

WHEREAS, Emergency medicine physicians and staff are often the first point of contact for patients who face significant health disparities, and it is critical that these providers uphold the principles of DEI to foster trust, reduce health inequities, and ensure that marginalized communities are not further disadvantaged[3]; and

WHEREAS, Maintaining DEI in the ED requires ongoing education, training, and policy development to address unconscious bias, discrimination, and barriers to care that may arise, especially in a politically charged environment[4]; and

WHEREAS, Emergency physicians frequently care for patients from diverse cultural, religious, and ethnic backgrounds, and must be aware of variations in attitudes toward health, illness, pain expression, gender concordance in examinations, and preferences for traditional versus Western medical practices; and

WHEREAS, ACEP has long championed diversity, equity, and inclusion in health care, and it is essential for the organization to continue advocating for the protection of these principles within the ED, especially in light of evolving political landscapes[5]; therefore be it

RESOLVED, That ACEP reaffirm its commitment to promoting and maintaining equal access to care in the emergency department, ensuring that all patients and staff are treated with respect, dignity, and fairness; and be it further

RESOLVED, That ACEP advocate for the implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; and be it further

RESOLVED, That ACEP support the continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; and be it further

RESOLVED, That ACEP support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and be it further

RESOLVED, That ACEP call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

Resolution References

1. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Available at: https://www.ncbi.nlm.nih.gov/books/NBK220358/. Accessed 2/18/25.
2. American Civil Liberties Union. The Impact of Politics on Healthcare Equity. Available at: https://www.aclu.org/issues/health-care. Accessed 2/18/25.
3. American College of Emergency Physicians. Diversity and Inclusion in Emergency Medicine. Available at: https://www.acep.org/diversity. Accessed 2/18/25.
4. National Institutes of Health. Addressing Unconscious Bias in Healthcare. Available at: https://www.nih.gov/about-nih/what-we-do/nih-almanac/addressing-unconscious-bias. Accessed 2/18/25.
5. American Medical Association. Promoting Diversity, Equity, and Inclusion in Healthcare. Available at: https://www.ama-assn.org/delivering-care/public-health/diversity-equity-and-inclusion. Accessed 2/18/25.
6. American Hospital Association. Achieving Health Equity: A Guide for Healthcare Organizations. Available at: https://www.aha.org/achieving-health-equity. Accessed 2/18/25.
7. Accreditation Council for Graduate Medical Education. Diversity, Equity, and Inclusion in Medical Education. Available at: https://www.acgme.org/What-We-Do/Accreditation/Diversity-Equity-and-Inclusion. Accessed 2/18/25.
8. National Public Health Institute. Health Equity in a Divided Society. Available at: https://www.nphii.org/equity-advocacy. Accessed 2/18/25.

Background

Note: Components of this resolution are similar to Resolution 26(25) Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in Emergency Medicine and Resolution 40(25) Support Ongoing Education on Implicit Bias and Structural Inequity. Much of the background information from these resolutions are included in the background for this resolution.

This resolution calls for ACEP to: 1) Reaffirm commitment to promoting and maintaining equal access to care in the ED, ensuring that all patients and staff are treated with respect, dignity, and fairness; 2) Advocate for implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; 3) Support continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; 4) Support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and 5) Call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

Ensuring patient-centered and equitable care in the emergency department are foundational principles in emergency medicine. Emergency physicians caring for individuals from highly diverse racial, ethnic, socioeconomic, gender, and cultural backgrounds and often in moments of critical need. Upholding equal access to care values in emergency medicine is essential for improving health outcomes, fostering patient trust, and addressing longstanding health disparities. These values are increasingly under scrutiny with legislative proposals in several states potentially undermining the ability of emergency departments to maintain inclusive and culturally competent care. Emergency physicians and health care staff must be prepared to navigate these tensions while continuing to serve all patients with dignity and respect.

ACEP has a longstanding commitment to the principles of equal access to care as integral to its mission and to advancing emergency medicine. ACEP has demonstrated consistent support through adoption of Council and Board actions, policy statements, and national leadership in multi-organization efforts such as the All-EM DEI Vision Statement. Recent developments at the state and federal level have introduced new challenges that may hinder the continuation of DEI initiatives in health care and academic settings.

ACEP's policy statement "Diversity, Equity, and Inclusion" states (in part):

> "ACEP is committed to fostering an inclusive and equitable health care environment for all individuals. We recognize that diversity within our organization is crucial to reflecting the diverse backgrounds and experiences of the patients we serve. This diversity enhances our cultural competence and improves the effectiveness of our care."

Internally, ACEP's work on DEI initiatives have been championed by the Access, Belonging, & Community (formerly DEI) Committee and the Access, Belonging, & Community (formerly DIHE) Section. The committee and section have worked to raise awareness, develop tools and resources, and guide integration of DEI principles across the College's strategies. Recognizing the deep importance of intentional language, ACEP's recent updates to its committee and section nomenclature reflect a broader shift away from the term "DEI" toward a more inclusive and active framing – Access, Belonging, & Community (ABC) – emphasizing inclusion as a lived experience rather than a topic of discussion. The scope of their efforts often extends beyond traditional definitions and addresses health disparities and equal access to care across all communities and reflects a holistic approach to achieving health equity in emergency medicine. Reaffirming DEI principles aligns with ACEP's values. The principles of diversity, equity, and inclusion are foundational to ensuring equitable access to care, supporting a thriving emergency medicine workforce, and addressing health disparities that affect patient outcomes.

Implicit biases – unconscious attitudes or stereotypes – can have negative influences on clinical decision-making, communication between patients and physicians or other health care professionals, and perpetuate health disparities, particularly for marginalized groups. These biases can lead to inequitable care, reduced patient trust, and poorer health outcomes.[1-5] Education that addresses implicit bias increases awareness of self-biases, provides strategies to mitigate their impact, and fosters critical reflection, which are essential for delivering equitable care. Without such education, biases may remain unrecognized and unaddressed, contributing to ongoing disparities in health care delivery and outcomes. Integrating implicit bias education is a critical step toward advancing health equity and professionalism in medicine[1-5]

ACEP has taken several steps to address implicit bias within emergency medicine. These actions include developing and promoting educational resources, supporting policy changes, and encouraging open dialogue about bias.[6-8] Amended Resolution 14(19) Implicit Bias Awareness and Training called for developing and publicizing a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias. The policy statement "Implicit Bias Awareness and Training" was developed in response to Amended Resolution 14(19). Additionally, a Policy Resource & Education Paper (PREP) was developed by the Academic Affairs Committee as an adjunct to the policy statement. (The PREP is pending journal publication. It will be available on the ACEP website as soon as available.)

ACEP currently offers a wide range of educational content and resources to address implicit bias. The following educational sessions have been presented at previous ACEP annual meetings and are available in ACEP Anytime:

Racism and Bias in the ED Environment (2024) – Jenice Baker, MD, FACEP
How to Talk About Race and Medicine With Patients (2024) – Jenice Baker, MD, FACEP
Belonging: The Intersection of Diversity, Equity and Inclusion and Physician Well-Being (2024)
- Al'ai Alvarez, MD, FACEP
Belonging: The Intersection of Diversity, Equity, and Inclusion, and Physician Well-Being (2023) – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2023 – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2022 – Bernard Lopez, MD, FACEP

ACEP Anytime will be updated to include additional courses as they are developed.

Recently, several states have enacted laws restricting or banning certain types of implicit bias training, particularly in educational and health care settings. Florida, North Dakota, Tennessee, and Texas have passed legislation restricting the use of state or federal funds for diversity, equity, and inclusion (DEI) programs, including mandatory implicit bias training. Tennessee has gone further by prohibiting public institutions from mandating implicit bias training for educators and employees, according to Tennessee State Government (.gov). These laws often focus on prohibiting mandatory training that promotes what they consider "divisive concepts" or "identity politics." Other states such as California, Delaware, Maryland, Massachusetts, Michigan, New Jersey, and Washington have enacted legislation requiring implicit bias training, especially for health care providers. Illinois and Minnesota also have such requirements for health care professionals.[9] It is important to note that the legal landscape regarding implicit bias training is complex and constantly evolving. Some laws prohibiting bias training have faced legal challenges. Additionally, some states or organizations may still implement such training without a specific state mandate, or even if they face restrictions, they may adapt their training programs to be compliant with current laws and regulations.

Both the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) have recently taken steps to suspend enforcement of certain "diversity" requirements. This action follows concerns about potential conflicts between these requirements and state laws, as well as criticism from some regarding the emphasis on DEI in medical education.[10,11]

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to identify and eliminate health disparities and implement broad, systemic solutions to address social determinants of health that create disparities, address structural racism, and improve health equity in the health care system.

Background References

1. Twelve Tips for Teaching Implicit Bias Recognition and Management. Gonzalez CM, Lypson ML, Sukhera J. Medical Teacher. 2021;43(12):1368-1373. doi:10.1080/0142159X.2021.1879378.
2. The Time Is Now: Addressing Implicit Bias in Obstetrics and Gynecology Education. Royce CS, Morgan HK, Baecher-Lind L, et al. American Journal of Obstetrics and Gynecology. 2023;228(4):369-381. doi:10.1016/j.ajog.2022.12.016.
3. Educational Strategies in the Health Professions to Mitigate Cognitive and Implicit Bias Impact on Decision Making: A Scoping Review. Thompson J, Bujalka H, McKeever S, et al. BMC Medical Education. 2023;23(1):455. doi:10.1186/s12909-023-04371-5.
4. Implicit Bias in Health Professions: From Recognition to Transformation. Sukhera J, Watling CJ, Gonzalez CM. Academic Medicine : Journal of the Association of American Medical Colleges. 2020;95(5):717-723. doi:10.1097/ACM.0000000000003173.
5. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Vela MB, Erondu AI, Smith NA, et al. Annual Review of Public Health. 2022;43:477-501. doi:10.1146/annurev-publhealth-052620-103528.
6. https://www.acep.org/news/acep-newsroom-articles/change-is-happening-fast-acep-is-your-voice-in-washington-when-it-matters-most
7. https://www.acepnow.com/article/addressing-bias-racism-and-disparities-in-the-emergency-department/
8. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/implicit-bias-and-cultural-sensitivity---effects-on-clinical-and-practice-management.pdf
9. https://www.asha.org/advocacy/state/state-mandates-around-diversity-equity-and-inclusion/states-with-restrictions-on-diversity-equity-and-inclusion-concepts-in-higher-education/
10. https://www.acgme.org/newsroom/2025/5/acgme-board-executive-committee-action/#:~:text=The%20ACGME%20has%20heard%20significant,for%20approval%20of%20accreditation%20requirements.
11. https://lcme.org/announcement-may-19-2025/#:~:text=On%20May%2019%2C%202025%2C%20the,information%20related%20to%20Element%203.3.

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 professional.

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.

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

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted. Directed ACEP to support and encourage evaluation for social determinants of health and advocate for national, state, and local resources and responses to be paired with the evaluation for social determinants of health.

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.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted. Directed ACEP to: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. 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 26(20) 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 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College (position statements, adopted resolutions, task forces) through the lens of health equity and provide a biennial assessment of the work of the College pertaining to health equity.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation 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

January 2025, approved the Legislative and Regulatory Priorities for the First Session of the 119th Congress.

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the policy statement "Appropriate Use of Race in Research."

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

Amended Resolution 51(22) Implementation of Social Determinants of Health Evaluation in the ED adopted.

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Amended Resolution 56(21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with 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.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College Through the Lens of Health Equity adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Tony Vellucci, CNE, CDE
Associate Executive Director, EMF

Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 28(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Establish a College-Wide Mentorship Program

PURPOSE: Create and implement a comprehensive mentorship program accessible to all members and include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

FISCAL IMPACT: Budgeted committee and staff resources to develop the framework for the program. Additional unbudgeted estimated minimum cost of $25,000 annually to support platform costs, staffing, and program coordination. Outside funding from a supporting partner or sponsor could help defray expenses.

WHEREAS, Mentorship plays a critical role in the professional development, retention, and satisfaction of emergency physicians at all stages of their careers; and

WHEREAS, Members from historically marginalized communities, including those underrepresented in medicine, continue to face unique challenges in accessing mentorship opportunities and career advancement; therefore be it

RESOLVED, That ACEP create and implement a comprehensive mentorship program accessible to all members; and be it further

RESOLVED, That ACEP's mentorship program include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

Background

This resolution requests ACEP to create and implement a comprehensive mentorship program accessible to all members and include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

Mentorship has long been recognized as a key factor in the growth, resilience, and satisfaction of emergency physicians at every stage of their professional journey. While ACEP has historically supported mentorship efforts, the most recent structured program was the Diversity Mentoring Initiative, which operated from 2019 through 2020 with exclusive support from Vituity. This initiative, developed in partnership with ACEP's Diversity, Inclusion & Health Equity (DIHE) Section (now the Access, Belonging, & Community Section) and the EMRA Diversity & Inclusion Committee, sought to foster leadership and career development across the spectrum of emergency medicine professionals to include medical students, residents, and attending emergency physicians. The program focused particularly on building diversity and equity within the specialty and helping address long-standing disparities in mentorship access for members of historically marginalized and underrepresented communities in medicine.

Vituity supported the development and implementation of the mentorship platform with a $50,000 commitment over two years, and partnered with ACEP to shape its strategy, visibility, and growth. The platform offered participants the opportunity to engage in valuable mentor-mentee relationships with a focus on career planning, research development, leadership pathways, and cultural competency. The program was not sustained beyond 2020 despite the program's impact and its alignment with ACEP's mission and values.

Re-establishing a comprehensive and accessible mentorship program for all members managed by ACEP would need to build on the prior success of the program sponsored by Vituity and expand its reach to all members. ACEP's

Access, Belonging, & Community Committee has an objective for the FY 2025-26 committee year to "Develop guidance and recommendations for consideration by the Board for the development of a personal mentorship and support program for all members based upon each member's unique and personal professional journey in emergency medicine."

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.

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

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

Fiscal Impact

Budgeted committee and staff resources to develop the framework for the program. Additional unbudgeted estimated minimum cost of $25,000 annually to support platform costs, staffing, and program coordination. Outside funding from a supporting partner or sponsor could help defray expenses.

Prior Council Action

Substitute Resolution 20(23) Emergency Medicine Research Mentorship Network adopted. Directed ACEP to foster collaborations with Society for Academic Emergency Medicine, Council of Residency Directors in Emergency Medicine, and Emergency Medicine Foundation, and other stakeholders to support robust research mentorship opportunities.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Prior Board Action

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

Substitute Resolution 20(23) Emergency Medicine Research Mentorship Network adopted.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

Background Information Prepared by: Tony Vellucci, CNE, CDE
Associate Executive Director, Emergency Medicine Foundation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 29(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Promote Equal Access in Leadership

PURPOSE: Develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

FISCAL IMPACT: Budgeted committee, section, and staff resources to continue current initiatives to promote access to leadership opportunities.

WHEREAS, The American College of Emergency Physicians (ACEP) recognizes the importance of representative leadership in shaping inclusive policies, guiding organizational culture, and advancing health equity; and

WHEREAS, Diverse leadership improves organizational performance, fosters innovation, and better reflects the populations served by emergency physicians; therefore be it

RESOLVED, That ACEP develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

Background

This resolution calls for ACEP to develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

ACEP has long acknowledged that diverse leadership is essential to creating inclusive policies, shaping organizational culture, and ensuring equal access to emergency care. Leadership reflecting the diversity of the emergency medicine workforce and the patients served contributes to stronger decision-making, improved innovation, and greater trust among communities. ACEP's policy statement "Diversity, Equity, and Inclusion" reinforces that "diversity within our organization is crucial to reflecting the diverse backgrounds and experiences of the patients we serve." The "Workforce Diversity in Health Care Settings" policy statement affirms the importance of recruiting, retaining, and promoting individuals from historically underrepresented groups.

There are several strategies in place within chapters and national ACEP to promote leadership development and availability of volunteer leadership positions. These leadership development initiatives strive to ensure that opportunities are open to all members. The Leadership Development Advisory Committee (LDAC), as codified in the Council Standing Rules, is a Council Committee charged with identifying and mentoring diverse College members to serve in leadership roles. The LDAC provides information and guidance to members interested in College leadership opportunities and, when applicable, how to obtain and submit materials necessary for consideration by the Nominating Committee if interested in seeking nomination for the Board of Directors or as a Council officer. The role of the Nominating Committee is limited to vetting candidates submitted by component bodies or self-nominations for leadership positions elected by the Council, which include the Board of Directors, President-Elect, Speaker, and Vice Speaker. No potential candidates have ever been excluded from nomination because of gender identity, ethnicity, political or religious beliefs, or sexual orientation.

The Access, Belonging, & Community Committee (formerly the Diversity, Equity, & Inclusion Committee) has an objective for the FY 2025-26 committee year to "Develop guidance and recommendations for consideration by the Board for the development of a personal mentorship and support program for all members based upon each member's unique and personal professional journey in emergency medicine."

ACEP has taken significant steps over the past several years to address health disparities, social determinants of health, and systemic inequities within emergency medicine. Initiatives to expand leadership opportunities within ACEP's volunteer leadership structure, including sections, committees, task forces, work groups, education faculty, the Council, Board of Directors, etc., are ongoing so that future leaders reflect the full breadth and strength of the communities they serve.

Amended Resolution 12(19) ACEP Composition Annual Report directed that the Council be provided with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment. A demographics report is provided to the Council annually and will continue to be provided since an end date is not specified.

ACEP will continue to promote the availability of leadership positions by publicizing national ACEP committee interest, Council committee interest, Board and Council officer nominations, etc. through promotion on the ACEP website in addition to articles in *ACEP Now,* the *EM Today* electronic newsletter, and other communication vehicles.

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.

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

- Build up the leadership pipeline within ACEP and throughout emergency medicine spheres of influence.
- Measure and showcase the diversity and character of ACEP leaders and members.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Budgeted committee, section, and staff resources to continue current initiatives to promote access to leadership opportunities

Prior Council Action

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted. Directed ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. The resolution directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion and create a road map to promote diversity, equity, and inclusion. The resolution also directed ACEP to embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP and provide a report to the 2022 Council regarding the outcome of the summit.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members

Amended Resolution 12(19) ACEP Composition Annual Report adopted. Directed that the Council be provided with an annual report on the demographics of councillors and alternate councillors on a chapter-by-chapter basis, as well as

the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership.

Prior Board Action

The Board of Directors approves the Strategic Plan annually.

September 2024, approved the policy statement "Diversity, Equity, and Inclusion"

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

Resolution 22(21) Expanding Diversity and Inclusion in Educational Programs adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

Amended Resolution 12(19) ACEP Composition Annual Report adopted.

January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.

May 2018, approved recommendations from the Leadership Diversity Task Force to collect demographic data. including the proportion of underrepresented populations within ACEP's overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council.

April 2017, approved the Diversity & Inclusion Task Force's recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges.

April 2017, approved the revised Strategic Plan objective "Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine."

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted.

April 2016, approved adding the objective "Promote and facilitate diversity and cultural sensitivity within ACEP" to ACEP's Strategic Plan.

Background Information Prepared by: Tony Vellucci, CNE, CDE
Associate Executive Director, EMF

Sonja Montgomery
Governance Operations Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Development of Research Grant Funding Opportunities Exclusively for ACEP Members as a Membership Benefit

PURPOSE: Work with EMF to develop research grant opportunities that require applicants to be ACEP members.

FISCAL IMPACT: Budgeted ACEP and EMF staff resources.

WHEREAS, ACEP founded the Emergency Medicine Foundation (EMF) in 1972 to promote research in emergency medicine; and

WHEREAS, The ACEP Council is the largest contributor to EMF annually; and

WHEREAS, The EMF is an independent organization and does not require ACEP membership to apply for or receive an EMF award; and

WHEREAS, ACEP currently lacks exclusive research grant funding opportunities for its members as a benefit of membership unlike organizations such as the Society for Academic Emergency Medicine (SAEM) and the Council of Residency Directors (CORD); and

WHEREAS, Both SAEM and CORD continue to accelerate growth of emergency medicine members by offering exclusive membership benefits including access to member only research grants, therefore be it

RESOLVED, That ACEP work with the Emergency Medicine Foundation to develop research grant opportunities that require applicants to be ACEP members.

Background

This resolution calls for ACEP to work with EMF to develop research grant opportunities that require applicants to be ACEP members.

EMF awards research grants to improve emergency medicine patient care. While most of the applicants are emergency physicians, EMF has awarded grants to other emergency care professionals, such as pharmacists and epidemiologists, depending on the research topic.

EMF currently partners with the Emergency Medicine Residents' Association (EMRA) and the Society for Academic Medicine Foundation (SAEMF) to award research grants to residents and medical students. The EMF partnered grants with SAEMF and EMRA do not have requirements that applicants must be members of EMRA, SAEM or ACEP.

EMF will have two grants this cycle that are not partnered grants – Pilot Studies and Early Career. The EMF Board of Trustees recently held a strategic planning meeting. One of the tasks was to develop research priorities for the next five years. The priorities the EMF Board suggested include health policy, infrastructure, health care delivery changes, and workforce. These topics may not fall under the research expertise of emergency physicians and may be better studied by non-emergency physicians. If this resolution is approved, ACEP and EMF leaders will need to determine the research priorities that can be studied solely by ACEP's emergency physician members. This may limit EMF's ability to fund certain research if ACEP members do not have expertise in certain topics.

While SAEM may require membership to apply for and be awarded a SAEMF grant, the SAEM has membership categories that are not limited to emergency physicians. Membership includes those professionals who are PhD, DSc, or equivalent who hold a university appointment or are actively involved in emergency medicine. Also, SAEM accepts physician assistant, nurse practitioner, and nurse research coordinators/project managers, lay public, and government officials as members in addition to emergency medicine pharmacists, residents, and medical students. SAEM has an emergency department administrative and business function level of membership that includes primary administration of an emergency medicine residency programs. ACEP membership is limited to emergency physicians, residents, and medical students. Providing EMF grants that require the applicant to be an ACEP member may or may not be a member benefit that increases membership.

ACEP Strategic Plan Reference

Practice Innovations: Develop an institutional framework that will support the creation of innovative models going forward.

Fiscal Impact

Budgeted ACEP and EMF staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Cynthia A. Singh, MS
Director of Grant Development
EMF Deputy Executive Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 31(25)

SUBMITTED BY: Joshua J. Davis, MD
Kenneth Frumkin, MD, PhD, FACEP

SUBJECT: Evaluate the Quality and Member Support for ACEP's Association with an Open Access Journal

PURPOSE: 1) conduct an internal review of the quality and impact of articles published in *Annals of Emergency Medicine* and *JACEP Open*; 2) survey members to assess perceptions about the *JACEP Open* publication fees; and 3) provide a report to the Council regarding the results of the quality assessment and member survey results within 12 months including any recommendations for future editorial direction or affiliation.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Estimated cost for an outside vendor to develop and administer a survey is approximately $15,000. Loss of revenue of approximately $250,000 per year plus any fees to break the contract with the publisher, if the College determined to no longer support an open access journal.

WHEREAS, ACEP holds a central role in promoting high standards of scientific publishing and clinical excellence in emergency medicine; and

WHEREAS, ACEP is currently affiliated with both *Annals of Emergency Medicine* (a traditional subscription journal) and *JACEP Open* (an open access journal published online only); and

WHEREAS, Open access publishing models have benefits in improving access to research, but also present concerns regarding article processing charges, peer review quality, and academic prestige; and

WHEREAS, There has been increasing scrutiny across academic medicine regarding the rigor, impact, and sustainability of open access journals, and their alignment with the mission and values of professional societies; and

WHEREAS, The current article processing charge for authors hoping to publish their scientific work in JACEP Open is $2,600; and

WHEREAS, Shifting costs of publishing to researchers is unfair, especially towards researchers in resource-poor environments and disciplines; and

WHEREAS, Experts have noted that the open access model to publishing perversely incentivizes journal proliferation, but not quality of content; and

WHEREAS, It is essential to ensure that ACEP's official publications uphold the highest standards of quality, transparency, and member trust; therefore be it

RESOLVED, That ACEP initiate an internal review of the quality and impact of articles published in both its official journals, *Annals of Emergency Medicine* and *JACEP Open*; and be it further

RESOLVED, That ACEP survey its membership to assess perceptions regarding ACEP's affiliation with an open access journal with publication charges; and be it further

RESOLVED, That the findings from both a journal quality assessment and a member survey of membership perceptions regarding an open access journal be reported to the ACEP Council within 12 months of resolution adoption, along with any recommendations for future editorial direction or affiliation.

Background

This resolution asks ACEP to conduct an internal review of the quality and impact of articles published in *Annals of Emergency Medicine* and *JACEP Open*, survey members to assess perceptions about the *JACEP Open* publication fees, and provide a report to the Council regarding the results of the quality assessment and member survey results within 12 months including any recommendations for future editorial direction or affiliation.

Open access publication has grown steadily over the last few years; approximately 50% of scientific articles are now published open access.[1] While *Annals of Emergency Medicine* does provide a "hybrid" model for both subscription and open access (authors who want to publish their articles open access can pay the article publication charge; more information can be found here: https://www.annemergmed.com/open-access-information), the creation of a purely open access journal, i.e., *JACEP Open*, allows ACEP to retain and publish high quality articles, many of which are not accepted for publication in *Annals* because of methodological or scope concerns, that currently are submitted and published by competitor journals. Note that as of July 8, 2025, there have been 3,819 articles submitted to *JACEP Open* and of these, 2,193 (57%) were transfers from *Annals of Emergency Medicine* with 895 (41%) transferred articles accepted for publication.

JACEP Open provides a citable, searchable, and easily discoverable journal venue for ACEP-generated papers and educational materials, including works submitted by committees, sections, and chapters. ACEP pays the publication fees for any submissions from committees that were developed based on an objective assigned to the committee. *JACEP Open* has an impact factor of 1.9 and ranks #25 out of 56 emergency medicine journals and the journal helps position the College as a leader in the free open access medical education arena by providing high quality, open access educational materials to its members and the emergency medicine specialty as a whole.

JACEP Open launched in 2019 with Wiley as its publisher, with the first issue being published in January/February 2020. It quickly passed the scientific quality evaluation phase of the PubMed Central application (October 2020) and became indexed in PubMed Central. The journal was accepted into Web of Science in 2021 for coverage in the Emerging Sources Citation Index (ESCI), was accepted to Scopus in January 2022 and received its first impact factor in June 2023. Additionally, in April 2020, it was the first emergency medicine journal to publish a COVID-19 paper.

These accomplishments speak to the scientific rigor and integrity of the journal's editorial board. Editor Emeritus Henry E. Wang, MD, MS, FACEP. spearheaded the launch of the journal and its continued growth for the first five years of its existence. His dedication and energy in creating a journal from scratch, building an editorial board of recognized experts in the field of emergency medicine, including content experts in EMS, pediatrics, infectious disease, practice management, and more, were integral for the early success of the journal. Marianne Gausche-Hill, MD, FACEP, an internationally known leader in emergency medicine, recently became the second editor in chief and continues the successful growth of the journal. The journal received almost 750 manuscripts in 2024, a 20% increase over 2023. The journal's acceptance rate for scientific works in 2024 was 35%. *JACEP Open* has published 34 issues on www.jacepopen.com. The 2024 annual report can be found at https://www.jacepopen.com/article/S2688-1152(25)00034-7/fulltext.

The journal has also surpassed all financial estimates for the College. Optimistic calculations in 2020 suggested a potential return of $25,000 to the College and the actual results were double. The 2020-2024 royalty chart below displays the actual royalties *JACEP Open* received per its former contract with Wiley (25% of all revenues collected, including article publication charges, advertising, permission fees, etc.).

JACEP Open Royalty 2020-2024	
2020	$51,626
2021	$60,273
2022	$79,229
2023	$52,453
2024	$75,384

ACEP signed a contract with Elsevier to become the new publisher for *JACEP Open*, effective January 1, 2025.

Elsevier, in consultation with journal staff, sets the article publication charges. Elsevier's pricing models ensure attractive price/value positioning to authors and funders and a strong financial return for *JACEP Open,* both now and in the future. The pricing proposals are created by reviewing the journal's quality and competition within its specific field, including field and author community, and then proposing a model that is a competitive price/quality ratio within this group of competitors. *JACEP Open's* article publication charges are in line or less than other emergency medicine journals in Elsevier's collection. Elsevier offers discounts of 20% for papers transferred from *Annals* or if any of the authors are ACEP members.

ELSEVIER

Article Publishing Charge (APC) price list

Emergency Medicine Journals

All prices excluding taxes. Prices as of date: 09-May-2025

ISSN	Title	Business model	List price *			
			USO	EUR	GBP	JPY
2211-419X	African Journal of Emergency Medicine	Open access	2,140	2,000	1,710	265,420
0735-6757	The American Journal of Emergency Medicine	Hybrid	3,980	3,720	3,190	493,640
0196-0644	Annals of Emergency Medicine	Hybrid	3,850	3,600	3,080	477,520
2588-994X	Australasian Emergency Care	Hybrid	2,160	2,020	1,730	267,900
2688-1152	JACEP Open	Open access	2,600	2,430	2,080	322,480
0099-1767	Journal of Emergency Nursing	Hybrid	2,500	2,340	2,000	310,080
0736-4679	The Journal of Emergency Medicine	Hybrid	3,390	3,170	2,710	420,460
2405-4690	Visual Journal of Emergency Medicine	Hybrid	1,640	1,530	1,310	203,410

Background Reference

[1]Directory of Open Access Journals (DOAJ). Accessed June 30, 2025.https://doaj.org/

ACEP Strategic Plan Reference

Member Engagement and Trust: Enhance ACEP's branded positioning and communication strategies.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The estimated cost for utilizing an outside vendor to develop and administer the survey is in the range of $15,000. Additionally, loss of revenue of approximately $250,000 per year plus any fees to break the contract with the publisher, if the College determined to no longer support an open access journal.

Prior Council Action

None

Prior Board Action

October 2016, approved proceeding with development of a second peer-reviewed, open access, online-only journal for ACEP.

Background Information Prepared by: Tracy Napper
Editorial Director, Scientific Journals

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 32(25)

SUBMITTED BY: California Chapter

SUBJECT: Transparency in Vendor and Speaker Communication Restrictions at Scientific Assembly

PURPOSE: 1) Release the current guidelines on restricted or censored topics; 2) Refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; 3) , Any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS**,** ACEP's Scientific Assembly is the organization's largest educational meeting, intended to promote education, exchange of ideas, and advancement of emergency medicine practice; and

WHEREAS**,** The exhibition hall serves as a venue for attendees to engage with organizations and explore emerging practices in emergency medicine; and

WHEREAS, There are no publicly available guidelines for vendors or speakers outlining restrictions on specific words or topics; and

WHEREAS, Decisions regarding communication restrictions/censorship should be thoughtful, deliberate, and consistent with the organization's policies and ACEP's mission to promote education, evidence-based practice, and open discourse in emergency medicine; and

WHEREAS, Recent national discussions have raised concerns about the censorship or suppression of legitimate medical perspectives on topics such as gender-affirming care, reproductive health, addiction treatment, and pandemic response strategies; and

WHEREAS, Transparency around such restrictions is critical to preserve the trust of members, encourage diverse viewpoints, and ensure that evolving evidence can be freely discussed in professional forums; and

WHEREAS, Policies that limit what medical professionals may say – without clear justification or process – risk undermining scientific progress and may chill open discourse; therefore be it

RESOLVED, That ACEP publicly release its current guidelines on restricted or censored topics; and be it further

RESOLVED, That ACEP refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; and be it further

RESOLVED**,** That any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council to ensure transparency and accountability.

Background

This resolution requests ACEP to release the current guidelines on restricted or censored topics, refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards. The last resolved requests that "any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council to ensure transparency and accountability."

Pertaining to the last resolved, although the Council can "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" (ACEP Bylaws Article VIII – Council, Section 2 – Powers of the Council), the "management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws" (ACEP Bylaws IX – Board of Directors, Section 1 – Authority). It would be beyond the scope of responsibility for the Council to review and approve policies related to Scientific Assembly vendors and speakers.

Since the Council meets only once each year, at the annual meeting, it is impractical for the Council to review and approve any policy changes so that they may be enacted in a timely manner. Speakers are selected in the late winter-spring by the Scientific Assembly Planning Subcommittee for the fall annual meeting. Vendor purchases may occur at any time in advance of the annual meeting, but many, if not most, occur in the summer before the meeting.

ACEP adheres to the Council of Medical Specialty Societies (CMSS) "Code for Interactions with Companies" and ACEP's "Guiding Principles for Interactions with External Entities" to ensure that all interactions with corporate entities uphold the highest ethical standards of transparency, independence, and alignment with ACEP's goals.

Speaker Guidelines and Educational Content

ACEP's Scientific Assembly and educational meetings are designed to serve as premier forums for high-quality, evidence-based education for emergency physicians and related healthcare professionals. Faculty speakers are selected based on their subject matter expertise, relevant experience, and, when applicable, prior speaker evaluations and course content scores from previous engagements. Additionally, the Education Committee's Scientific Assembly Planning Subcommittee ensures all content is not contradictory to ACEP's Board approved policies. All CME-accredited content is governed by the Accreditation Council for Continuing Medical Education (ACCME) Standards for Integrity and Independence in Accredited Continuing Education, which require faculty to present fair, balanced, and scientifically valid content, free from commercial influence.

ACEP does not impose additional guidelines that restrict or censor the topics speakers may address beyond those required for CME accreditation. Presentations that comply with ACCME standards and are appropriate for our professional audience are not limited in the scope of discussion or content areas other than to ensure they do not contradict approved policies. Faculty are expected to uphold standards of professionalism, inclusion, and appropriate language, as outlined in the "Presentation Policy for ACEP Faculty." This policy is provided before the faculty agreement is signed and it reinforces ACEP's commitment to educational excellence and respect for a diverse audience.

Exhibit Hall and Endorsements

ACEP recognizes that some attendees may perceive the presence of exhibitors in the exhibit hall as an endorsement by the College. It is important to clarify that, while exhibitors are valued participants at Scientific Assembly, their products and services are not endorsed by ACEP. Exhibitor participation is governed by longstanding exhibit hall policies, which include restrictions on products related to firearms, tobacco, and alcohol. These policies align with ACEP's mission and are designed to maintain the integrity of the educational and professional environment of our meetings.

ACEP's rules and regulations for exhibitors state: "The Exhibitor agrees to abide by and assumes all responsibility for compliance with all pertinent laws, regulations and codes of duly authorized local, state and federal governing bodies including, but not limited to, fire, safety, environmental and health laws, ordinances, or regulations, together with the rules and regulations provided by ACEP and the operators and/or owners of the property where the exhibit space and or Event is located." The complete "Rules and Regulations" can be found **online here**. These established practices reflect ACEP's commitment to transparency, educational integrity, and trust within the emergency medicine community.

All exhibitors must meet ACEP's rules regarding "Eligibility for Exhibiting" (excerpted from the "Rules and Regulations"):

> The Event is the American College of Emergency Physicians' premier meeting. Its purpose is to enhance the professional and scientific education of the registrants in the field of emergency medicine. ACEP reserves the

exclusive and total right to control all aspects of the conduct of the Event. ACEP specifically reserves the right to determine the acceptability of applications for exhibit space. All applications must meet the following criteria:

- The products or services to be exhibited are of professional or educational interest or benefit to the registrants and are, in the opinion of ACEP, related to the field of emergency medicine or the physician's practice. Exhibiting at the Event does not imply ACEP's endorsement of products or services.
- The applicant or the goods or services to be exhibited will not be permitted if they, to the knowledge of ACEP staff, are contrary to Board-approved ACEP policies.
- The applicant is reasonably determined by ACEP to be highly ethical and reputable, and the goods and services to be exhibited are reasonably determined by ACEP not to be fraudulent.
- The applicant agrees to comply with ACEP Rules and Regulations governing the Event.
- The application and required documents must be filled out completely and accurately.
- Applications may be refused or booth space restricted due to space limitations or other reasons determined by ACEP.
- All pharmaceutical and medical device products exhibited must meet FDA guidelines and standards.
- All organizations in the Recruiting/Staffing category or those that are recruiting/staffing for physicians must complete the ACEP Employment Practices Survey. This includes physician groups, hospital systems, locums tenens companies, and government agencies. (Results of the surveys can be found on **ACEP Open Book** online.)

Exception: The only exception to the above guidelines pertains to those companies that are considered to be of "consumer interest" to the Event attendees. These companies may include, but are not limited to, automobile manufacturers, credit card companies, banking institutions, jewelers, etc. Exhibitor understands and agrees that the information contained in this website and the ACEP "Rules and Regulations" are an integral and binding part of the exhibit space contract.

ACEP reserves the right to refuse exhibits, even after an application has been approved, curtail activities, or to close exhibits or parts of the exhibit that do not by ACEP's determination comply with its rules and regulations.

In addition to the rules and regulations governing the exhibit hall, below are the terms that can be found on our Advertising Insertion Order used for conference-based advertising. These opportunities include, but are not limited to, print advertising in the "Onsite Schedule-at-a-Glance." hanging banners, escalator clings, email banner ads in daily eNewsletters, "know before you go" emails, etc.

Advertising Insertion Order Terms

- This order constitutes a legally binding agreement between the Advertiser and ACEP for the listed advertising opportunity(ies) at the ACEP25 Scientific Assembly, September 7-10 in Salt Lake City.
- It is represented and warranted by the Advertiser that the person signing this order is fully authorized to submit the order on behalf of the Advertiser.
- All advertisements submitted are subject to review and approval by ACEP,
- Advertisers may not use any ACEP name, mark, or logo in advertising with the exception of informational references, such as "See our booth at ACEP25 in Salt Lake City." Advertisers who violate this provision may not be allowed to participate in future ACEP meetings and may be subject to civil penalties. The ACEP25 logo may be used only with written permission from ACEP Show Management.
- The advertisement of products at ACEP25 does not constitute an endorsement by ACEP. Advertisers are not permitted to imply or represent in any media that ACEP has endorsed or approved their goods and services unless ACEP has specifically provided such an endorsement in writing.
- ACEP concludes that by signing the order, the Advertiser understands and confirms their commitment to the opportunity(ies) listed.
- If Advertiser cancels for any reason, there will be no refund, and Advertiser will remain responsible for any balance due.
- Advertiser grants ACEP a revocable, limited, non-exclusive license to use its name and logo and other pertinent intellectual property as specifically described in this Agreement and for no other purpose.

- Advertiser's Total Amount Payable listed above is due within 30 days from the date of this signed agreement by both parties and shall be payable to the **American College of Emergency Physicians** and may be mailed to: **American College of Emergency Physicians MISC ACEP | PO Box 222291 | Dallas, TX 75222-2291**
- For your accounting/legal purposes, ACEP's EIN is 38-1888798.

ACEP Strategic Plan Reference

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 19(23) Scientific Assembly Vendor Transparency adopted. Directed ACEP to encourage vendors recruiting emergency physicians for employment be encouraged to bring a current contract for physicians to review during Scientific Assembly exhibits and the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on transparency in billing/collections.

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."

Substitute Resolution 10(01) Commercial Sponsorships adopted. The resolution called for 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."

Prior Board Action

Amended Resolution 19(23) Scientific Assembly Vendor Transparency adopted.

October 2017, approved the revised "Guiding Principles for Interactions with External Entities." These guiding principles contain the exhibitor policy contained in the "Rules and Regulations" for exhibitors.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Background Information Prepared by: Robert Heard, MBA, CAE
Chief Operating Officer

Liz Cardello
Development Director

Ansley Colbeck
Senior Manager, Education Development

Stephanie Batson
Senior Manager, Exhibits and Corporate Development

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 33(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Medicine Public Education

PURPOSE: Identify and work with stakeholders to develop a public education campaign to help patients decide when it is appropriate to seek emergency care at an emergency department versus an urgent care facility.

FISCAL IMPACT: Budgeted committee and staff resources for ongoing communications work. Expanding current efforts with additional content creation and deliverables, such as video, PSA, stakeholder outreach, media placement, etc., could require additional unbudgeted costs of $100,000 – $500,000 depending on the scale and scope of the campaign.

WHEREAS, There is a spectrum of care and resources available to patients seeking urgent and emergency care in the United States, ranging from urgent care centers to freestanding emergency departments through emergency departments in hospital settings; and

WHEREAS, The available resources and capabilities across these sites often range broadly; and

WHEREAS, The cost of healthcare associated with each site varies greatly; and

WHEREAS, Patients seeking care in emergency departments for lower acuity issues that could similarly be addressed in other settings can have downstream impact to the timely care of other patients seeking care in emergency departments; and

WHEREAS, Patients seeking care at urgent care centers when they require emergency department resources can delay their care in emergent situations and increase their cost of healthcare when a patient is required to go from an urgent care center to an emergency department; and

WHEREAS, ACEP is the leader in unscheduled care in the United States and has members who practice and have expertise both in urgent care and emergency department settings; and

WHEREAS, There have been successful advertising campaigns in other countries such as England and Australia to educate patients on what complaints are better suited for an urgent care setting versus those better suited for an emergency department setting[1-4]; therefore be it

RESOLVED, That ACEP identify and work with other key stakeholders to develop a public education campaign targeted to help patients better understand which complaints are appropriate for an urgent care center environment versus an emergency department to help streamline their care and costs.

References

1. https://www.england.nhs.uk/urgent-emergency-care/about-uec/
2. https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-visit-an-urgent-treatment-centre/
3. https://www.health.gov.au/find-a-medicare-ucc/when-to-visit
4. https://www.aihw.gov.au/reports/primary-health-care/use-eds-lower-urgency-care-2020-21-and-2021-22/contents/lower-urgency-care/summary

Background

This resolution calls for the College to identify and work with stakeholders to develop a public education campaign to

help patients decide when it is appropriate to seek emergency care at an emergency department versus an urgent care facility.

ACEP provides patient-facing content on www.emergencyphysicians.org. The site includes both the ACEP "Know When to Go" and "ER 101" campaigns in addition to multiple other topics. These materials are shared routinely through ACEP-owned social media channels and through traditional media.

Expanding public awareness efforts with a targeted campaign would require approximately 6-12 months from planning to launch and evaluation.

Key Steps:

- Strategy and Planning: Define goals, target audiences, and messaging.
- Stakeholder Collaboration: Identify, recruit and convene partners from urgent care associations, hospitals, insurers, and advocacy groups to co-develop and amplify the campaign.
- Content Development: Create easy-to-understand print, digital, and video materials tailored for diverse audiences.
- Campaign Launch: Roll out via social media, health care settings, and partner channels.
- Monitoring and Evaluation: Measure impact through web analytics, surveys, and care utilization trends.

Resources Needed:

- ACEP communications and public affairs staff
- Budget for content creation, media placement, and outreach (could range $100,000 – $500,000 depending on the scale and scope of the campaign)
- Input and amplification from partners

The success of such a campaign would depend on aligned messaging, amplification by trusted voices, and sustained engagement across partner channels.

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.

- Enhance ACEP brand positioning and communication strategy.

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

Fiscal Impact

Budgeted committee and staff resources for ongoing communications work. Expanding current efforts with additional content creation and deliverables, such as video, PSA, stakeholder outreach, media placement, etc., could require additional unbudgeted costs of $100,000 – $500,000 depending on the scale and scope of the campaign.

Prior Council Action

Amended Resolution 23(21) Media Marketing of Value of Emergency Medicine Board Certification adopted. Directed ACEP to focus more on marketing to and educating the public on the value of 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 board certified emergency physicians go through compared to non-board certified emergency physicians and non-physician practitioners; and 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.

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted. The resolution directed ACEP to create a public awareness campaign highlighting the unique skill set, knowledge base, and value of those that meet the ACEP definition of emergency physician; and partner with the American Medical Association and with other national medical specialty societies on a campaign to promote the unique skill set, knowledge base, and value of residency trained and board certified physicians.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted. Directed ACEP to develop a repository of public relations materials on the ACEP Website demonstrating the value of emergency medicine and develop public relations materials regarding the value of emergency medicine for legislators; and

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted. Directed ACEP to continue efforts to promulgate the value and role of emergency medicine as a critical component of an effective health care delivery system to other medical and healthcare organizations, the media, and the American public.

Prior Board Action

The Board has supported multiple public relations efforts to promote the value and role of emergency physicians and emergency medicine.

October 2017, approved funding of up to $100,000 to fund a study on the value and cost effectiveness of emergency care.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted.

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted.

Background Information Prepared by: Steve Arnoff
Director of Public Relations

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 34(25)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Recognition of Public Media as a Public Health Necessity

PURPOSE: Recognize public media as a public health necessity and support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

WHEREAS, A well-informed public is essential for the prevention of disease, the promotion of healthy behaviors, and the effective response to public health emergencies[1]; and

WHEREAS, Public media reaches millions of Americans with free, fact-based, accessible information that often addresses health literacy gaps and underserved communities[2]; and

WHEREAS, Public media has historically played a critical role in communicating health information during crises such as natural disasters and disease outbreaks, particularly when other communication channels were inaccessible or distrusted[3]; and

WHEREAS, Emergency physicians are uniquely positioned to contribute to and benefit from public media's reach by communicating health guidance, correcting misinformation, and improving public trust in health care; and

WHEREAS, Diminishing funding or political threats to public media may jeopardize its ability to serve as a reliable source of timely, accurate, and science-based public health messaging; therefore be it

RESOLVED, That ACEP recognize public media as a public health necessity, which is a vital component of a well-informed public and public health infrastructure; and be it further

RESOLVED, That ACEP support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

References

[1] https://www.who.int/tools/your-life-your-health/a-healthy-world/people-s-roles/the-role-of-media-in-supporting-health
[2] https://cpb.org/aboutpb/what-public-media
[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC3778998/

Background

This resolution calls for the College to recognize public media as a public health necessity and support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

As of July 2025, the House has approved a Trump administration plan to rescind $9 billion in previously allocated funds, including $1.1 billion for the Corporation for Public Broadcasting (CPB). This action removes all federal support for National Public Radio (NPR), the Public Broadcasting System (PBS), and their member stations, as well as approximately $7 billion in foreign aid.

These cuts pose significant operational threats for public media outlets. NPR has warned that, "many of those stations, especially those broadcasting to rural areas or to underserved audiences, such as Native Americans, could be forced to

shut down as a result of the funding rollback." (Congress Rolls Back $9 Billion in Public Media Funding and Foreign Aid, NPR 7/18/25)

Public media airs health-focused shows and documentaries that explain medical topics, public health concerns, and wellness strategies (examples are PBS NewsHour and NOVA). Public service announcements can provide nonprofit organizations the opportunity to air short messages on issues such as mental health, nutrition and exercise, and disease prevention. Local stations can collaborate with their local health departments and community organizations to discuss local health issues. Finally children's programming teaches hygiene, emotions, and wellness.

However, the current media has changed drastically since the start of publicly supported media with many more streaming alternatives, podcasts, etc., with more access to free information than ever before. Critics contend that these services are duplicated by the media outlets of the CDC and National Institutes of Health. Others contend that while the public media has educational value, financial sustainability should come from diversified sources instead of government 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 professional.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Steve Arnoff
Director of Public Relations

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 35(25)

SUBMITTED BY:	James Humble, MD, FACEP	Delaware Chapter
	Joseph D. Lykins, MD	Illinois College of Emergency Physicians
	Daniel Martin, MD, MBA, FACEP	Dual Training Section
	Vinay Mikkilineni, MD	Observation Medicine Section
	Travis Olives, MD, MPH, FACEP	Pediatric Emergency Medicine Section
	Katherine Ren, DO	

SUBJECT: Appropriate Representation in the Review Committee for Combined Emergency Medicine Residency Programs

PURPOSE: Work with the ACGME and the Emergency Medicine Review Committee to advocate for required representation from dual-trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and engage with other subject matter experts.

WHEREAS, The American College of Emergency Physicians (ACEP) is committed to supporting the advancement of emergency medicine education across all pathways; and

WHEREAS, Combined emergency medicine residency programs are growing in number and complexity, requiring coordinated efforts to ensure educational standards, equity, and integration within the broader emergency medicine community as well as other specialties; and

WHEREAS, Our experience and research show that combined emergency medicine graduates provide unique values and perspectives reaching across departments with often taking roles in academics, leadership, education, and rural medicine while continuing to have high job satisfaction[1]; and

WHEREAS, Going forward, the Emergency Medicine Review Committee will have to dictate the unique needs and challenges of combined training pathways as they will be individually accredited and their accreditation will no longer be based on the accreditation of the parent programs (as of July 1, 2025); and

WHEREAS, Such a committee only has half the expertise to offer guidance on best practices for curriculum design, navigating dual-training requirements, faculty development, and career pathways for combined-program graduates; therefore be it

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and the Emergency Medicine Review Committee to advocate for required representation from dual trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee.

Background

This resolution requests that ACEP work with the Accreditation Council for Graduate Medical Education (ACGME) and the Emergency Medicine Review Committee to advocate for required representation from dual-trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee
Combined emergency medicine residency training first started in 1989. There are now five Combined Emergency Medicine Residency Programs, including Emergency Medicine – Internal Medicine, Emergency Medicine – Family Medicine, Emergency Medicine – Anesthesiology, Emergency Medicine – Pediatrics, and Emergency Medicine –

Aerospace. This resolution seeks to update the composition of the ACGME Review Committee (RC) tasked with overseeing the accreditation of combined emergency medicine residency programs. Combined residency programs in emergency medicine and other specialties are increasingly important for training physicians capable of addressing diverse patient populations and complex clinical settings.

Effective February 2024, the ACGME Board of Directors approved a new plan to initiate accreditation of combined programs. Beginning July 1, 2025, and going forward, the accreditation of combined training programs will be under a single reviewing committee. There are currently 5 combined specialties.

Specialty	Responsible RC	Number of Programs (2024 Match)	Number of Positions (2024 Match)
Aerospace-EM	Preventive Medicine	New	New
Anesthesia-EM	Anesthesia	1	1
EM-Pediatrics	EM	4	8
EM-Internal Medicine	EM	13	34
EM-Family Medicine	EM	3	7

Currently the Emergency Medicine Review Committee includes:
3 members nominated by the American Board of Emergency Medicine (ABEM)
3 members nominated by the American College of Emergency Physicians (ACEP)
3 members nominated by the American Medical Association (AMA)
2 members nominated by the American Osteopathic Association (AOA)
1 public member
1 resident member
4 ex-officio members from each of the four constituent organizations (ABEM, ACEP, AMA, and AOA)

Review Committees currently have eexpertise and depth in specialty and subspecialty areas and may not have the same expertise in the combined specialty area. Dual training programs find themselves in a situation where they do not have the same representation on the RC as core programs. Requiring dual trained representatives could be the first step in advocating for improved representation on the RC. A Combined Emergency Medicine RC with appropriate representation would help support better standardization efforts, appropriate oversight, and ensure the growth and sustainability of these unique training pathways. However, given the small number of program and graduates, such an approach may not be feasible.

Background References

1. https://www.acgme.org/globalassets/pfassets/presentations/2025-specialty-updates/emergency-medicine-update-2025.pdf
2. https://www.acgme.org/programs-and-institutions/programs/combined-programs/
3. https://www.acgme.org/about/committees-and-members-selection-process/

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and engage with other subject matter experts.

Prior Council Action

None specific to advocating for required representation from dual trained physicians in writing requirements or to create a separate Combined Emergency Medicine Review Committee.

Prior Board Action

None

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 36(25)

SUBMITTED BY: California Chapter
Young Physicians Section

SUBJECT: Reaffirming Support for 3-Year and 4-Year Emergency Medicine Residency Program Accreditation

PURPOSE: Reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length, and reaffirm the commitment to represent ACEP policy statements when making public statements on behalf of the College.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine residency programs in the United States have historically operated under both three-year and four-year training formats, each rigorously accredited by the Accreditation Council for Graduate Medical Education (ACGME); and

WHEREAS, The American Board of Emergency Medicine (ABEM) recognizes both three-year and four-year programs as valid routes to board eligibility; and

WHEREAS, Multiple peer-reviewed studies, including those published in *JACEP Open* and *AJEM*, have found no conclusive superiority in clinical performance, milestone achievement, or board certification outcomes between three- and four-year residency graduates[1-2]; and

WHEREAS, In 2023, ACEP adopted Council Resolution 22 "Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation," recognizing the value of choice in emergency medicine residency training formats and support for the continued accreditation of both three-year and four-year emergency medicine residency programs; and

WHEREAS, In April 2024, subsequent to the adoption of the aforementioned resolution, the Board adopted the policy statement "Length of Residency in Training in Emergency Medicine" affirming the value of both 3-year and 4 year programs; and

WHEREAS, The ACEP policy statement "Length of Residency in Training in Emergency Medicine" from April 2024 highlights "There is no current evidence to suggest superior or non-inferior educational outcomes of either three- or four-year programs"[3]; therefore be it

RESOLVED, That ACEP reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," established by Council Resolution 22(23) recognizing the value of and supporting continued accreditation of both three- and four-year emergency medicine residency programs; and be it further

RESOLVED, That ACEP oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length; and be it further

RESOLVED, That the Board of Directors reaffirm their commitment to represent ACEP policy statements when making public statements on behalf of the College.

Resolution References

1. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. JACEP Open. 2023;4:e12991. doi:10.1002/emp2.12991
2. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. Am J Emerg Med. 2023;69:100-107. doi:10.1016/j.ajem.2023.04.017
3. American College of Emergency Physicians. Length of Residency in Training in Emergency Medicine - Policy Statement. Originally approved April 2024. Available at: https://www.acep.org/patient-care/policy-statements/length-of-residency-in-training-in-emergency-medicine.

Background

This resolution calls for ACEP to reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length, and reaffirm the commitment to represent ACEP policy statements when making public statements on behalf of the College.

ACEP's "Length of Residency in Training in Emergency Medicine" states:

> "The American College of Emergency Physicians (ACEP) recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year programs. There is no current evidence to suggest superior or non-inferior educational outcomes of either three- or four-year programs. ACEP believes supporting both training formats benefits the specialty, trainees, and patients. Future changes to the length of training requirements in emergency medicine should be evidence-based."

The second resolved requesting ACEP to "oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length" would require ACEP to change the current policy. The 2023 resolution directed that ACEP support both models and did not direct ACEP to oppose a mandate.

Between 2004 and 2024, the Council has requested additional content to be added to the ACGME program requirements on multiple occasions including topics on rural medicine, telehealth, physician led teams, climate change, advocacy, early pregnancy loss, buprenorphine initiation and harm reduction skills, professional liability litigation process, risk management, sexual assault, stigma, telehealth, implicit bias training, etc. Every 10 years, the ACGME Review Committees undertake a process to revise the applicable specialty-specific Program Requirements. The process seeks input from key stakeholders and includes scenario-based strategic planning to think rigorously and creatively about what the specialty will look like in the future.[1]

In 2021, a workgroup of emergency medicine organizations convened to consider the anticipated revision of the emergency medicine program requirements. The workgroup included representatives from emergency medicine organizations, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), American College of Osteopathic Emergency Physicians (ACOEP), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents Association (EMRA), American Academic of Emergency Medicine (AAEM), AAEM Resident and Student Association (RSA), Society of Academic Emergency Medicine (SAEM), and SAEM Resident and Medical Student Association (RAMS). The group performed literature searches, reviewed existing evidence, and made consensus recommendations as a framework to guide future training requirements. The process focused on identifying gaps in current training and modifying the requirements to address them. The major consensus point was that the bar needed to be raised for emergency medicine training. Several themes emerged in the recommendations, which included procedural training, pediatric resuscitation, critical care, scholarly activity, curriculum/rotations, faculty, and facility requirements. Consensus could not be reached over the length of training, and therefore, the recommendation was that the future length of training should be based on curricular elements and the time needed to achieve competency.

The ACGME began the revision process in 2022. After nearly three years of strategic planning, data analysis, comment periods, and stakeholder input, the ACGME Emergency Medicine Review Committee released the proposed requirements on February 12, 2025.[2] The proposed changes included additional emergency medicine time, time in low

acuity and low resource time, and more pediatric and critical care exposure. New content areas added, including addiction medicine, acute psychiatric emergencies, administration, observation, and telemedicine. These additions encompass many of the content areas that have been debated at previous Council meetings and in the all-emergency medicine consensus report.

The program revision writing group also published a report entitled "Building the Future Curriculum for Emergency Medicine Residency Training." They described the process by which they "built the foundational residency curriculum to train emergency physicians of the future." They further state that they were encouraged to think about the revisions "free from constraints and biases" inherent in the current requirements used by existing programs.[3] The writing group took the approach of identifying the component blocks to build a curriculum. The themes and key insights that emerged included the length of training, curricular building blocks, resources, procedural, scholarly, and didactic aspects.

As part of the revision process, the ACGME conducted a survey of program directors to determine the ideal length of individual training components and then calculated the overall length of training needed by adding them up. The overall results of the program director's survey were an average total required training time for residents was 43.4 months (SD=10.8, median=42). According to the survey, program directors from 3-year programs summed average was 41.6 months (SD=10.4, median=40) with program directors from 4-year programs having a summed average of 50.7 months (SD=9.5, median=49).

This finding is remarkably consistent with a similar study conducted almost 10 years ago. In this 2014 study, program directors were asked about the ideal length of residency training and the ideal length of individual blocks. The ideal length of training averaged 41.5 months (SD = 5.5, range = 36 to 60 months). When asked to provide durations of individual clinical experiences for their ideal emergency medicine program, the sum total (n = 104) averaged 44.7 months (SD = 10.5). Program directors who directed and trained in PGY 1–3 format programs provided the shortest ideal duration (mean = 38.9 months), whereas program directors who directed and trained in PGY 1–4 and 2–4 format programs provided the longest ideal duration (mean = 46.6 months).

Currently, about 80% of emergency medicine residents and residencies are in the 3-year format, and according to both studies, individuals associated with 3-year formats express a preference for shorter training lengths. Interestingly, both studies found that the average ideal length of training for 3-year program directors was more than 36 months.

Studies on performance on ABEM exams and measures of clinical care and practice patterns related to efficiency, safety, and flow have found similar results for 3-year and 4-year graduates. The length of stay, patient-to-hour ratio, RVUs, and 72-hour returns were similar for all.[5,6]

Currently, the ACGME requirements allow both 3- and 4-year training formats. Emergency medicine is the only specialty that allows for two different training lengths. Only pediatrics, internal medicine, and family medicine have 3-year programs, all of which are primary care-based. All other ACGME specialties are a minimum of 4 years in length.

The ACGME requested comments about the proposed changes to the emergency medicine program requirements by May 1, 2025. ACEP President Alison Haddock, MD, FACEP, held several town hall listening sessions with members to hear comments and concerns about the proposed changes and to help inform ACEP's response to the ACGME. ACEP members were also encouraged to submit their comments directly to the ACGME. ACEP submitted comments to the ACGME by the May 1 deadline and posted a statement on the ACEP website about the response. The statement included reference to ACEP's current policy statement, based on a 2023 Council resolution, that "supports the value of both three-year and four-year emergency medicine training programs" and "acknowledges that the increasing complexity and demands of emergency medicine require us to be open-minded to the evolution of the specialty and the existing policy. ACEP supports ACGME in making changes to program requirements, including the length of training, using a robust, evidence-based approach, and gathering sufficient input from key stakeholders to inform final decisions."

Background References

1. Regan L, McGeeD, Davis F, Murano T. Building the Future Curriculum for Emergency Medicine Residency Training. J Grad Med Educ

2025; doi: https://doi.org/10.4300/JGME-D-25-00101.1
2. Requirements for Review and Comment: Proposed Program Requirements Emergency Medicine. Accessed Feb 16, 2025. https://www.acgme.org/globalassets/pfassets/reviewandcomment/2025/110_emergencymedicine_rc_02122025.pdf
3. Gray, BK, Lumpkin JR, Gallery ME, Rorrie CC. Length of residency training in emergency medicine: An outcome-oriented approach. Annals of Emergency Medicine, 15(4), 493.
4. Hopson L, Regan L, Gisondi MA, Cranford JA, Branzetti J. Program Director Opinion on the Ideal Length of Residency Training in Emergency Medicine. Acad Emerg Med. 2016 Jul;23(7):823-7. doi: 10.1111/acem. 12968. Epub 2016 Jun 20. PMID: 26999762.
5. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. JACEP Open. 2023;4:e12991. doi:10.1002/emp2.12991
6. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. Am J Emerg Med. Apr 15 2023;69:100-107.

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 professional.

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.

- Remain diligent in addressing workforce solutions to ensure emergency physicians set the course for the future

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 22(23) Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation adopted. Acknowledges that ACEP recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year programs.

Resolution 48(20) Residency Program Expansion referred to the Board of Directors. Requested ACEP to engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Directed ACEP to address workforce shortages and lobby for the removal of barriers to increasing the number of residency slots available in emergency medicine. Also directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to work with other emergency medicine organizations to use existing workforce data to identify current and future needs for board certified emergency physicians, recommend strategies based on the projected need to ensure appropriate numbers of emergency medicine residency graduates meet the need, and advocate to eliminate barriers to create adequate numbers of emergency medicine residency positions and achieve optimal funding for those positions.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Resolution 28(92) Emergency Medicine Residency Training Pilot Program not adopted. The resolution called on ACEP to facilitate, develop, and pilot a model training program in emergency medicine designed to allow practicing emergency physicians who completed training in other specialties to meet the requirements of the RRC-EM and become eligible for the ABEM exam. The pilot programs would be completed in a timely manner, through part-time

and independent work, while in practice.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Prior Board Action

April 30, 2025, discussed the ACGME's proposed changes to the emergency medicine residency program requirements.

February 26, 2025, discussed the ACGME's proposed changes to the emergency medicine residency program requirements.

April 2024, approved the policy statement "Length of Residency in Training in Emergency Medicine."

Resolution 22(23) Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation adopted.

January 2021, appointed a multi-organization ACGME Emergency Medicine Requirements Consensus Task Force appointed to develop recommendations in response to Referred Resolution 48(20) Residency Program Expansion.

June 2018, reaffirmed the policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles;" reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

Amended Resolution 15(09) Emergency Medicine Workforce Solution adopted.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs adopted. The Board amended the substitute resolution to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted**.**

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 37(25)

SUBMITTED BY: International Emergency Medicine Section
Maryland Chapter

SUBJECT: Support for Funding Resident Training Away from Home Institutions

PURPOSE: Advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Emergency physicians serve an increasingly multicultural and diverse population, requiring cultural understanding to provide effective care; and

WHEREAS, Immersive experiences, whether abroad or in underserved domestic settings, offer unique opportunities to deepen cultural competence and clinical adaptability; and

WHEREAS, Current Centers for Medicare & Medicaid Services regulations prohibit funding for resident physicians during clinical rotations away from their primary training site, creating a barrier to such experiences; therefore be it

RESOLVED, That ACEP advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

Background

This resolution calls for ACEP to advocate for changes in Centers for Medicare & Medicaid Services (CMS) policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

Medicare is the largest single payer for graduate medical education (GME) in the U.S., playing a central role in funding residency training programs. However, current CMS regulations typically restrict reimbursement to training that occurs within a resident's primary hospital affiliation or closely affiliated sites. These regulations limit the ability of medical residents to participate in rotations that take place in rural, underserved, or international settings – areas where clinical experience could enhance cultural competency, broaden clinical skills, and address workforce gaps. Professional liability coverage is another concern related to international rotations.

ACEP's policy statement "Workforce Diversity in Health Care Settings" illustrates the College's beliefs about the value of diversity towards inclusive work environments and equitable patient care:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with highly qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care.
- Attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal.

- Health professionals, educators, and administrators must recognize and address institutional barriers and policies that may contribute to underrepresentation of certain groups in the workforce.
- To maintain and increase the supply of primary care physicians who care for vulnerable populations over the coming decades, educational and health care entities should establish and promote pipelines to develop and support future professionals.
- A diverse workforce can display increased cultural competence across cultural practices, languages, and social issues.
- Culturally congruent health care interactions can improve adherence, trust, and patient experience, thereby expanding quality of, and access to, care for traditionally hesitant or disengaged populations.

The policy statement also provides context about the value of increasing diversity within the health care workforce:

> "In 2004, the Institute of Medicine, later renamed the National Academy of Medicine, identified ensuring diversity in health care settings as a compelling interest. Physicians who belong to URM groups are much more likely to practice in environments where they treat minority patients and patients of lower socioeconomic strata. Studies show that diversity among health professionals promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[3-5] Additionally, increasing diversity in the workforce has the potential to reduce existing health disparities and decrease their associated economic and social burdens."

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that "cultural awareness is essential to the training of health care professionals in providing quality patient care. It also confirms ACEP's position that resources should be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background.

With respect to the longstanding workforce and staffing needs for rural communities, according to the AHA nearly 35% of hospitals in the US are considered rural. The "National Study of the Emergency Physician Workforce, 2020," reported that the nation's rural emergency physician shortage is expected to worsen in the coming years, the authors note. Of the 48,835 clinically active emergency physicians in the United States, 92 percent (44,908) practice in urban areas with just 8 percent (3,927) practicing in rural communities, down from 10 percent in 2008.

There are several barriers to rural experiences for emergency medicine residents. Medicare GME funding is tied to resident rotating at the home institution, so when a resident rotates at rural site, it may result in the loss of the funding for the duration of the rotation. However, as part of the year-end omnibus appropriations package passed in December 2020, Congress included ACEP-supported provisions to address the Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations, allowing hospitals to host a certain number of medical residents for short-term rotations without triggering the permanent full-time equivalent resident cap or Per Resident Amounts (PRAs). The law also included 1,000 new Medicare-funded GME positions (the first increase in Medicare GME positions in nearly two decades), with 10 percent of those positions dedicated to rural areas. Other legislative efforts to increase the number of Medicare-funded residency positions continue, such as the "Resident Physician Shortage Reduction Act," (H.R. 3890) introduced by Reps. Terri Sewell (D-AL) and Brian Fitzpatrick (R-PA), which would add an additional 14,000 new slots over a seven-year period to train more physicians and address the projected physician shortage. The bill specifically addresses primary care and rural areas, but does not address international placements.

Accreditation Council for Graduate Medical Education (ACGME) requirements may also create challenges for faculty and supervision of residents during rural rotations, considering larger workforce and faculty shortage challenges. According to section II.B.2.g) of the ACGME Program Requirements in Emergency Medicine, "Faculty members supervising emergency medicine residents in an adult emergency department must either be ABEM/AOBEM board-eligible or have current ABEM and/or AOBEM certification in emergency medicine."

ACEP has had three separate task forces in the past ten years to address the issue of attracting emergency physicians to practice in rural areas. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates showed that

few, if any, of those who answered the survey took jobs in the rural area, even though 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. 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.

ACEP's current legislative and regulatory priorities for the First Session of the 119th Congress also include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.

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 professional.

Fiscal Impact

Budgeted resources for current advocacy initiatives.

Prior Council Action

Amended Resolution 44(24) Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations adopted. The resolution directed ACEP to: 1) continued to advocate for CAH funding for emergency medicine resident rotations at rural CAHs; 2) support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the section and shared with the Council of Residency Directors in Emergency Medicine; and 3) request the ACGME to encourage all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted. Called for ACEP to advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine.

Resolution 49(22) Enhancing Rural Emergency Medicine Patient Care not adopted. The resolution called for ACEP to 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; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and 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.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors. The resolution directed ACEP to: 1) Support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; 2) support rural health services research to better understand the optimal funding mechanism for rural hospitals; 3) support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care; 4) support changes in CMS regulation to allow rural off-campus EDs and rural emergency hospitals to collect the facility fee as well as the professional fee; and 5) 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.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted. The resolution directed 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.

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.

Prior Board Action

June 2025, reaffirmed the policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" revised and approved June 2018 with the current title; reaffirmed April 2012 and October 2006; originally approved June 2000 titled "Resident Training for Practice in Non-Urban Areas."

January 2025, March 2024, February 2023, January 2022, and January 2021 approved legislative and regulatory priorities that included several initiatives related to rural emergency care.

Amended Resolution 44(24) Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations adopted.

Amended Resolution 38(23) Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals adopted.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted.

June 2022, approved the revised policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas 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.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

Background Information Prepared by: Fred Essis, MA, MBA
Congressional Lobbyist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 38(25)

SUBMITTED BY: Jamila Goldsmith, MD, FACEP
Alexandra N. Thran, MD, FACEP
Vermont Chapter
Locum Tenens Section

SUBJECT: Inclusion of ACEP Leadership Roles as Approved Practice Improvement Activities for ABEM Certification

PURPOSE: Advocate for ABEM to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements, work with ABEM to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification, and work with ABEM toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort.

WHEREAS, The American Board of Emergency Medicine (ABEM) requires all emergency physicians to participate in approved, externally developed Practice Improvement (PI) activities as a component of their Maintenance of Certification (MOC) process; and

WHEREAS, These Practice Improvement activities are essential for ensuring that emergency physicians maintain up-to-date medical knowledge and improve the quality of care provided to patients; and

WHEREAS, The current ABEM guidelines for PI activities do not recognize participation in leadership roles within the American College of Emergency Physicians (ACEP) – including serving on national committees, state chapter leadership positions, national leadership positions, including serving on the ACEP board, or fulfilling roles as a section chair, section board member, councilor, or Council Speaker or Vice-speaker as qualifying for fulfilling PI requirements; and

WHEREAS, Engaging in ACEP leadership roles fosters professional development, enhances the practice of emergency medicine, and contributes to the advancement of the profession by allowing physicians to influence policies and practices that directly affect patient care; and

WHEREAS, Recognizing these leadership roles as valid Practice Improvement activities would not only incentivize greater participation in ACEP leadership but would also enhance the overall quality of emergency medicine practice through shared leadership experiences and collective improvements in patient care; therefore be it

RESOLVED, That ACEP advocate for the American Board of Emergency Medicine to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements; and be it further

RESOLVED, That ACEP collaborate with the American Board of Emergency Medicine to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification; and be it further

RESOLVED, That ACEP and the American Board of Emergency Medicine work toward implementing the

criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

Background

This resolution seeks for ACEP advocate for ABEM to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements, work with ABEM to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification, and work with ABEM toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

One of the elements of ABEM's continuing certification process is the Improvement in Medical Practice (IMP). This requirement focuses on practice-based learning and improvement in areas such as patient care and communication. To fulfill this requirement you must attest to the completion of one **Patient Care Practice Improvement (PI) Activity** during each 5-year certification cycle.

According to the ABEM, a Practice Improvement (PI) activity is a structured process where emergency physicians assess their clinical practice, identify areas for improvement, implement changes, and then re-evaluate those changes to ensure they have a positive impact on patient care. It is a core component of ABEM's Maintenance of Certification program, requiring physicians to demonstrate ongoing commitment to improving their practice.

To be considered a valid PI activity for ABEM, it must include the following four steps:

1. Measurement: The physician selects a specific clinical care process, outcome, or area related to the Model of the Clinical Practice of Emergency Medicine and collects data on it, focusing on at least ten patients.
2. Comparison to Standards: The collected data is compared to established benchmarks, guidelines, or standards of care to identify areas where performance falls short.
3. Improvement: The physician implements changes or interventions aimed at addressing the identified gaps in performance, such as adopting new protocols, enhancing communication, or modifying workflows.
4. Re-measurement: After implementing the changes, the physician re-measures the same clinical care process or area to assess the impact of the interventions and confirm whether the desired improvements were achieved.

Finally, after completing the activity, the physician must attest to the activity and submit the name of the person who can verify completion of the PI activity. This is considered a fifth step in addition to the four steps of the traditional PI process.

Examples of PI activities include projects focused on improving:

- Door-to-doctor times: Reducing the time it takes for patients to be seen by a physician.
- Door-to-balloon times: Reducing the time it takes for patients with ST-elevation myocardial infarction (STEMI) to receive percutaneous coronary intervention (PCI).
- Pain management: Improving the timeliness and effectiveness of pain management for patients with various conditions.
- Patient experience: Enhancing patient satisfaction and communication.
- Throughput times: Improving the efficiency of patient flow through the emergency department.
- Compliance with clinical guidelines: Ensuring adherence to established guidelines for specific conditions or procedures.

ABEM also provides resources and guidance on how to select, implement, and report PI activities through their portal and through resources like the ABEM Improvement in Medical Practice Attestation Process.

Currently, ABEM requires a patient improvement plan to be completed based on a physician's own patient data. For emergency physicians who work at multiple sites or perform locums work, the process can be more challenging. This is especially true as they may not be participating or part of ongoing department-sponsored PI activities like door-to-balloon time and other measures.

This resolution proposes that ACEP support participation in College leadership activities in lieu of the local PI activities. Leadership participation would include chapter and section leadership roles, serving on national committees, participating in Council meetings, or serving on the Board of Directors. Careful consideration would be needed to create a model where ACEP service would follow the four steps of patient care practice improvement (measure, compare to standard, implement an improvement, and re-measure) to meet the ABEM requirement.

Background References
https://www.abem.org/stay-certified/improvement-in-medical-practice/
https://www.abem.org/wp-content/uploads/2024/07/imp-faqs.pdf
https://www.abem.org/wp-content/uploads/2024/07/practice-improvement-guide.pdf

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort.

Prior Council Action

Resolution 24(17) Maintenance of Competence for Practicing Emergency Physicians referred to the Board of Directors. The referred resolution sought for ACEP to: 1) study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians to demonstrate ongoing competence and skills necessary for their own practice setting; 2) Develop appropriate guidelines for "maintenance of competence" with minimum and legitimate barriers to continued practice; and 3) Develop a report for the 2018 Council.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted. Directed ACEP to communicate appreciation to ABEM for sensitivity in interpreting ABMS mandates; develop policy supporting the ABMS MOC as appropriate state medical license MOL, but actively oppose mandates that linking MOC as requirements for ongoing MOL; and develop policy opposing efforts of ABMS and its specialty boards to become independent sole source and for-profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy

Prior Board Action

April 2023, approved revised policy statement ACEP Recognized Certifying Bodies in Emergency Medicine

October 2016, the Board approved the committee's recommendations regarding Amended Resolution 31(15) to: 1) communicate appreciation to ABEM for its efforts in the realm of ABMS mandates; 2) take no further action *at this time* regarding development of a policy opposing mandates linking maintenance of certification as the only path to maintenance of licensure; and 3) take no further action *at this time* regarding development of a policy opposing specialty boards as the sole source mandating continuing education credit.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs.

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(25)

SUBMITTED BY: New Mexico Chapter
Michigan College of Emergency Physicians

SUBJECT: Support Board Certification as an Exemption for State Mandated CME Topics

PURPOSE: 1) Collaborate with ABEM, AOBEM, and ABMS to advocate to states that board certification should be an exemption and obviates the need for state-mandated CME. 2) ACEP, ABEM, AOBEM, and ABMS work with state medical boards and state legislatures to ensure CME for non-boarded physicians is specialty-relevant and based on science. 3) ACEP develop and disseminate educational materials about the problem with state-mandated CME requirements that can be used for advocacy.

FISCAL IMPACT: Opposing merit badges and mandated CME is a current initiative of the College. The advocacy component and the development of educational materials are unbudgeted and would require diverting current budgeted staff resources from other work to support this effort.

WHEREAS, State legislatures increasingly mandate continuing medical education (CME) topics for physician licensure, often without adequate medical oversight; and

WHEREAS, Forty states currently mandate one or more CME topics such as pain management, palliative care, geriatrics, medical ethics, professional responsibility, sexual harassment prevention, cultural competency, implicit bias training, infection control, child abuse, patient safety, behavioral health, sexual assault, domestic violence, medical error prevention, diversion and addiction, risk management, suicide prevention, human trafficking, and weapons of mass destruction; and

WHEREAS, Available courses to fulfill these legislatively mandated CME topics may lack relevance to specific medical specialties, potentially diverting physicians from essential, specialty-specific education; and

WHEREAS, The American Board of Medical Specialties (ABMS) board certification process is designed to ensure rigorous and comprehensive physician knowledge within their respective specialties; and

WHEREAS, Board certification and maintenance of certification processes already address many of the core competencies targeted by state-mandated CME, potentially leading to redundant and less specialty-specific educational requirements; and

WHEREAS, Precedent exists for the exemption of board certified physicians from other mandated CME such as the exemption of “all practitioners that are board certified in addiction medicine or addiction psychiatry” from the 2023 Consolidated Appropriations Act of 2023, which mandated eight hours of opioid CME for Drug Enforcement Agency (DEA) certificate renewal; and

WHEREAS, The imposition of disparate state-mandated CME topic requirements creates an administrative burden for physicians holding licenses in multiple states; and

WHEREAS, The potential exists for politically motivated or scientifically unsound state-mandated CME topics to negatively impact patient care; and

WHEREAS, ACEP has previously lobbied against “merit badge” medicine such as ATLS, ACLS, and more as superfluous for American Board of Emergency Medicine (ABEM) and American Board of Osteopathic Emergency Medicine (ABOEM) boarded emergency physicians; and

WHEREAS, ACEP, ABEM, AOBEM, and ABMS share a commitment to ensuring the highest standards of physician competence and patient care; therefore be it

RESOLVED, That ACEP actively engage with the American Board of Emergency Medicine, the American Board of Osteopathic Emergency Medicine, and the American Board of Medical Specialties to advocate for the recognition of board certification as an exemption for relevant state-mandated CME requirements; and be it further

RESOLVED, That ACEP, in collaboration with American Board of Emergency Medicine, the American Board of Osteopathic Emergency Medicine, and the American Board of Medical Specialties, and other relevant medical organizations, initiate a proactive effort to work with state medical boards and legislatures to ensure that mandated continuing medical education topics for non-boarded physicians are evidence-based, specialty-relevant, and aligned with the principles of best medical practice; and be it further

RESOLVED, That ACEP create and distribute educational materials to its members highlighting the potential pitfalls of poorly designed state-mandated "merit badge" continuing medical education and the benefits of relying on American Board of Medical Specialties board certification for ensuring physician competence and support its members in their efforts to educate and advocate to state legislatures on this issue.

Background

This resolution asks for ACEP to collaborate with ABEM, AOBEM, and ABMS to advocate to states that board certification should be an exemption, thereby obviating the need for state-mandated CME. Additionally, it asks that these groups work with state medical boards and state legislatures to ensure that CME for non-boarded physicians is specialty-relevant and based on science. Finally, the resolution calls on ACEP to develop and disseminate educational materials about the problem with state-mandated CME requirements that can be used for advocacy.

Physicians' continuing medical education (CME) requirements vary significantly by state. Generally, states require a specific number of CME hours within a set timeframe (e.g., every two years) for license renewal. Some states may also have specific requirements for certain topics, such as pain management, opioid use disorders, or geriatric care.

ACEP has engaged in many efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated via subsequent board certification by the ABEM, AOBEM, or American Board of Pediatrics (ABP) and ABEM partner boards for dual/subspecialties. Emergency physicians are trained in a broad range of acute medical conditions during residency and must complete an intensive written and oral examination demonstrating mastery of the skills necessary to diagnose and treat these conditions. Emergency physicians must complete their Maintenance of Certification, which tests these skills on an ongoing basis, to maintain board certification.

ACEP has a number of existing policies regarding required CME and short courses.

The policy statement "CME Burden" discusses the increasing burden of required courses. The policy states:

> "The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."
>
> and
>
> "Therefore, ACEP, in supporting high-quality, safe, and efficient emergency care for all patients, believes that CME requirements as a part of maintenance of board certification should be self-determined by the specialty organization and by practicing emergency physicians to reflect their practice environments."

ACEP's policy statement "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" states:

> "The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP's policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" states:

> "ACEP believes that the ED medical director* should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of providers of emergency care with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by ABEM or AOBEM, or pediatric emergency medicine subspecialty certification by the American Board of Pediatrics is an excellent, but not the sole benchmark for decisions regarding an individual's ability to practice emergency medicine. Especially in rural areas, physicians who trained in other specialties may provide emergency care and be granted privileges by an objective measurement of care provided, sufficient experience, prior training, and evidence of continuing medical education."
>
> "*ED medical director refers to the chair, medical director, or their designee."

ACEP provides a set of personalized cards attesting they are currently board certified by ABEM or AOBEM and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP is a CME partner for an ABEM MyEMCert module on resuscitation and physicians receive a certificate of completion.

ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early 2017, the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

> "Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These "merit badges" add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges

> set a lower bar than a diplomate's education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for continuous professional development and medical merit badges dismiss the quality of those educational efforts."

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey. Their findings have been published in *JACEP Open*.[1] Key findings show that 83.6% of physicians practicing in states with state-mandated, topic-specific CME requirements perceived that participation in ABEM continuing certification could be used to reduce the need for state-mandated, topic-specific CME requirements, and 70.8% believed that state-mandated, topic-specific requirements were unlikely to improve patient care. The authors concluded that, although well-intended, state CME requirements may lack relevancy and could place an undue burden on emergency physicians. Tailoring CME requirements to increase relevance to their patient populations and reducing barriers to completing CME could enhance knowledge translation and improve patient outcomes.

The Federation of State Medical Boards (FSMB) serves as a central resource for state medical boards, supporting them in their efforts to protect the public's health and safety through various means. They achieve this by providing education, assessment, data, research, and advocacy, ultimately promoting patient safety, quality healthcare, and regulatory best practices. Advocating with the FSMB to use ABEM/AOBEM board certification to eliminate the need for state-specific CME would probably be an important step.

This resolution would also seek to ease the state-specific CME burden for legacy emergency physicians by ensuring the requirements are evidence-based and relevant to the practice of emergency medicine.

ACEP's policy statement "The Role of the Legacy Emergency Physician in the 21st Century" states:

> "ACEP acknowledges that emergency medicine's development and rapid growth resulted in a workforce that includes physicians who are not eligible for ABEM or AOBEM specialty certification. These legacy emergency physicians, many of whom are residency trained and/or board certified in other specialties, began the practice of emergency medicine prior to the 21st century.
>
> ACEP acknowledges that legacy emergency physicians, by virtue of their primary training and emergency medicine practice experience, still play an important role in the current emergency medicine workforce and patient care safety net."

Background Reference

1. Gausche-Hill, M., Bhakta Y., Bond, M. C., Schneider, S. M., Druck, J., Livingston, C. E., Moreno-Walton, L., Jones, J. S., and Barton, M. A. (2024). Emergency physicians' perspectives of state continuing medical education requirements for medical licensure. Journal of the American College of Emergency Physicians Open, 5(5). **https://doi.org/10.1002/emp2.13314**

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 professional.

Fiscal Impact

Opposing merit badges and mandated CME is a current initiative of the College. The advocacy component and the development of educational materials are unbudgeted and would require diverting current budgeted staff resources from other work to support this effort.

Prior Council Action

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted. Directed ACEP to discuss with TJC ACEP's opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and/or sub-board on Pediatric Emergency Medicine of the American Board of Pediatrics, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing-Off" Processes by Other Specialties adopted. Directed ACEP to establish College liaisons and relationships with other medical specialty societies, the American Medical Association, the Alliance for Specialty Medicine, the Coalition for Patient -Centric Imaging, and other interested parties actively and fully opposes the imposition upon the specialty of Emergency Medicine of a requirement of any credentialing, certification, or "signing -off" process by other specialties for any core skill within the scope of practice of emergency medicine.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses

such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on "Merit Badge Medicine" with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

Prior Board Action

March 2024, approved the revised policy statement "The Role of the Legacy Emergency Physician in the 21st Century;" reaffirmed February 2018 and April 2012; originally approved June 2006.

January 2024, reaffirmed the policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles;" reaffirmed June 2018 and April 2012; revised and approved January 2006; originally approved November 2001.

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted.

January 2022, approved the revised policy statement "CME Burden;" originally approved April 2016.

January 2022, approved the revised policy statement, "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" revised and approved January 2016 and April 2012; reaffirmed September 2005; Revised in June 1999, June 1997, August 1992; originally approved January 1984 titled "Certification in Emergency Medicine.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, and June 2004; reaffirmed October 1999; Revised with current title September 1995 and June 1991; originally approved April 1985 titled, "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing-Off" Processes by Other Specialties adopted.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(25)

SUBMITTED BY: Access, Belonging, & Community Section

SUBJECT: Support Ongoing Education on Implicit Bias and Structural Inequity

PURPOSE: Provide and encourage ongoing education for members on implicit bias systemic, inequities, culturally responsive, and equal access to care for all.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing initiatives.

WHEREAS, Implicit bias and structural inequities significantly contribute to disparities in health care access, quality, and outcomes, particularly in emergency medicine; and

WHEREAS, Ongoing education on these topics equips physicians to deliver more equitable, culturally responsive care and aligns with ACEP's commitment to lifelong learning and professional development; therefore be it

RESOLVED, That ACEP provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

Background

This resolution requests ACEP to provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

Implicit biases – unconscious attitudes or stereotypes – can have negative influences on clinical decision-making, communication between patients and physicians or other health care professionals, and perpetuate health disparities, particularly for marginalized groups. These biases can lead to inequitable care, reduced patient trust, and poorer health outcomes.[1-5] Education that addresses implicit bias increases awareness of self-biases, provides strategies to mitigate their impact, and fosters critical reflection, which are essential for delivering equitable care. Without such education, biases may remain unrecognized and unaddressed, contributing to ongoing disparities in health care delivery and outcomes. Integrating implicit bias education is a critical step toward advancing health equity and professionalism in medicine[1-5]

ACEP has taken several steps to address implicit bias within emergency medicine. These actions include developing and promoting educational resources, supporting policy changes, and encouraging open dialogue about bias.[6-8] Amended Resolution 14(19) Implicit Bias Awareness and Training called for developing and publicizing a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias. The policy statement "Implicit Bias Awareness and Training" was developed in response to Amended Resolution 14(19). Additionally, a Policy Resource & Education Paper (PREP) was developed by the Academic Affairs Committee as an adjunct to the policy statement. (The PREP is pending journal publication. It will be available on the ACEP website as soon as available.)

ACEP currently offers a wide range of educational content and resources to address implicit bias. The following educational sessions have been presented at previous ACEP annual meetings and are available in ACEP Anytime:

Racism and Bias in the ED Environment (2024) – Jenice Baker, MD, FACEP
How to Talk About Race and Medicine With Patients (2024) – Jenice Baker, MD, FACEP

Belonging: The Intersection of Diversity, Equity and Inclusion and Physician Well-Being (2024)
- Al'ai Alvarez, MD, FACEP

Belonging: The Intersection of Diversity, Equity, and Inclusion, and Physician Well-Being (2023) – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2023 – Al'ai Alvarez, MD, FACEP
Unlearning Implicit Bias 2022 – Bernard Lopez, MD, FACEP

ACEP Anytime will be updated to include additional courses as they are developed.

Recently, several states have enacted laws restricting or banning certain types of implicit bias training, particularly in educational and health care settings. Florida, North Dakota, Tennessee, and Texas have passed legislation restricting the use of state or federal funds for diversity, equity, and inclusion (DEI) programs, including mandatory implicit bias training. Tennessee has gone further by prohibiting public institutions from mandating implicit bias training for educators and employees, according to Tennessee State Government (.gov). These laws often focus on prohibiting mandatory training that promotes what they consider "divisive concepts" or "identity politics." Other states such as California, Delaware, Maryland, Massachusetts, Michigan, New Jersey, and Washington have enacted legislation requiring implicit bias training, especially for health care providers. Illinois and Minnesota also have such requirements for health care professionals.[9] It is important to note that the legal landscape regarding implicit bias training is complex and constantly evolving. Some laws prohibiting bias training have faced legal challenges. Additionally, some states or organizations may still implement such training without a specific state mandate, or even if they face restrictions, they may adapt their training programs to be compliant with current laws and regulations.

Both the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) have recently taken steps to suspend enforcement of certain "diversity" requirements. This action follows concerns about potential conflicts between these requirements and state laws, as well as criticism from some regarding the emphasis on DEI in medical education.[10,11]

Background References

1. Twelve Tips for Teaching Implicit Bias Recognition and Management. Gonzalez CM, Lypson ML, Sukhera J. Medical Teacher. 2021;43(12):1368-1373. doi:10.1080/0142159X.2021.1879378.
2. The Time Is Now: Addressing Implicit Bias in Obstetrics and Gynecology Education. Royce CS, Morgan HK, Baecher-Lind L, et al. American Journal of Obstetrics and Gynecology. 2023;228(4):369-381. doi:10.1016/j.ajog.2022.12.016.
3. Educational Strategies in the Health Professions to Mitigate Cognitive and Implicit Bias Impact on Decision Making: A Scoping Review. Thompson J, Bujalka H, McKeever S, et al. BMC Medical Education. 2023;23(1):455. doi:10.1186/s12909-023-04371-5.
4. Implicit Bias in Health Professions: From Recognition to Transformation. Sukhera J, Watling CJ, Gonzalez CM. Academic Medicine : Journal of the Association of American Medical Colleges. 2020;95(5):717-723. doi:10.1097/ACM.0000000000003173.
5. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Vela MB, Erondu AI, Smith NA, et al. Annual Review of Public Health. 2022;43:477-501. doi:10.1146/annurev-publhealth-052620-103528.
6. https://www.acep.org/news/acep-newsroom-articles/change-is-happening-fast-acep-is-your-voice-in-washington-when-it-matters-most
7. https://www.acepnow.com/article/addressing-bias-racism-and-disparities-in-the-emergency-department/
8. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/implicit-bias-and-cultural-sensitivity---effects-on-clinical-and-practice-management.pdf
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10. https://www.acgme.org/newsroom/2025/5/acgme-board-executive-committee-action/#:~:text=The%20ACGME%20has%20heard%20significant,for%20approval%20of%20accreditation%20requirements.
11. https://lcme.org/announcement-may-19-2025/#:~:text=On%20May%2019%2C%202025%2C%20the,information%20related%20to%20Element%203.3.

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 emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Fiscal Impact

Budgeted committee and staff resources for current and ongoing initiatives.

Prior Council Action

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 26(20) 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 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Sexual Orientation 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

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

July 2024, reviewed the "Implicit Bias Awareness and Training" Policy Resource & Education Paper (PREP).

June 2023, approved the revised policy statement "Workforce Diversity in Health Care Settings;" revised and approved November 2017; reaffirmed June 2013 and October 2007; originally approved October 2001.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

October 2021, approved the policy statement "Implicit Bias Awareness and Training."

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; revised and approved April 2008 with current title; originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with 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.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

Substitute resolution 41(05) Sexual Orientation Non-Discrimination adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2025 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 41-60

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 41(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Advocate for No-Fault Medical Liability Reform and Redefinition of Negligence in Health Care

PURPOSE: 1) Support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; 2) Collaborate with stakeholders and legal experts to advocate for legislative and regulatory changes to shift away from a fault-based system to a no-fault compensation model; and 3) Promote reevaluation of the legal definition of negligence in health care advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to develop policy positions and messaging, build up a coalition of stakeholder partners, and consult with legal experts. Costs for outside legal consultation could range in excess of $30,000 depending on the scope of work and the timeline for completion.

WHEREAS, The current definition of negligence in medical malpractice cases is based on a fault-based system that does not account for the complexities of modern health care; and

WHEREAS, Negligence is often defined as a deviation from the standard of care, but in reality, errors in medicine frequently result from systemic issues rather than individual incompetence or malfeasance; and

WHEREAS, The fear of malpractice lawsuits contributes to defensive medicine, leading to unnecessary tests and procedures that increase health care costs without improving patient outcomes; and

WHEREAS, A no-fault medical liability system, similar to those implemented in other countries, could provide fair compensation to patients while reducing the adversarial nature of medical malpractice claims; and

WHEREAS, Shifting to a no-fault model would encourage reporting and analysis of medical errors, allowing for systemic improvements in patient safety rather than punitive measures against individual practitioners; and

WHEREAS, Narrow-scope no-fault compensation systems such as Florida's and Virginia's birth-related neurological injury programs, as well as state workers' compensation laws, demonstrate that limited no-fault models can reduce litigation costs, provide timely compensation, and promote system-level safety improvements; and

WHEREAS, These programs have successfully operated within the U.S. legal framework, offering precedent for expanding no-fault principles to broader areas of medical care, particularly in high-risk or systemically complex domains; and

WHEREAS, Physicians and hospitals often face financial and reputational damage from lawsuits that fail to differentiate between system-based errors and actual misconduct; and

WHEREAS, In 2024, the American Law Institute revised the legal standard for assessing medical negligence, moving away from strict reliance on customary practice toward a more patient-centered concept of reasonable medical care that incorporates evidence-based guidelines and acknowledges systemic factors affecting patient safety; and

WHEREAS, The new legal standard, while still including elements of prevailing medical practice, invites courts to focus more directly on promoting patient safety and improving care delivery, thus creating an opportunity to reconsider how medical negligence is assessed; and

WHEREAS, This shift aligns with the concept of a no-fault medical liability system by recognizing that medical errors are often multifactorial and rooted in system deficiencies rather than individual failure; and

WHEREAS, ACEP has recognized that the increasing use of criminal liability for adverse medical outcomes, despite a lack of criminal intent, undermines the culture of safety and fails to account for the systemic factors influencing medical errors, highlighting the urgent need for legal frameworks that distinguish between human error and true criminal conduct; and

WHEREAS, ACEP has long supported comprehensive tort reform through federal and state legislation, including policies such as non-economic damage caps, expert witness standards, and communication resolution programs, reinforcing the College's commitment to legal reforms that balance accountability with fairness and support innovation in addressing medical liability; therefore be it

RESOLVED, That ACEP support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders and legal experts to advocate for legislative and regulatory changes that shift medical liability from a fault-based system to a no-fault compensation model; and be it further

RESOLVED, That ACEP promote a reevaluation of the legal definition of negligence in health care, advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

References

1. American College of Emergency Physicians. *Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided.* Policy Statement. Approved June 2022. Available at: https://www.acep.org/patient-care/policy-statements/protection-of-physicians-and-other-health-care-professionals-from-criminal-liability-for-medical-care-provided/
2. American College of Emergency Physicians. *Reform of Tort Law.* Policy Statement. Revised October 2023. Available at: https://www.acep.org/patient-care/policy-statements/reform-of-tort-law/

Background

This resolution requests ACEP to support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment, collaborate with stakeholders and legal experts to advocate for legislative and regulatory changes to shift away from a fault-based system to a no-fault compensation model, and promote reevaluation of the legal definition of negligence in health care advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

Emergency physicians face a uniquely high-risk practice environment with significant external factors and systemic contributors outside of their control that can impact patient safety and outcomes, and ACEP has long prioritized advocating for reform of the current medical liability system. Individual ACEP chapters, often with ACEP's support, have also pursued liability reform through legislation, ballot initiatives, and other efforts.

As the resolution notes, errors in medicine frequently result from systemic issues rather than individual incompetence or malfeasance. One common such systemic issue is that of boarding and/or crowding in EDs, which multiple studies have shown are associated with a reduction in quality of care, resulting in unfavorable clinical outcomes and adverse

events (Rocha et al.; Loke et al.). ACEP has done significant work in recent years to bring more attention to the boarding crisis and push policymakers to act on proposed solutions.

The resolution also calls for ACEP to collaborate and advocate for legislative and regulatory changes that shift medical liability from a fault-based system to a no-fault compensation model that prioritizes patient compensation and systemic health care improvements over physician punishment. ACEP has recognized the increasing use of criminal liability for adverse medical outcomes, despite a lack of criminal intent, and taken steps to address this growing problem. In March of 2022, a Tennessee nurse was convicted of reckless homicide and impaired adult abuse as a result of a patient dying as the result of medical mistakes in the care of that patient. The nurse admitted to medical error, and it seemed to be acknowledged in the case that the mistakes were not intentional. While physicians and other health care providers have long been subject to civil liability with regard to alleged mistakes in the provision of medical care, this case seems to break new ground in regarding such errors as opening the door to criminal prosecution. ACEP's policy statement Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided" provides guidance on this important topic.

The resolution also calls for ACEP to promote a reevaluation of the legal definition of negligence in health care, advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

Root Cause Analysis (RCA) is a structured method used to analyze serious adverse events and other patient safety incidents. RCAs help health care organizations that have experienced sentinel events determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and allows them to identify opportunities to change their culture, systems, and processes to prevent unintended harm. ACEP's Medical-Legal Committee recently developed a policy statement "Legal Protection of Participants in Peer Review" that was passed by the ACEP Board that affirmed ACEP's support for the passage and strengthening of state laws that provide QI/QA activities with legal protections, such as RCA, Peer Review, and similar activities.

The Medical-Legal Committee also currently has an objective to develop an information paper describing use of Communication and Resolution Programs (CRPs) and their impact on liability claims in states with and without traditional liability reforms, working with the College's State Legislative and Regulatory Committee. As well, ACEP's advocacy staff currently track and display state tort reform and patient safety measures as part of its State Legislative Dashboard. ACEP's policy, "Reporting of Medical Errors," supports a standardized system of medical error reporting for the purpose of aiding practitioners and institutions in efforts to improve patient safety. The policy calls for statutory protection from liability to providers and institutions that report data to the system.

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 professional.

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.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to develop policy positions and messaging, build up a coalition of stakeholder partners, and consult with legal experts. Costs for outside legal consultation could range in excess of $30,000 depending on the scope of work and the timeline for completion

Prior Council Action

Amended Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted. Directed ACEP to advocate for and support the development of policies to ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and provide a written proposal to the Joint Commission and other relevant accrediting organizations suggesting a revision to the framework for Root Cause Analysis and corrective actions that includes emergency department and hospital capacity constraints and overcrowding as a "Root Cause Type" and "Causal Factor" as part of the root cause analysis.

Resolution 37(22) Enhance Patient Safety and Physician Wellness adopted. The resolution directed ACEP to 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.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted. The resolution directed ACEP to oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Resolution 7(15) Apology adopted. Directed ACEP to support legislative efforts to enact legal protections for physicians who apologize regarding an unfortunate outcome or event.

Amended Resolution 32(10) Support for Reform of the Present System of Medical Liability adopted. It called for ACEP to endorse and promote a policy that transforms the medical liability system and encourage the need for a baseline culture of safety facilitating blame-free communication, rigorous patient safety improvement efforts, and alternative dispute resolution mechanisms.

Resolution 15(07) Apology adopted. It called for the College to support legislation to protect and make non-discoverable the apology or expression of sympathy or regret thereto, during any legal proceedings that might take place.

Resolution 35(05) Health Courts adopted. The resolution endorsed the need for comprehensive litigation reform and supported the concept of health courts as an alternative to the current process

Resolution 29(04) Medical Liability Reform – Alternative Dispute Resolution adopted. Directed the College to advocate for the concepts of alternative dispute resolution, including mediation, and medical courts, as alternatives to the current tort system as part of the federal medical liability reform initiative.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution called on the College to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and direct the College's lobbyist to further that position with Congress and via its key contact system

Amended Resolution 27(87) State Liability and Tort Reform adopted. The resolution called on the College to encourage chapters to take an active role in their state medical societies' liability and tort reform efforts and independently where appropriate.

Amended Resolution 28(85) Malpractice and Practice Modification adopted. Directed ACEP to endorse in principle the use of practice analysis and resultant recommendations for practice modification to reduce the incidence and severity of medical malpractice.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. The resolution endorsed in principle state legislation or constitutional amendments to implement specific tort legal reforms.

Prior Board Action

January 2025, approved the policy statement, "Legal Protection of Participants in Peer Review".

Amended Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted.

October 2023, approved the revised policy statement, "Reform of Tort Law;" reaffirmed April 2017; revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985 titled "Reform of Tort Law."

March 2023, approved the revised policy statement, "Disclosure of Medical Errors;" revised and approved April 2017 and April 2010; originally approved September 2003.

Resolution 37(22) Enhance Patient Safety and Physician Wellness adopted.

June 2022, approved the policy statement, "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided".

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

Resolution 7(15) Apology adopted.

Amended Resolution 32(10) Support for Reform of the Present System of Medical Liability adopted.

Resolution 15(07) Apology adopted.

Resolution 35(05) Health Courts adopted.

Resolution 29(04) Medical Liability Reform – Alternative Dispute Resolution adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Amended Resolution 28(85) Malpractice and Practice Modification adopted.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted.

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Advocacy & Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(25)

SUBMITTED BY: Jeffrey D. Anderson, MD, FACEP
Sean Vanlandingham, MD, MBA, FACEP
Alabama Chapter

SUBJECT: Occurrence-Based Malpractice Coverage for All Emergency Physicians

PURPOSE: Collaborate with relevant stakeholders to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians and use the results to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to conduct the feasibility study. Costs could range in excess of $30,000 depending on the scope of work and the timeline for completion.

WHEREAS, Professional liability insurance is an essential and non-optional requirement for the practice of emergency medicine; and

WHEREAS, Many emergency physicians are provided with claims-made malpractice coverage, which requires a costly "tail" policy upon separation from an employer to maintain protection against future claims; and

WHEREAS, Recent bankruptcies of major contract management groups—including NES Health, American Physician Partners, and Envision Healthcare—have resulted in emergency physicians being left without promised tail coverage and without compensation for clinical services rendered; and

WHEREAS, These failures have placed individual emergency physicians at risk of personal financial liability and legal exposure through no fault of their own, undermining trust in employer-provided coverage structures; and

WHEREAS, These vulnerabilities contribute to a toxic and destabilizing practice environment, especially in a landscape increasingly influenced by corporate and private equity interests; therefore be it

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, physician advocacy groups, and regulatory bodies, to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians; and be it further

RESOLVED, That ACEP use the results of a feasibility study on the implementation of occurrence-based malpractice insurance to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

Background

This resolution directs ACEP to collaborate with relevant stakeholders to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians and use the results to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

Emergency physicians face a uniquely high-risk practice environment that necessitates comprehensive and reliable malpractice coverage. Traditionally, physician groups have provided claims-made malpractice insurance policies with tail coverage, which requires an additional premium to cover claims made after the physician leaves the group. While this model has functioned in stable corporate settings, employers having to make difficult decisions under financial stress have exposed significant vulnerabilities for frontline emergency physicians. Recently, several prominent emergency physician groups have undergone financial reorganization or bankruptcy, without always honoring their commitment to provide tail malpractice coverage for employed physicians. These bankruptcies have exposed emergency physicians to long-term legal and financial risks. Many were faced with the prospect of personally funding expensive tail policies or assuming open-ended legal liability for their prior clinical work having been unaware that their tail coverage was not guaranteed in the event of corporate bankruptcy. These events have created distrust in existing malpractice insurance arrangements. The use of claims-made malpractice insurance with tail coverage places undue risk on the individual physician, especially when coverage is contingent on the solvency of an employer. Establishing fair contracts would improve career stability and well-being for emergency physicians. The proposed resolution to study the feasibility of requiring occurrence-based malpractice insurance supports systemic reforms that prioritize physician protection and reduce administrative burdens and post-employment legal threats.

ACEP maintains resources for members (Medical Professional Liability Insurance) that defines the types of malpractice insurance models. Occurrence insurance policies provide coverage for incidents that happened during the policy period, no matter when the claim is filed. Premiums tend to be more expensive than claims-made policy premiums (until the claims-made policy reaches maturity). Because of the high initial costs, occurrence policies remain relatively rare for physicians since insurers have difficulty estimating the cost of claims long after a policy expires.

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 professional.

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.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to conduct the feasibility study. Costs could range in excess of $30,000 depending on the scope of work and the timeline for completion.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Adam Krushinskie, MPA
Senior Director, State Legislative and Reimbursement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 43(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Emergency Medicine Workforce Section

SUBJECT: Support for Eliminating Physician Non-Compete Clauses in Contracts

PURPOSE: Support emergency physicians in removing restrictive non-compete clauses from their contracts by creating a generic support letter for use in negotiations and publicly affirming that such clauses are unfair, ethically problematic, and harmful; and continue monitoring and updating members on state and federal efforts to prohibit non-compete agreements that interfere with a physician's ability to provide care.

FISCAL IMPACT: Budgeted staff resources for current advocacy initiatives.

WHEREAS, Non-compete clauses in emergency physician (EP) contracts that restrict the ability to practice clinical medicine within a geographic area are increasingly recognized as antithetical to the ethical practice of medicine and detrimental to patient access, continuity of care, and public health; and

WHEREAS, The American Medical Association (AMA) has issued policy (E-9.02) stating that non-compete agreements that restrict a physician's right to practice medicine after termination are unethical if they unduly restrict access to care or disrupt continuity of care;[1] and

WHEREAS, Professional organizations such as the American Academy of Emergency Medicine (AAEM), and American Academy of Family Physicians (AAFP) have taken formal positions opposing restrictive covenants that impede the clinical practice of medicine;[2,3] and

WHEREAS, The Federal Trade Commission (FTC) finalized a nationwide rule in April 2024 banning most non-compete clauses, citing extensive evidence that they depress wages, restrict worker mobility, and limit patient access to needed services in the healthcare sector;[4] and

WHEREAS, Non-competes designed to prevent direct competition for hospital or group contracts may be distinct from those that prevent a physician from continuing to practice medicine altogether in a geographic area, with the latter representing a greater threat to professional autonomy and patient welfare; and

WHEREAS, Contractual provisions that prohibit clinical practice – rather than guarding legitimate business interests – often force physicians to relocate, abandon patients, or accept lower-quality positions, leading to burnout and workforce instability;[5] therefore be it

RESOLVED, That ACEP develop and make available publicly a generic support letter that emergency physicians may use during contract negotiations to advocate for the removal of non-compete clauses that prohibit clinical practice within a defined region; and be it further

RESOLVED, That ACEP clearly state in a generic support letter that emergency physicians can use during contract negotiations that non-compete clauses restricting the clinical practice of medicine, as opposed to limiting contractual competition for hospital coverage, are fundamentally unfair, ethically problematic, and harmful to public health and physician well-being; and be it further

RESOLVED, That ACEP continue monitoring and updating members on state and federal developments regarding non-compete reform and support physician advocacy efforts on this issue.

References
1. American Medical Association. AMA Code of Medical Ethics Opinion 9.02: Restrictive Covenants
2. American Academy of Emergency Medicine. Position Statement on Non-Compete Clauses.
3. American Academy of Family Physicians. Advocacy Against Restrictive Covenants.
4. Federal Trade Commission. Final Rule on Non-Compete Clauses. April 2024.
5. Jackson, J. The Impact of Non-Compete Clauses on Physician Workforce Mobility. Health Affairs Blog, 2023.

Background

This resolution calls for the College to support emergency physicians in removing restrictive non-compete clauses from their contracts by creating a generic support letter for use in negotiations and publicly affirming that such clauses are unfair, ethically problematic, and harmful. The resolution also calls on the College to continue monitoring and supporting state and federal efforts to prohibit non-compete agreements that interfere with a physician's ability to provide care.

ACEP has been a national leader in efforts to ban non-compete clauses in emergency medicine. The College strongly supported the Federal Trade Commission's (FTC) proposed rule in 2024 banning most non-compete agreements, citing the damaging effect these clauses have on emergency physician mobility, wages, and patient access. ACEP actively engaged with the FTC during the rulemaking process, submitted member testimony, and represented emergency physicians in high-level discussions with FTC leadership and key legislators.

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 College emphasizes that employment agreements should support the professional independence of emergency physicians and the continuity of patient care. ACEP has expressed concern that non-compete provisions may limit physician mobility, contribute to burnout, increase consolidation, and exacerbate staffing shortages, particularly in underserved areas. The June 2025 RAND report highlights how these trends may limit access to emergency services, reduce transparency, and undermine physician leverage in employment negotiations. Consolidation can also result in lower compensation, diminish due process protections, and greater barriers to employment mobility, including the use of noncompete clauses.

Additionally, ACEP has supported throughout multiple sessions of Congress the "Workforce Mobility Act" (S. 2031), bipartisan legislation introduced by Sens. Christopher Murphy (D-CT), Todd Young (R-IN), Kevin Cramer (R-ND) and Tim Kaine (D-VA) that would prohibit the use of non-compete clauses in employment contracts across all industries, including health care. ACEP believes this legislation will empower physicians to make career decisions that reflect their needs and their patients' best interests without being unfairly restricted by coercive contract terms.

ACEP has a current legislative priority to "Support efforts to protect physician autonomy and monitor legislative efforts regarding non-compete clauses, consolidation, and transparency in health care ownership and financing."

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.

The Medical-Legal Committee has 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, ACEP members have access to legal and financial support assistance through an affinity program with Mines & Associates, the College's 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 Strategic Plan Reference

Resources and Accountability: ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency medicine.

Advocacy: Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and professional.

Fiscal Impact

Budgeted staff resources for current advocacy initiatives.

Prior Council Action

Amended Resolution 19(22) Due Process and Interaction with ACEP adopted.

Resolution 17 (21) Fair Emergency Physician Employment Contract Template not adopted. The resolution called for the collect to develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right; 2) revise the policy statement "Emergency Physician Rights and Responsibilities;" 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

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 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 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.

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.

Substitute Resolution 50(94) Restrictive Covenants in Emergency Medicine adopted. The resolution directed ACEP to clarify, study, and report to the Council no later than September 1995 the issue of restrictive covenants (including non-compete clauses of various kinds).

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.

Resolution 40(90) Restrictive Covenants in Emergency Physician Contracts referred to the Board of Directors. The resolution called for the College to take a position against the use of restrictive covenants

Prior Board Action

Amended Resolution 19(22) Due Process and Interaction with ACEP adopted.

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised June 2018, October 2012, January 2006, March 1999, August 1993 with current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised April 2015, April 2002, June 1997. Reaffirmed October 2008, April 1992; originally approved June 1988.

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

July 2019, reviewed the updated information paper "Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships;" revised June 1997, originally reviewed July 1996.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted.

July 2018, reviewed the Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships." The PREP is an adjunct to the policy statement "Emergency Physician Contractual Relationships."

May 2018, reviewed the information paper "Emergency Department Physician Group Staffing Contract Transition."

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.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Group adopted.

Substitute Resolution 50(94) Restrictive Covenants in Emergency Medicine adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Background Information Prepared by: Fred Essis, MA, MBA
Congressional Lobbyist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 44(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Advocating for National Leadership on Workplace Violence in Health Care through the AMA

PURPOSE: Direct the AMA Section Council on Emergency Medicine delegates to elevate workplace violence in health care as a top national advocacy priority, support mandatory and standardized reporting of violent incidents across all health care settings, and promote the development and implementation of evidence-based, trauma-informed strategies to protect the health care workforce.

FISCAL IMPACT: Budgeted staff resources to work with the AMA Section Council on Emergency Medicine.

WHEREAS, Nearly 75% of all workplace assaults in the United States occur in health care and social service settings, according to the Occupational Safety and Health Administration (OSHA); and

WHEREAS, Emergency departments are especially vulnerable to violence, with 91% of emergency physicians reporting that they, or a colleague, were a victim of violence in the past year). 47% of emergency physicians report being physically assaulted while at work, and 71% having witnessed a colleague be assaulted (ACEP Emergency Physician Workplace Violence Poll, 2024); and

WHEREAS, Workplace violence poses a direct threat to the well-being of health care professionals and undermines the delivery of safe, effective care to patients; and

WHEREAS, Workplace violence continues to impact emergency departments at alarming rates, with the 2024 ACEP Emergency Department Violence Poll reporting that 91% of emergency physicians had themselves or a colleague assaulted in the past year, 47% were physically assaulted, and 71% witnessed a colleague being assaulted; and

WHEREAS, The 2024 State of the U.S. Health Care Workforce report from the Health Resources and Services Administration (HRSA) found that nearly half of physicians report experiencing burnout, one in five report symptoms of depression, and nearly 29% of all health care workers, including physicians, intend to leave their jobs within two years—pointing to worsening workforce instability exacerbated by unsafe and stressful work environments; and

WHEREAS, Threatening and intimidating behavior towards healthcare workers contributes to an unsafe work environment and exacerbates critical staffing shortages; and

WHEREAS, The American College of Emergency Physicians (ACEP) has stated workplace violence against emergency physicians is a major public health problem and adopted a policy calling for stronger institutional protections and reporting mechanisms (*ACEP Policy Statement:* Protection from Violence and the Threat of Violence in the Emergency Department, revised June 2022); and

WHEREAS, Current efforts to collect and report workplace violence data are inconsistent across jurisdictions, limiting the ability of health systems and policymakers to understand and address trends at a national level; and (Institute for Healthcare Improvement, 2025)

WHEREAS, The American Medical Association plays a critical role in establishing physician advocacy priorities and promoting national health policy initiatives; therefore be it

RESOLVED, That ACEP direct its delegates to the American Medical Association to introduce and support AMA policy that prioritizes addressing workplace violence in health care as a top national advocacy issue; and be it further

RESOLVED, That ACEP directs its delegates to the American Medical Association to advocate for mandatory, standardized reporting of workplace violence incidents across all health care settings and support the aggregation and public dissemination of this data to inform research, benchmarking, and national policy development; and be it further

RESOLVED, That ACEP directs its delegates to the American Medical Association to advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce.

References

- American College of Emergency Physicians. *ED Violence: Dangerous, Rising and Unacceptable.* (Workplace Poll) January 2024 https://www.acep.org/siteassets/new-pdfs/advocacy/acepmemberpoll-edviolencejan2024.pdf
- Health Resources & Services Administration, Bureau of Health Workforce. (November 2024). State of the U.S. health care workforce, 2024 (pdf). U.S. Department of Health and Human Services. Retrieved from Health Resources & Services Administration website
- Institute for Healthcare Improvement. *Framework for Standardized Data Collection of Workplace Violence Incidents in Health Care*. Boston, MA: Institute for Healthcare Improvement; 2025. https://www.ihi.org/sites/default/files/resources/publications/Framework-Standardized-Data-Collection-Workplace-Violence-Incidents-Health-Care.pdf
- Occupational Safety and Health Administration. *Workplace Violence in Healthcare: Understanding the Challenge*. OSHA 3826-12/2015.
- Protection from Violence and the Threat of Violence in the Emergency (reviewed June 22) https://www.acep.org/patient-care/policy-statements/protection-from-violence-and-the-threat-of-violence-in-the-emergency-department

Background

This resolution calls for the College to direct the American Medical Association (AMA) Section Council on Emergency Medicine delegates to elevate workplace violence in health care as a top national advocacy priority, support mandatory and standardized reporting of violent incidents across all health care settings, and promote the development and implementation of evidence-based, trauma-informed strategies to protect the health care workforce.

The AMA has fairly extensive policy, directives, and activity around workplace violence in health care, such as the following, several of which touch on supporting mandatory reporting of violence incidents and use of evidence-based strategies to protect the health care workforce:

- Directive: Affirmatively Protecting the Safety and Dignity of Physicians and Trainees as Workers D-515.977 · Directive: Preventing Violent Acts Against Health Care Providers D-515.983
- Policy: Violence and Abuse Prevention in the Health Care Workplace H-515.966
- Policy: Protecting Physicians and Other Healthcare Workers in Society H-515.950
- Policy: Workplace Violence Prevention H-215.978
- Policy: Violent Acts Against Physicians H-515.982
- Policy: Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

The AMA Section Council on Emergency Medicine is a specialty advisory body representing emergency medicine to the AMA, serving as a forum for the discussion of emergency medicine related issues within the AMA. It relates, through its chair, to the AMA leadership, other section councils, caucuses, committees, task forces, and Councils of the AMA when requested. The purpose of the Section Council is to bring together EM organizations to work with the AMA, state medical societies, and national specialty societies on issues affecting the health care environment in general and EM in particular, and to assist the AMA in the development of policy through appropriate mechanisms including the introduction of resolutions on issues of importance to emergency medicine.

Members of the Section Council on Emergency Medicine are chosen from the membership of the specialty societies representing emergency physicians who meet the criteria for representation in the AMA House of Delegates and who are also members of the AMA. Currently, these are ACEP and the American Academy of Emergecy Medicine (AAEM). ACEP currently has 9 delegate seats in the AMA and AAEM has 3 seats. ACEP provides funding for our 9 delegates to attend the AMA Annual House of Delegates meeting in June as well as the interim meeting in November.

ACEP's president and president-elect are also funded to attend both meetings as alternate delegates. Based on this structureand process, while ACEP's delegates and alternate delegates who comprise a portion of the Section Council on Emergency Medicine can bring ACEP's priority issues to the attention of the Section Council for consideration and potential action, such as introduction of a resolution, there is not a mechanism for them to direct the Section Council's activity, as called for in this resolution.

ACEP's Legislative & Regulatory Priorities for the First Session of the 119th Congress include:

- Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.(Legislative)
- Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department. (Regulatory)
- Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.(Legislative)

ACEP has taken a leading role in addressing the growing problem of violence in emergency departments. Surveys conducted by ACEP in 2024, 2022, and 2018 reveal an alarming and escalating trend: nearly half of emergency physicians reported being physically assaulted at work in 2018, with 91% indicating in 2024 that they or a colleague had experienced violence within the past year. Many physicians believe hospitals can do more to enhance safety through increased security measures, such as deploying security personnel, installing surveillance systems, and implementing stricter visitor screening protocols. In response, ACEP has collected more than 800 personal accounts from emergency physicians detailing workplace violence and has advocated for improved local reporting mechanisms. These findings highlight the prevalence regarding workplace violence in emergency settings.

ACEP has advocated for local reporting of violence in the ED. While a national database of violent acts would provide important information on the incidence and prevalence of ED based or hospital violence, creation of such a portal would be costly and time consuming. It would require a data analyst to clean the data and compile the reports. It would also require input of data from a sufficient number of hospitals to be meaningful, which would require a standardized reporting structure as well as universal terminology. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements.

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has been featured as one of the key advocacy priorities during several ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC, including as recently as 2024.

ACEP helped inform and continues to support the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2531/S.1232), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This legislation would compel the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. ACEP was the first physician organization to ever endorse this legislation and has worked closely with the sponsors for several Congresses. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.

- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

ACEP has also worked directly with OSHA for many years as they have attempted to develop and issue regulations on this front, efforts that have been in progress since 2015. The agency had hoped to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024, however the agency ultimately did not release the proposed rule prior to the end of President Biden's term.

ACEP also helped inform and supports the bipartisan, "Save Healthcare Workers Act" (H.R. 3178/S.1600), previously known as the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) in past Congresses. This bipartisan, bicameral legislation was introduced by Madeleine Dean (D-PA) and Reps. Mariannette Miller-Meeks (R-IA), and Sens. Cindy Hyde-Smith (R-MS) and Angus King (I-ME). This legislation would establish federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP President Alison Haddock, MD, FACEP, was quoted in the press release when the legislation was introduced.

In early 2024, ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA). ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence in March 2024. And in July 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced 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 standards.

ACEP began a partnership with ENA in 2019 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 and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of 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" and the "How Safe is Your Workplace" sample checklist.

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to address workplace violence issues. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

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 professional.

Fiscal Impact

Budgeted staff resources to work with the AMA Section Council on Emergency Medicine.

Prior Council Action

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted. Directed ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Amended Resolution 41(24) Workplace Violence Data Collection adopted. Directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

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 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

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

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted.

Amended Resolution 41(24) Workplace Violence Data Collection adopted.

Approved as legislative and regulatory priorities in January 2025, March 2024, February 2023, January 2022, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

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.

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Resolution 55(17) Workplace Violence adopted.

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 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Fred Essis, MA, MBA
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Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 45(25)

SUBMITTED BY: California Chapter
New Jersey Chapter
American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies

PURPOSE: Continue to advocate for the full preservation and expansion of Medicaid; create a unified policy statement affirming strong support for Medicaid and include current ACEP policy statements to create a single, robust policy statement on Medicaid; and affirm ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promote emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, The Medicaid program serves as a critical safety net for more than 85 million Americans, including millions of emergency department patients[1]; and

WHEREAS, Medicaid financing has been shown to support hospital operations, reduce uncompensated care costs, and sustain emergency physician services, particularly in rural and underserved areas[2-4]; and

WHEREAS, Uncompensated care burdens fell sharply in Medicaid expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs, with estimated savings across all hospitals in Medicaid expansion states totaling $6.2 billion[5]; and

WHEREAS, About two thirds (69%) of rural hospital closures from 2014 to 2024 occurred in states that had not expanded Medicaid, and rural hospitals in non-expansion states had median operating margins of -0.7 percent when excluding documented relief funds[3,4]; and

WHEREAS, 55% of an emergency physician's time is spent providing uncompensated care, and uncompensated and undercompensated ED care has increased and resulted in nonpayment of 20% of expected payment to ED physicians across all payer types, or about $5.9 billion annually[6,7]; and

WHEREAS, From 2011 and 2021, Medicaid ED visits as a share of all payers increased to 45% from 34%, demonstrating Medicaid's critical role in emergency care access[7]; and

WHEREAS, ACEP has existing policy statements titled "Medicaid Expansion"[8,] "Opposition to Copays for Medicaid Beneficiaries"[9], and "Work Requirements for Medicaid Beneficiaries"[10], that individually affirm ACEP's strong opposition to barriers and support for access to care for Medicaid patients; and

WHEREAS, Consolidating and modernizing these Medicaid-related positions into a unified policy document will improve ACEP's advocacy clarity and operational impact; therefore be it

RESOLVED, That ACEP continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; and be it further

RESOLVED, That ACEP create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements

"Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and be it further

RESOLVED, That ACEP policy affirms ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

References

1. Centers for Medicare & Medicaid Services. January 2025 Medicaid & CHIP Enrollment Data Highlights. Available at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed June 8, 2025.
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Background

This resolution calls for ACEP to continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements "Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and, ensure that ACEP policy affirms ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

This resolution is similar to Resolution 48(25) Support for Full Preservation of Medicaid. Much of the background information is the same for both resolutions.

As the resolution notes, ACEP has several current policies related directly to Medicaid:

- "Work Requirements for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of work requirements mandating employment or pursuit of employment for Medicaid beneficiaries to obtain or retain access to health insurance coverage."

- "Opposition to Copays for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of copays for Medicaid beneficiaries seeking care in the emergency department."

- "Medicaid Expansion"
  - "The American College of Emergency Physicians (ACEP) advocates for the expansion of Medicaid to the levels allowable by federal law as a crucial step towards improving health care access for our community's most vulnerable populations. This expansion will not only ensure that individuals receive the care they need but will also reduce the financial burden of uncompensated care on emergency departments, allowing for more efficient and effective health care delivery.

    ACEP urges policymakers to prioritize Medicaid expansion, recognizing its profound impact on public health, economic stability, and the overall efficiency of our health care system. By supporting this expansion, ACEP reaffirms our commitment to advancing health equity and providing high-quality, accessible care for all."

The resolution seeks to modernize and consolidate these policies into a single, unified policy statement to improve the College's advocacy clarity and operational impact. An objective has already been assigned to the State Legislative/ Regulatory Committee for 2025-26 that addresses the second resolved:

> Create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements "Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid beneficiaries" to create a single, robust policy statement on Medicaid.

Protecting and improving Medicaid has been and remains a legislative and regulatory priority for the College. The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include:

- Ensure Prudent Layperson Standard extends to Medicaid FFS and compliance measures are in place for other health plans.
- Monitor efforts to establish block grants, per-capita allotments for federal share of Medicaid funding, establishment of Medicaid work requirements, or other proposals regarding Medicaid eligibility requirements/restrictions.
- Seek permanent repeal of Medicaid IMD exclusion.
- Monitor efforts to establish/change Medicaid work requirements.
- Monitor legislative efforts to voluntarily expand Medicare or Medicaid to additional patient populations.

Especially over the first half of 2025, ACEP federal advocacy has prioritized the preservation of Medicaid in light of the substantial changes to the program that were being considered by Congress and were ultimately included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. Among the major Medicaid provisions included in the law are:

- **"Community Engagement" Requirements**: Establishment of work requirements for eligible adults that are part of the Affordable Care Act's Medicaid expansion population. The law requires that able-bodied individuals must work at least 80 hours per month or complete volunteer, community service, or other eligible educational programs, with limited exceptions. 40 states and the District of Columbia have expanded Medicaid to cover most adults under 138% of the federal poverty level (FPL). According to the Kaiser Family Foundation (KFF), "As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states."

- **State provider tax freeze and reduction**: Freezes the current Medicaid provider tax thresholds for all states for two years, and reduces the maximum allowable provider tax for expansion states from 6 percent to 3.5 percent by 2032 (in 0.5 percent increments annually).

  - Context: Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of their state costs with taxes on these health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the Federal Matching Assistance Percentage (FMAP) rate provided by the federal government.
  - Federal law requires a provider tax to be uniform and broad-based, meaning it must be applied at the same level and to all Managed Care Organizations (MCOs) in the state, not just Medicaid MCOs. A state can apply to the Centers for Medicare & Medicaid Services (CMS) to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test to demonstrate that the tax is generally redistributive.

- **State directed payment limits**: Sets the limit for state directed payments (SDPs) to 110 percent of Medicare rates for non-expansion states, and 100 percent of Medicare for expansion states. For states that newly expand Medicaid, all SDPs will be subject to this provision, even if previously approved.
  - Context: SDPs allow states to direct MCOs to pay providers according to specific rates or methods, and can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. States have had significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments). The Biden administration's managed care rule capped the SDP ceiling for certain services at the average commercial rate.

- **Medicaid cost-sharing & copays**: Requires states to impose cost-sharing/copays on certain services for Medicaid expansion adults with incomes above 100 percent of the federal poverty level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5 percent of the family income. Certain types of services are exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.
  - Context: Under existing federal law, such cost-sharing requirements by a state Medicaid program were already permitted with the above limitations, but now will be required. States with existing Medicaid copay policies for non-emergent ED use include Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina, and Washington.

ACEP created a summary of the emergency medicine-specific provisions of the law detailing these and other relevant provisions and associated implementation timelines and deadlines.

ACEP's existing policies have served and continue to serve as the foundation of the College's ongoing advocacy work, supplemented by the April 2025 RAND report, "Strategies for Sustaining Emergency Care in the United States," other ACEP resources, and coalition efforts among other physician and provider specialties.

Protecting the emergency care safety net, including protecting Medicaid, was also a key legislative priority during the 2025 ACEP Leadership & Advocacy Conference (LAC) in Washington, DC in April 2025. Emergency physician advocates went to Capitol Hill urging Congress to help repair and stabilize the safety net, highlighting continued financial threats to the viability of emergency medicine through declining Medicare reimbursements that also do not account for inflation, declining commercial payments, and the vital role of Medicaid in supporting emergency care in particular, even despite payment rates that are well below the costs of providing care.

In addition to regular federal legislative advocacy work and numerous grassroots campaigns throughout the budget reconciliation process, in May 2025, ACEP was part of a coalition of 42 national medical organizations that sent a letter to congressional leadership opposing the House of Representatives' proposed changes to Medicaid in their budget reconciliation proposal (H.R. 1). ACEP President Alison Haddock, MD, FACEP, also issued a statement later in May urging Congress to reject the proposed Medicaid changes that the non-partisan Congressional Budget Office (CBO) estimates will lead to millions more individuals without insurance coverage, highlighting the disproportionate

impact on emergency medicine and emergency departments that are already under significant strain. In June 2025, ACEP once again joined a coalition of 31 national medical organizations in a letter to Senate leadership, urging changes to the House-passed language and asking the Senate to protect Medicaid access by severely reducing or ideally eliminating the Medicaid provisions that are projected to directly or indirectly increase the number of uninsured patients. On July 1, 2025, Dr. Haddock issued another statement after the Senate passed their amended version of the bill, noting concerns that "…this legislation will carry serious, long-term consequences for the emergency care safety net, the broader health care system, and most importantly, the patients we serve." The statement urged Congress to reject the most damaging provisions of the reconciliation package, "…particularly those that would increase the number of uninsured, further strain emergency departments, and diminish the pipeline of future emergency physicians."

ACEP continues monitoring legislative activity in the wake of the passage and enactment of the "Big Beautiful Bill," as some Republican legislators have indicated they are seeking changes to some of the Medicaid provisions of the law. For example, on July 15, 2025, Senator Josh Hawley (R-MO) introduced the "Protect Medicaid and Rural Hospitals Act," (S. 2279), which would repeal the law's provider tax moratorium and future reduction of provider tax authority, repeal provisions in the reconciliation bill regarding state directed payments that could reduce Medicaid provider reimbursements, double the funding for the Rural Health Transformation Fund from $50 billion to $100 billion and extending the duration of the funding distribution from five to ten years. However, some legislators have indicated there may be another push to do another budget reconciliation bill in the next fiscal year (beginning October 1, 2025) that could once again target increased savings from federal health programs and funding. House Budget Committee Chairman Jodey Arrington (R-TX) has indicated that potential savings targets for another reconciliation bill include additional reductions to the Medicaid FMAP for the expansion population and additional penalties to states that fail to enforce existing laws preventing the use of Medicaid funds/benefits for undocumented individuals, among other savings proposals like site-neutral payments under Medicare. It remains unclear as of writing what further Medicaid reductions are realistically under consideration and if another budget reconciliation package will be pursued by Congress.

ACEP will continue the ongoing work to fight for the preservation and expansion of Medicaid to the fullest extent possible.

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 professional.

Fiscal Impact

Budgeted resources for current advocacy initiatives.

Prior Council Action

Resolution 40(22) Support for Medicaid Expansion adopted. Directed 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.

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Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Prior Board Action

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Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 46(25)

SUBMITTED BY: Abbas Husain, MD, FACEP
District of Columbia Chapter
American Association of Women Emergency Physicians Section
Wellness Section

SUBJECT: Support for Full Preservation of Medicaid

PURPOSE: Advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and publicly affirm support for comprehensive Medicaid benefits for patients across the United States.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Medicaid covers approximately 19% of all patients in the United States; and

WHEREAS, Approximately 45% of all emergency department (ED) patients are insured through Medicaid; and

WHEREAS, Medicaid beneficiaries currently have access to timely, high-quality, and appropriate care in all payment systems; and

WHEREAS**,** The loss or reduction of Medicaid benefits could result in deferred or delayed care, leading to exacerbation of medical conditions and increased reliance on emergency departments, where treatment is often more complex and costly; and

WHEREAS**,** Medicaid cuts would increase healthcare costs, reduce access to care for low-income individuals, and place significant financial pressure on healthcare providers; and

WHEREAS**,** Denial or limitation of Medicaid insurance could result in the closure of hundreds of rural hospitals, delayed care with significant health consequences, worsening of pediatric and mental health outcomes, and impediments to emergency physicians in coordinating care for high-risk patients; and

WHEREAS**,** Reduction in Medicaid coverage would increase the number of uninsured and further strain the emergency care safety net; and

WHEREAS**,** Medicaid cuts will impede the ability of emergency physicians to provide timely and needed care, thereby worsening moral injury and potentially leading to more burnout and emergency physicians exiting the specialty; therefore be it

RESOLVED, That ACEP advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and be it further

RESOLVED, That ACEP publicly affirm support for comprehensive Medicaid benefits for patients across the United States.

Background

This resolution calls for ACEP to advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and, to publicly affirm support for

comprehensive Medicaid benefits for patients across the United States.

This resolution is similar to Resolution 47(25) Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies. Much of the background information is the same for both resolutions.

Protecting and improving Medicaid, including increasing funding levels and advocating for more robust reimbursement levels, has been and remains a legislative and regulatory priority for the College. The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include:

- Ensure Prudent Layperson Standard extends to Medicaid FFS and compliance measures are in place for other health plans.
- Monitor efforts to establish block grants, per-capita allotments for federal share of Medicaid funding, establishment of Medicaid work requirements, or other proposals regarding Medicaid eligibility requirements/restrictions.
- Seek permanent repeal of Medicaid IMD exclusion.
- Monitor efforts to establish/change Medicaid work requirements.
- Monitor legislative efforts to voluntarily expand Medicare or Medicaid to additional patient populations.

The College has also developed materials and resources designed to assist ACEP chapters in advocating for fair and adequate reimbursement at the state level and how to advocate for reforms that protect access to emergency care for all who need it, while at the same time promoting fiscal responsibility and the provision of quality care.

ACEP has longstanding policy, "Universal Health Care Coverage," promoting access for all Americans to health benefits coverage that provides for timely, unrestricted access to emergency care. The policy states:

> "The American College of Emergency Physicians (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."

ACEP also has several current policies related directly to Medicaid:

- "Opposition to Copays for Medicaid Beneficiaries"
  - "The American College of Emergency Physicians (ACEP) opposes the imposition of copays for Medicaid beneficiaries seeking care in the emergency department."
- "Medicaid Expansion"
  - "The American College of Emergency Physicians (ACEP) advocates for the expansion of Medicaid to the levels allowable by federal law as a crucial step towards improving health care access for our community's most vulnerable populations. This expansion will not only ensure that individuals receive the care they need but will also reduce the financial burden of uncompensated care on emergency departments, allowing for more efficient and effective health care delivery.

    ACEP urges policymakers to prioritize Medicaid expansion, recognizing its profound impact on public health, economic stability, and the overall efficiency of our health care system. By supporting this expansion, ACEP reaffirms our commitment to advancing health equity and providing high-quality, accessible care for all."

Especially over the first half of 2025, ACEP federal advocacy has prioritized the preservation of Medicaid in light of the substantial changes to the program that were being considered by Congress and were ultimately included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. Among the major Medicaid provisions included in the law are:

- **"Community Engagement" Requirements**: Establishment of work requirements for eligible adults that are part of the Affordable Care Act's Medicaid expansion population. The law requires that able-bodied individuals must work at least 80 hours per month or complete volunteer, community service, or other eligible educational programs, with limited exceptions. 40 states and the District of Columbia have expanded Medicaid to cover most adults under 138% of the federal poverty level (FPL). According to the Kaiser Family Foundation (KFF), "As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states."

- **State provider tax freeze and reduction**: Freezes the current Medicaid provider tax thresholds for all states for two years, and reduces the maximum allowable provider tax for expansion states from 6 percent to 3.5 percent by 2032 (in 0.5 percent increments annually).
  - Context: Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of their state costs with taxes on these health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the Federal Matching Assistance Percentage (FMAP) rate provided by the federal government.
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Congressional Affairs Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 47(25)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Protecting Medicaid Disproportionate Share Hospital (DSH) Payments to Preserve Emergency Care Access

PURPOSE: Recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians, have been shown to increase the amount of rural hospital closures; partner with relevant organizations such as America's Essential Hospitals (AEH) to further the cause of protecting Disproportionate Share Hospital payments; and advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts for fiscal years 2026 through 2028

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Medicaid Disproportionate Share Hospital (DSH) payments provide critical financial support to hospitals that care for a high volume of low-income and uninsured patients, including many emergency departments; and

WHEREAS, Emergency physicians serve on the front lines of care for vulnerable populations, and reductions in DSH funding threaten the financial viability of emergency departments in both urban and rural safety-net hospitals; and

WHEREAS, Studies and national health data show that past DSH cuts have been correlated with increased hospital closures, particularly in rural areas, disproportionately impacting access to emergency care; and

WHEREAS, Rural and underserved communities often rely on a single hospital or emergency department for timely care, and closures due to funding shortfalls can lead to delayed treatment, worsened outcomes, and increased mortality; and

WHEREAS**,** The loss of DSH payments places greater financial strain on hospitals with high levels of uncompensated care, making it more difficult for them to maintain emergency services, staffing, and critical infrastructure; and

WHEREAS**,** ACEP is committed to advocating for equitable access to emergency care for all patients, including those who are uninsured or underinsured; and

WHEREAS**,** America's Essential Hospitals and other national organizations have already mobilized campaigns to repeal or delay the DSH cuts, which have been successful in the past, and have invited collaboration with physician specialty societies to strengthen advocacy; and

WHEREAS**,** Bipartisan legislation, such as the Supporting Safety Net Hospitals Act (H.R. 2665), has been introduced in Congress to delay DSH cuts through fiscal year 2028 and has received widespread support from hospitals and patient advocacy groups; and

WHEREAS, ACEP has a strong history of partnering with allied organizations to advance healthcare policies that support emergency medicine and protect safety-net resources; and

WHEREAS, Failure to act against impending DSH reductions will disproportionately harm hospitals that serve a majority of Medicaid and uninsured patients, threatening the stability of the nation's emergency care safety net;

therefore be it

RESOLVED, That ACEP recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; and be it further

RESOLVED, That ACEP partner with relevant organizations such as America's Essential Hospitals to further the cause of protecting Disproportionate Share Hospital payments; and be it further

RESOLVED, That ACEP advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts scheduled for fiscal years 2026 through 2028.

Background

The resolution directs ACEP to recognize the Disproportionate Share Hospital (DSH) cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; partner with relevant organizations such as America's Essential Hospitals (AEH) to further the cause of protecting DSH payments; and, advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts for fiscal years 2026 through 2028.

Medicaid Disproportionate Share Hospital (DSH) payments are paid to qualifying hospitals that serve disproportionately large volumes of Medicaid and low-income uninsured patients. States are provided with an annual allotment to account for the costs of caring for these populations that are not paid by other payers (i.e., commercial insurance, Medicare, etc.) in order to help particularly vulnerable hospitals with the financial burdens associated with higher volumes of uncompensated care. DSH payments have been made to hospitals since 1981 when Medicaid hospital payments were decoupled from Medicare, and Congress set limits on DSH payments in 1991 in order to curtail the rapid spending growth that resulted.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) imposed annual reductions for DSH payments that were scheduled to phase in gradually between fiscal year (FY) 2014 through FY 2020. The justification for reducing DSH payments was based on the assumption that the Medicaid expansion, one of the cornerstones of the ACA, would be adopted uniformly by all states and thereby reduce the number of uninsured individuals by extending Medicaid coverage to nearly all those under age 65. Thus, DSH payments could be reduced to reflect lower uncompensated care costs that were anticipated. However, as the Medicaid expansion provisions were later deemed unconstitutionally coercive by the U.S. Supreme Court (*National Federation of Independent Business v. Sebelius*, 2012), Medicaid expansion effectively became optional and fewer states expanded their programs and more individuals remained uninsured than had been expected; however, the scheduled reductions to DSH payments remained in statute.

The DSH cuts have never gone into effect as Congress has delayed or eliminated these cuts more than a dozen times, most recently in H.R. 1968, the March 2025 continuing resolution (CR) to provide continued funding for the federal government, until the end of the current fiscal year that ends on September 30, 2025. The impending DSH cut for FY 2026 is $8 billion, with another $8 billion for each of the next two fiscal years following for a total of $24 billion. Historically, advocacy to prevent the DSH cuts has been led by hospitals and health systems as they are the direct recipients of the payments.

H.R. 2665, the "Supporting Safety Net Hospitals Act," was a bipartisan bill introduced in the U.S. House of Representatives during the 118th Congress (2023-2024) by Reps. Yvette Clarke (D-NY), Dan Crenshaw (R-TX), Diana DeGette (D-CO), and Michael Burgess, MD (R-TX), with a total of 131 bipartisan cosponsors. The legislation proposed delaying pending DSH cuts by two years, moving back the implementation date for cuts scheduled to take effect in FY 2024 until FY 2026. Similar language was included in the "Lower Costs, More Transparency Act," that was passed by the House of Representatives in December 2023, but this legislation was not considered by the Senate before the end of the 118th Congress. In the current 119th Congress, the "Protect DSH Act" (H.R. 3581) was introduced on May 23, 2025, by Representative Dan Crenshaw (R-TX), to delay the DSH cuts from taking effect from

FY2029 through FY2031 (instead of FY2026-FY2028). Unlike previous iterations of this effort, H.R. 3581 was not introduced with bipartisan sponsors and has zero cosponsors as of July 21, 2025.

Concerns regarding the continued stability and viability of both urban and rural safety net hospitals have been front and center in the 119th Congress, particularly with respect to the considerable reductions in Medicaid spending included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. The law does not make modifications or delays to the DSH program, but organizations like America's Essential Hospitals (AEH) urged Congress to reject the proposals that would reduce overall Medicaid funding given the myriad financial threats facing essential hospitals especially. The law did include a provision to establish a $50 billion "Rural Health Transformation Fund" to help provide some funding stability and certainty for hospitals and health care providers as a result of the law's major changes to Medicaid; however, hospitals and health systems remain concerned about the significant financial pressures on the horizon.

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 professional.

Fiscal Impact

Budgeted resources for current advocacy initiatives.

Prior Council Action

The Council has discussed and adopted many resolutions regarding Medicaid, however, none that are specific to the Medicaid Disproportionate Share Hospital (DSH) payments.

Resolution 40(22) Support for Medicaid Expansion adopted. Directed 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.

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.

Prior Board Action

January 2025, approved the policy statement "Medicaid Expansion."

Resolution 40(22) Support for Medicaid Expansion adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 48(25)

SUBMITTED BY: Scott H. Pasichow MD, MPH, FACEP
New Jersey Chapter
American Association of Women Emergency Physicians Section
Young Physicians Section

SUBJECT: Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA

PURPOSE: Directs ACEP to: 1) update the policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; 2) affirm that federal EMTALA obligations supersede conflicting state laws or mandates; 3) advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements; 4) work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and 5) provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

FISCAL IMPACT: Budgeted committee and staff resources to update the policy statement. Budgeted resources for current advocacy initiatives.

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) that requires any hospital with an emergency department that participates in Medicare to provide a medical screening examination and stabilizing treatment for any emergency medical condition, regardless of a patient's ability to pay[1]; and

WHEREAS, EMTALA obligates participating hospitals to provide stabilizing treatment for patients with emergency medical conditions and defines "stabilizing treatment" as medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during transfer of the individual from a facility[2]; and

WHEREAS, In July 2022 Centers for Medicare & Medicaid Services (CMS) issued guidance titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss," which clarified that emergency medical conditions involving pregnant patients may include ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders such as preeclampsia, and stated that "a physician's professional and legal duty to provide stabilizing medical treatment preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment"[3]; and

WHEREAS, Effective June 3, 2025, CMS rescinded the July 2022 directive (QSO-22-22-Hospitals and QSO-21-22-Hospitals) stating it "[does] not reflect the policy of this Administration"[3]; and

WHEREAS, Despite rescinding the guidance, CMS affirmed it "will continue to enforce EMTALA, which protects all individuals who present to an emergency department seeking examination or treatment, including for identified emergency medical conditions that place the health of a pregnant woman or her unborn child in serious jeopardy";[4] and

WHEREAS, The American College of Emergency Physicians (ACEP)'s current policy on "Access to Reproductive Health Care in the Emergency Department" supports the position that early termination of pregnancy is

a medical procedure involving shared decision-making between patients and physicians, and ACEP specifically opposes penalization of patients, physicians, healthcare workers, and health systems for receiving, assisting, or referring patients to receive reproductive health services, and supports clear legal protections for emergency physicians providing federally mandated emergency care, particularly in cases of conflict between state and federal laws;[5] and

WHEREAS, The fundamental statutory requirements of EMTALA remain unchanged regardless of administrative guidance and emergency physicians retain both legal obligations under federal law and ethical obligations to provide life-saving stabilizing care; and

WHEREAS, The rescission of the 2022 guidance has created legal uncertainty for hospitals and physicians regarding emergency abortion care, with medical experts expressing concern that this policy shift will make physicians more reluctant to provide life- or health-saving care for pregnant patients,[6] though the removal of specific CMS guidance does not remove emergency physicians' ethical obligation to provide medically necessary emergency care consistent with the intent and requirements of federal law; and

WHEREAS, The obligation to provide life-saving stabilizing care for anyone who presents to an emergency department is not only a legal obligation under EMTALA, but also an ethical obligation for physicians as outlined in ACEP policy;[5] therefore be it

RESOLVED, That ACEP update its policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' unwavering ethical and legal obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; and be it further

RESOLVED, That ACEP affirm that federal EMTALA obligations supersede conflicting state laws or mandates that would prevent emergency physicians from providing medically necessary stabilizing treatment for emergency medical conditions; and be it further

RESOLVED, That ACEP advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements, particularly when such care conflicts with state laws; and be it further

RESOLVED, That ACEP work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and be it further

RESOLVED, That ACEP provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

References

1. Zibulewsky J. The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians. Proc (Bayl Univ Med Cent). 2001 Oct;14(4):339-46. doi: 10.1080/08998280.2001.11927785. PMID: 16369643; PMCID: PMC1305897.
2. 42 U.S.C. § 1395dd. Examination and treatment for emergency medical conditions and women in labor. Emergency Medical Treatment and Labor Act (EMTALA).
3. Centers for Medicare & Medicaid Services. Rescinded Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss. May 29, 2025. Available at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos/policy-memos-states-and-cms-locations/rescinded-reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing
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5. American College of Emergency Physicians. Access to Reproductive Health Care in the Emergency Department. Policy Statement. June 2023. Available at: https://www.acep.org/patient-care/policy-statements/access-to-reproductive-health-care-in-the-emergency-department
6. ABC News. Revoking EMTALA guidance on abortions will only further confuse doctors, experts say. June 6, 2025. Available at: https://abcnews.go.com/US/revoking-emtala-guidance-abortions-confuse-doctors-experts/story?id=122552727

Background

This resolution directs ACEP to: 1) update the policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; 2) affirm that federal EMTALA obligations supersede conflicting state laws or mandates; 3) advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements; 4) work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and 5) provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

Last year, the Council and the Board of Directors adopted Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care directing ACEP to develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options. The resolution was assigned to ACEP's Medical-Legal Committee to develop a policy statement and that work is currently in progress.

In September 2021 HHS had released guidance reaffirming physicians' legal obligations under EMTALA, specifically when treating patients who are pregnant or are experiencing pregnancy loss.

The following year, the June 24, 2022 decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization* held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Because emergency departments commonly see patients presenting with obstetrical emergencies, this decision immediately triggered significant uncertainty on whether, in light of the existing federal EMTALA law, restrictions or prohibitions could now be imposed on their treatment in states with abortion and related reproductive health restrictions. In response to the ruling, ACEP issued a statement expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, and 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.

Just weeks later, in July 2022 CMS issued additional EMTALA guidance. 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.
- States that with respect to what constitutes an EMC, 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."
- 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."

Yet some grey area remained after the additional guidance from CMS, since while it noted that EMTALA can be raised as a defense by a physician facing state action, it 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 to allow abortion if it's to prevent the death of the pregnant patient, but as noted EMTALA requires stabilizing treatment to prevent "serious impairment of bodily functions," "serious dysfunction of any bodily organ or part," or to prevent placing the health of the patient "in serious jeopardy." ACEP has noted this is a key area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA to avoid potential civil monetary penalties or following the state law to avoid potential criminal charges.

Therefore, ACEP joined amicus briefs addressing these issues. ACEP and the Idaho Chapter submitted a brief in the U.S. District Court for the District of Idaho on August 15, 2022, in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. Because the Idaho law only allows for abortion if the life of the mother is in danger, the brief argued that if applied to emergency medical care, 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 EMTALA. The State of Texas had filed suit (*State of Texas v. Becerra*) arguing the federal government did not have the authority to provide medical guidance. The amicus brief emphasized the proper interpretation of EMTALA and the possibility that what under Texas law would constitute pregnancy termination may be appropriate in the emergency department when deemed necessary to provide stabilizing treatment of the patient, and that the Federal guidance merely restated physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

Since that time, there has been significant activity at the state level, in the courts, and at the federal level regarding EMTALA and pregnancy-related emergencies.

State

- Several states, including Colorado, New York, Illinois, and Washington have added EMTALA-like protections into state statutes to ensure emergency abortion care is mandatory at the state level regardless of federal guidance or activity.
- Following the May 29, 2025 rescission of the Biden-era EMTALA guidance, 22 states' Attorneys General jointly sent a letter to the American Hospital Association (AHA) to remind hospitals that they are obliged to provide emergency abortion care to patients under EMTALA.
- On June 4 the Centers for Medicare & Medicaid Services released its investigative findings that a Texas hospital had violated EMTALA in failing to provide an appropriate Medical Screening Exam for a patient who presented to its ED with an ectopic pregnancy.

Courts

- *United States v. State of Idaho*: following the Supreme Court's ruling in June of dismissing the case as improvidently granted (essentially returning it to the lower courts), the case was reheard by the Ninth Circuit in December 2024. The Justice Department under newly-elected President Trump's second term filed to drop the lawsuit in March 2025. However, ahead of this, St. Luke's, the largest hospital system in Idaho, filed a separate challenge to the state law, and had obtained a similar injunction to allow hospitals to provide emergency abortion serviced under the federal requirement in the state. On July 17, a consent decree approved by a federal judge prevents the state's Attorney General and county prosecutors from prosecuting healthcare providers who refer, counsel, or otherwise provide information to patients seeking abortions in other states.
- *State of Texas v. Becerra:* following the Fifth Circuit's ruling that EMTALA does not mandate abortion in emergency settings and is not preemptive of Texas law, in October 2024 the U.S. Supreme Court declined to intervene in the case, leaving in place that injunction limiting federal enforcement of EMTALA-based abortion guidance in Texas.

Federal

- On May 29, 2025, HHS rescinded the Biden Administration's 2022 guidance referenced above. Since that 2022 guidance largely reiterated existing EMTALA law, it's rescission created some uncertainty regarding what, if any, impact it would hold on emergency physicians, especially in states with restrictions related to pregnancy or reproductive health. Following that rescission, ACEP quickly put out a press release reiterating its commitment to EMTALA and its importance in ensuring emergency physicians can provide stabilizing care to any patient who needs it, including pregnant patients, and urging policymakers and federal officials to continue to uphold and enforce the law in a manner that protects patients and supports emergency physicians' clinical judgment and autonomy. reaffirm
- On June 17, 2025, HHS' Secretary Kennedy sent a letter to provider organizations with new guidance

reaffirming HHS' commitment to enforcing EMTALA and clarifying that EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care. It provides examples of obstetric emergencies that the EMTALA obligation applies to, such as "ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions." The guidance then states, "Although EMTALA preempts any State or local law that 'directly conflicts' with its requirements, providers should not misconstrue existing State laws, or rely on inaccurate media reports, as a basis for denying stabilizing care to any pregnant woman facing an emergency medical condition. EMTALA continues to be the law of the land, and HHS commits to both expeditious review of complaints filed and appropriate and timely action if violations are found, to ensure that pregnant women facing emergency medical conditions have access to stabilizing care."

- On June 24, 2025, Sec. Kennedy spoke about the letter and reiterated the Administration's commitment in it when asked while testifying during the House Energy & Commerce Committee's hearing on the President's 2026 budget. Short (3 min) clip here.
- In November 2024, the Centers for Medicare and Medicaid Services (CMS) finalized two changes to the Conditions of Participation (CoP) program: a new Obstetrical Services CoP, focused on obstetrical services, and changes to the existing Emergency Services CoP (42 CFR §482.55). As part of these changes, facilities with dedicated emergency units will be subject to new requirements regarding emergency services readiness and transfer protocols. The American College of Obstetricians and Gynecologists (ACOG) and ACEP have partnered to provide information for members (to be released soon) on the second set of requirements that went into effect on July 1, 2025: emergency services readiness and transfer protocols, since more specific federal guidance is still pending.

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 professional.

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 resources for current advocacy initiatives.

Prior Council Action

Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care adopted. The resolution directed ACEP to develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP 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. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving 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. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the 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. Directed ACEP to 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.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted. Directed that ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Prior Board Action

Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care adopted.

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship"

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

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.

Background Information Prepared by: Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 49(25)

SUBMITTED BY: Joshua Davis, MD
John F. McMaster, MD, FACEP

SUBJECT: Support for EMTALA Reform to Ensure Timely Access to Definitive Care

PURPOSE: Support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate for patients requiring transfer to a higher level of care and create legislation to update or replace EMTALA to better ensure that patients receive safe and timely care.

FISCAL IMPACT: Budgeted committee and staff resources and current advocacy initiatives. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed and the timeline for completion.

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986 to ensure that all individuals regardless of insurance status or ability to pay, receive emergency medical services and are not inappropriately denied or refused screening, stabilization, or appropriate transfer to higher levels of care; and

WHEREAS, Current EMTALA provisions mandate that all hospitals that participate in Medicare with or without specialized capabilities, accept transfers of patients requiring higher levels of care if capacity exists, but enforcement is inconsistent and self-serving while violations are difficult to address in real time; and

WHEREAS, The real time emergency physicians present at the bedside routinely encounter delays, denials, and refusals in transferring patients to appropriate facilities or covering sub-specialists—such as trauma centers, stroke centers, psychiatric hospitals, specialty care units, or sub-specialists—despite the clinical urgency and ethical/legal obligations of the receiving hospitals and sub-specialists; and

WHEREAS, Such barriers to transfer contribute to poorer patient outcomes, prolonged emergency department boarding, delayed definitive care, and increased risks to patient safety; and

WHEREAS, Systemic challenges including economics, capacity/sub-specialty gaming, opaque bed availability, and inadequate accountability mechanisms undermine the intent of EMTALA and place undue strain on emergency physicians, emergency departments, and patients alike; therefore be it

RESOLVED, That ACEP support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate and ensure that patients requiring transfer to a higher level of care are not inappropriately denied or delayed; and be it further

RESOLVED, That ACEP investigate legislation to replace or update EMTALA with a more contemporary alternative that reflects the current practice of emergency medicine and better ensures that patients receive the medical care they need in a safe and timely manner.

Background

The resolution calls for ACEP to support legislative, regulatory, and policy reforms to strengthen the Emergency Medical Treatment and Active Labor Act (EMTALA) mandate for patients requiring transfer to a higher level of care and create legislation to update or replace EMTALA to better ensure that patients receive safe and timely care.

EMTALA is the federal law requiring Medicare-participating hospitals with emergency departments to screen and

treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed, or color. EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. The law was enacted in 1986 in response to reports about "patient dumping," a practice where hospitals and emergency rooms would refuse to treat poor or uninsured patients or transfer or discharge emergency patients based upon the anticipation of high costs of diagnosis and treatment. EMTALA requires Medicare-participating hospitals, as a condition of participation (COP) under Medicare, to provide services to any individual presenting at an emergency department, regardless of insurance status or ability to pay, or face potential enforcement actions and penalties for violations.

Hospitals have three main obligations under EMTALA:

1. 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 (EMC).
2. 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.
3. 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 (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

EMTALA violations may result in the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issuing civil monetary penalties on a hospital ($129,233 for hospitals with more than 100 beds, $64,618 for hospitals with fewer than 100 beds/per violation) or physician ($129,233 per violation) pursuant to 42 CFR §1003.500 for refusing to provide either unnecessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. The HHS OIG also has the authority to exclude physicians from participation in Medicare and State health care programs, and the Centers for Medicare & Medicaid Services (CMS) may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping and equitable relief as appropriate.

Under current federal regulations (42 CFR §489.24) the term "capacity" under EMTALA is defined as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits."

As the overall shape of the U.S. health care system has evolved over the decades since the enactment of EMTALA, some suggest that the law has not similarly evolved and does not reflect the current reality of care delivery in emergency departments and hospitals throughout the country. In particular, some suggest these conditions have led to perverse incentives that discourage hospitals and facilities from accepting transfers of patients from transferring facilities in direct conflict with the intended purpose of EMTALA's fundamental patient protections. ACEP's policy statement "Appropriate Interfacility Patient Transfer" outlines principles regarding patient transfer for those patients who require transfer from the ED to another facility. Among these principles is that "[a]greement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer."

Adding to the complexity of this problem is that despite being only four pages when signed into law and focused on protecting patient access to emergency medical care, EMTALA now functions in a more expansive manner as a result of several subsequent amendments, regulatory interpretation and enforcement, and legal determinations that have shaped the law since its enactment. The resolution notes that in 1986, medical center "capacity" was defined as "the number of physically unoccupied beds and OR tables," and that since then, "capacity" has subsequently been redefined as the number of "staffed beds" which is determined by arbitrary "nursing ratios." The resolution goes on to explain that this interpretation has resulted in perverse incentives or consequences, where transfers of patients to higher care facilities are refused because of this interpretation of "capacity," and that hospitals refuse to declare or place contingency or emergency standards of care in effect to override nursing ratio requirements in order to facilitate accepting additional transfers into unoccupied beds from facilities that cannot provide care, leading to dangerous delays in care, even death, hours of frustration for transferring personnel, and often transfers of hundreds and even thousands of miles from the nearest capable medical centers for patients.

The issue of patient transfers given the constraints of the federal EMTALA mandate remains an area of concern and persistent challenge for overwhelmed EDs. In some cases, an ED or hospital with insufficient resources or ability to care for a patient with complex needs is unable to transfer that patient to a receiving hospital because that facility is also overwhelmed with boarding patients, full units, or insufficient staff. This has resulted in patients succumbing to traumatic wounds or serious illnesses and conditions due to the inability to transfer those patients in a timely fashion. As the resolution also notes, this has been exacerbated as hospitals and facilities have not implemented emergency or crisis standards of care protocols to override nursing ratios or other resource scarcity issues.

A June 2024 article published in *ACEPNow* by James Augustine, MD, FACEP, sheds additional light on this issue. Dr. Augustine notes:

> "The additional lengthy ED stays for transfer patients are equally resource-intense for emergency physicians and especially emergency nurses. Some hospital systems have developed transfer centers or flow centers, which attempt to coordinate patient movement to the best site of care within the system. But for independent, and particularly smaller and rural hospitals, the process of finding an accepting hospital for patients needing transfer is a huge burden that involves placing one phone call or digital request at a time. Once a patient is accepted somewhere, the facility must then begin the process of finding a transport resource, coordinating the right time of transfer with the receiving facility, and completing the required documentation."
>
> This points to a need for centers that may specialize in regional patient movement, to include all hospitals and systems. In regions like San Antonio, Texas, this innovation has taken place already and serves needs across a large geographic region and many patient types (https://www.strac.org/). The state of Georgia has developed and funded a coordinating center for patient movement and EMS communications on hospital capabilities (https://georgiarcc.org/). These coordinating centers have been advantageous when patient surges occurred, such as those experienced during the most stressful days of the COVID-19 pandemic."

There are ongoing efforts outside of amending EMTALA requirements aimed at reducing barriers to patient transfers. Some stakeholders like Apprise Health Insights and others have implemented automated, real-time statewide and regional bed tracking and capacity management systems to facilitate quicker transfer of patients to appropriate facilities that have the ability and capacity to provide care. ACEP is also in the process of working with legislators to draft federal legislation to help expand the proliferation of these systems throughout the country. Additionally, ACEP has partnered with the American College of Surgeons (ACS) and the ACS Committee on Trauma (COT) to help develop a National Trauma Emergency Preparedness System (NTEPS) blueprint, which envisions a system that provides awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. This coordinated effort should be built upon a framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care.

RMOCCs are envisioned as having the following essential functions:

- Operationalize the regional plan for patient distribution and health system load balancing for any mass casualty or large public health event;
- Facilitate clinical expertise and consultation for all health-related hazards and coordinate the expertise into the regional plan through current hazard vulnerability assessments;
- Integrate all levels of healthcare leadership (public health, administrative, physician and nursing) from the regional health systems and hospitals into the framework of the emergency operations center and operational plans;
- Provide real-time situational awareness of health care capability and capacity to all regional healthcare systems and other salient healthcare entities. This function includes data collection, analysis, and dissemination (i.e., hospital and EMS capacity data);
- Support dynamic movement of patients when required and load balance the medical facilities to mitigate the need for crisis standards implementation and resource rationing;
- Provide a single point of contact at both the RMOCC and at each hospital/health system for referral requests and life-saving resource sharing;
- Align and coordinate regional resources (e.g., supplies, equipment, medications, etc.) and personnel with the goal of maintaining regional systems for time sensitive care such as cardiac, stroke and trauma that may or may not be directly impacted by the surge event; and
- Provide a communication link to other RMOCCs to lead or participate in a broader coordinated multi-regional, state, or national effort. This includes both a multi-state response and nationwide network integration.

Some of these concepts are included in the Draft Guidelines Regional Health Care Emergency Preparedness and Response Systems issued by the Administration for Strategic Preparedness and Response (ASPR), but ACEP and our partners in this effort continue to encourage ASPR to make RMOCCs the centerpiece of the regionalized approach. ACEP also continues to advocate to Congress to implement this approach as part of our nation's larger emergency preparedness infrastructure.

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources and current advocacy initiatives. Alternatively, utilizing a consulting firm with specific legislative drafting expertise and services would incur unbudgeted costs ranging from $10,000 – $50,000 depending on the scope of services needed and the timeline for completion.

Prior Council Action

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted. Directed ACEP to collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/Hospital Crowding & Inter-Hospital Transfer data to a relevant state entity (e.g., State Dept of Health) and develop a statewide system to facilitate inter-facility transfers.

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs referred to the Board of Directors. Requests ACEP to: 1) work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; 2) advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and 4) support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals.

Amended Resolution 23(11) EMTALA adopted. Directed ACEP to submit recommendations to CMS regarding uniform interpretation and fair application of EMTALA; work with CMS to institute confidential, peer-reviewed process for complaints; work with CMS and others to require that complaints be investigated consistently according to ACEP-developed standards and investigators required to adhere to principles of due process and fairness during investigations; and provide a report to the 2012 Council on this issue.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate and submit recommendations for the CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among all the CMS regional offices, protection of peer review confidentiality, and utilizing consultative peer review for issues involving medical decision making.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA and for the Board to provide a report to members in 2001.

Prior Board Action

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted.

Amended Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

Amended Resolution 27(23) Addressing Interhospital Transfer Challenges for Rural EDs assigned to the ACEP Federal Government Affairs Committee and State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

January 2019, reaffirmed the policy statement "EMTALA and On-Call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999),"Medical Staff Responsibility for Emergency Department Patients" (1997), and "Medical Staff Call Schedule."

Amended Resolution 23(11) EMTALA adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Background Information Prepared by: Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 50(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Emergency Department Staffing Transparency

PURPOSE: Advocate for strict enforcement of federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including explanation of how emergency medical needs will be addressed when a physician is not present.

FISCAL IMPACT: Budgeted committee and staff resources for current advocacy initiatives.

WHEREAS, Recent data indicate that 1 in 13 emergency departments operate at times without a physician physically on-site and on duty; and

WHEREAS, The American College of Emergency Physicians (ACEP) affirms that, regardless of geographic location, all patients who present to emergency departments (EDs) deserve access to high-quality, patient-centered care delivered by emergency physician-led teams; and

WHEREAS, The ACEP Emergency Department Accreditation Program promotes transparency to help patients make informed decisions when seeking emergency care; and

WHEREAS, The general public reasonably expects that a visit to an "Emergency Department" will involve being evaluated by a physician; and

WHEREAS, A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency; and

WHEREAS, The Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B.489.20 - Basic Commitments. Section w (5) states:

> "Each dedicated emergency department, as that term is defined in § 489.24(b), in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition, as defined in § 489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital."; therefore be it

RESOLVED, That ACEP advocate for strict enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present.

Background

This resolution calls for the College to advocate for strict enforcement of federal regulation requiring hospitals without 24/7 on-site physician coverage to post notices informing patients there is not a physician on site, and how the

hospital will meet the emergency medical needs of any patient when a physician is not present. This is in compliance with the Code of Federal Regulation, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B.489.20 - Basic Commitments. Section w (5).

Section 1866(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 contacted the EMTALA compliance office within CMS about what signs are permitted/prohibited in response to Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians 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. If an individual surveyor finds that signs "deter or discourage" patients from seeking emergency care, facilities would be subject to EMTALA related penalties/fines. Resolution 39(22) was amended by the Council to "encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered."

The 2022 National ED Inventory (NEDI)-USA survey found that 7.4%, or one in every 13, EDs did not have an attending physician on duty 24/7. This phenomenon was more frequent in critical access hospitals (89%) and rural locations (72%) with an annual visit volume greater than 10,000.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" most recently updated in October 2024 states:

> "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."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. 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."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "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."

ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023 that includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's Advocacy team, was instrumental in helping states pass legislation that requires a physician in the ED at all times.

In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law requiring all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet to begin and continue participating in Medicare and Medicaid. This action would have the effect of creating a federal mandate that EDs in Critical Access Hospitals (CAH) and Rural Emergency Hospitals (REH) be staffed 24/7 by a qualified physician. This would parallel the requirement in Indiana, Virginia, and ACEP's model legislation, but does not require a board certified emergency physician in the rural setting.

ACEP has continually promoted and advocated the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy and Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs. (Legislative)
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas. (Legislative)
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities. (Legislative)
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option. (Regulatory)

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 committee and staff resources for current advocacy initiatives.

Prior Council Action

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

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 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to publish 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; and support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

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 and provide findings to the Council by July 1, 2022.

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.

Prior Board Action

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners."

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and 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" and 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 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

Background Information Prepared by: Brianna Hanson, MPH
Reimbursement and State Legislative Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 51(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Supporting Board Certified Physicians in Every Emergency Department

PURPOSE: Support state and federal legislative and regulatory efforts that require a board-certified or eligible emergency physician be physically present and available in every emergency department at all times, and develop draft legislation.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing federal and state advocacy initiatives.

WHEREAS, Emergency departments (EDs) serve as critical access points for medical care, often providing life-saving treatment for patients experiencing acute medical emergencies; and

WHEREAS, The complexity and urgency of emergency care require the knowledge, training, and decision-making skills unique to board-certified emergency physicians; and

WHEREAS, ACEP asserts that the gold standard for ED care is provided by emergency physicians certified or eligible for certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM); and

WHEREAS, Board certification through the ABEM or ABOEM ensures that physicians have met rigorous standards of competency and excellence in emergency care; and

WHEREAS, ACEP acknowledges the integral role of Physician Assistants (PAs) and Nurse Practitioners (NPs) in the ED care team, it maintains that these professionals do not possess the specialized training and expertise of emergency physicians; and,

WHEREAS, ACEP guidelines stipulate that PAs and NPs should not perform independent, unsupervised care in the ED. Supervision by a board-certified emergency physician is required, with the supervising physician having real-time involvement in patient care decisions; and

WHEREAS, The presence of board-certified emergency physicians in EDs enhances patient safety, improves clinical outcomes, and ensures the highest standards of care; and

WHEREAS, Many hospitals and systems, particularly in rural or underserved areas, increasingly rely on non-board-certified physicians or non-physician providers without physician oversight, potentially compromising the quality of emergency care; and,

WHEREAS, Indiana and Virginia have recently enacted legislation requiring that a licensed physician be physically present and on duty in every hospital ED at all times, setting a precedent for ensuring physician-led emergency care and reinforcing the standard of high-quality, accountable medical oversight in emergency settings; therefore be it

RESOLVED, That ACEP support state and federal legislative and regulatory efforts to require that a physician, ideally a board-certified or eligible emergency physician, be physically present and available in every emergency department at all times, which includes but is not limited to developing draft legislation on this topic.

Background

This resolution directs ACEP to support state and federal legislative and regulatory efforts to require that a physician, ideally a board-certified or eligible emergency physician, be physically present and available in every emergency department at all times, and for ACEP to develop draft legislation on this topic.

ACEP has continually promoted and advocated the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy and Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs. (Legislative)
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas. (Legislative)
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities. (Legislative)
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option. (Regulatory)

ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023 that includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's Advocacy team, was instrumental in helping states pass legislation that requires a physician in the ED at all times.

In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law that requires all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

ACEP advocated at the AMA House of Delegates for a resolution that adopts much of the model legislation used in Indiana and Virginia. The AMA adopted resolution 204 in June 2024 that compels the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and that the AMA seek federal legislation or regulation that would require all emergency departments to be staffed 24/7 by a qualified physician.

The State Legislative/Regulatory Committee developed a toolkit on strategies to combat scope of practice expansion by non-physicians. Additionally, the committee drafted template language requiring all EDs to have a physician on-site and on-duty 24/7/365 days of the year; and that no non-physician practitioner should be allowed to work independently and without supervision in an ED.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" most recently updated in October 2024 states:

> "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."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. 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."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "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."

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 professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources for current and ongoing federal and state advocacy initiatives.

Prior Council Action

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 52(24) Delegation of Critical Care to Non-Physician Practitioners referred to the Board of Directors. Revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement to include that: emergency physicians should retain primary responsibility for performing critical care activities within EDs to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; the scope of practice for nurse practitioners and physician assistants in EDs should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care

Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments adopted. Directed ACEP to promote the maintenance of more specific minimum standards for freestanding emergency departments (FSEDs)

pertaining to appropriate staffing, lab, security, service availability, and imaging capabilities, and update the FSED policy statement accordingly.

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Resolution 49(23) Enhancing Rural Emergency Medicine Patient Care not adopted. Directed ACEP to 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; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and 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.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP 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.

Resolution 44(22) Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP: 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 and reimbursement purposes.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

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 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 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to publish 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; and support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted. Directed ACEP to: 1) recognize that patients presenting to rural emergency departments are a vulnerable ED patient population in the U.S. and deserve increased support; 2) 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 on defined volumes; 3) 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; 4) encourage 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 5) 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.

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 and provide 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. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians 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

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners."

Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments adopted.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

Background Information Prepared by: Brianna Hanson, MPH
Reimbursement and State Legislative Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 52(25)

SUBMITTED BY: Gary Gaddis, MD, PhD, FACEP
Sonya Naganathan, MD, MPH, FACEP

SUBJECT: Investigation of State Licensure Requirement for Hospital Administrators

PURPOSE: 1) Investigate the potential advantages, disadvantages, feasibility, and practical aspects if states require licensure of health care administrators. 2) If investigation finds that health care administrators should be licensed, develop model state legislation and ask NEMPAC and chapters PACs to support enactment of appropriate state legislation. 3) If investigation supports licensure of health care administrators, collaborate with other stakeholders to advocate for state licensure. 3) Consider adding a course at a future Scientific Assembly to inform members about the case to be made in support of state licensure of health care administrators.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to perform the investigation. Costs could range in excess of a minimum of $50,000 depending on the scope of work and the timeline for completion.

WHEREAS, Physicians, Nurses, Advanced Nurse Practitioners, Physician Assistants, and practitioners of the Allied Health fields (Radiology Technology, Ultrasound Technology, Physical Therapy, Occupational Therapy, and others) are all required to maintain an active license from the state(s) in which they practice, as a prerequisite to their ability to provide patient care; and

WHEREAS, This requirement for licensure is rational, because it is in the interest of the various states and their citizens that those who provide health care meet the various standards required by the various states for licensure as a health care worker; and

WHEREAS, Among the underlying reasons for licensure is to minimize the potential for harm that might be caused to patients because of acts by underqualified, undertrained, compromised or underprepared clinicians; and

WHEREAS, Hospital and health care facilities must also be licensed by the state in which they are located, to enable them to function as sites that provide patient care; and

WHEREAS, These hospitals and health care facilities are all managed by various administrators, who are currently free of any licensure obligations by the state in which they work, despite their decisions also having great potential to help or harm patients' interests, and despite that administrators' decisions can impact patients on a much larger scale than any decision made by any single clinician about any individual patient; and

WHEREAS, If hospital administrators were licensed by the various states, those states would obtain a new means to intervene against administrators who persistently make patient-adverse decisions, toward safeguarding the interests of patient care and safety; and

WHEREAS, Model legislation advocating for licensure of health care administrators has been crafted for introduction to the legislatures of the States of Washington and Connecticut, and

WHEREAS, We were unable to find any current ACEP policy that addresses the matter of a requirement for state licensure of hospital administrators; therefore be it

RESOLVED, That ACEP investigate the potential advantages, disadvantages, feasibility, and practical aspects that would be inherent if states were to require licensure of health care administrators; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will develop model state legislation and advocate for such licensure, while asking the National Emergency Medicine Political Action Committee (NEMPAC) and the various state chapters' political action committees (PACs) to support enactment of appropriate state legislation on this matter; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will collaborate with other stakeholders, such as but not limited to the American Medical Association, to advocate for state licensure of health care administrators; and be it further

RESOLVED, That ACEP consider adding a course at a future Scientific Assembly to inform members about the case to be made in support of state licensure of health care administrators.

Background

This resolution calls for ACEP to investigate the potential advantages, disadvantages, feasibility, and practical aspects of state licensure of health care administrators and, based on favorable investigation, develop model state legislation and advocate for such licensure at the state level in collaboration with other stakeholders. Additionally, the resolution requests ACEP to consider adding a course at a future Scientific Assembly to inform members about the potential advantages of state licensure of health care administrators.

Neither the federal government nor any states currently require licensure for hospital administrators. According to the American College of Health Care Administrators, while hospital administrators do not require a license, as a federal requirement, every nursing home in the U.S. that provides Medicare and Medicaid services must operate under the supervision of a licensed administrator. Nursing Home Administrators are licensed by the states. Applicants are required to have at least a bachelor's degree from an accredited institution, complete an Administrator-in-Training program, and pass the national licensing exam administered by the National Association of Long-Term Care Administrator Boards (NAB).

Health care administrators voluntarily receive certification through the fellowship program such as those offered by the American College of Healthcare Executives (ACHE). Membership is only offered after obtaining an undergraduate or master's degree and being employed in a training role. Applicants are required to complete coursework and pass a certifying examination. Continuing education is required to maintain certification. Other options include the Healthcare Administration and Leadership and Management (HALM) offered through the American Board of Emergency Medicine.

States have considered further regulation of health care administrators, with the most recent attempt being Connecticut SB 7, introduced in the 2025 state legislative session. This legislation would create a new licensure requirement for hospital administrators, with minimum qualifications for education and work experience as well as passing a certifying examination and establishing actions administrators could be held liable for.

Advocating for certification of health care administrators by individual states would require a significant multi-year investment from the College as well as establishing strategic partnerships with other specialties, the American Medical Association (AMA), and identifying legislator champions in key states. Further investigation by the College would also be needed to determine if nursing home administrator licensing has resulted in improved outcomes as expansion of the current NAB model to include hospital administrator certification is the most realistic option for the majority of states to pursue.

Including a course at a future Scientific Assembly in support of state licensure of health care administrators could be accomplished by submitting a course proposal for consideration by ACEP's Education Committee.

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 professional.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort. Use of an outside consultant could be utilized to perform the investigation. Costs could range in excess of a minimum of $50,000 depending on the scope of work and the timeline for completion

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Adam Krushinskie, MPA
Senior Director, State Legislative and Reimbursement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 53(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Prior Authorization Reform to Reduce Delays in Care and Emergency Department Burden

PURPOSE: Advocate for federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in emergency department visits or hospitalizations, and advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Prior authorization requirements imposed by insurance companies frequently delay access to medically necessary care, contributing to disease progression, care fragmentation, and patient harm; and

WHEREAS, Although emergency physicians are generally not directly engaging in prior authorizations, they frequently care for patients whose conditions have worsened due to delayed access to diagnostic tests, specialist evaluations, medications, or procedures requiring prior authorization; and

WHEREAS, Such delays disproportionately affect patients with chronic illnesses, cancer, mental health conditions, and social vulnerabilities, many of whom ultimately present to emergency departments in avoidable crisis due to inability to obtain timely outpatient care; and

WHEREAS, Unnecessary ED visits and admissions driven by prior authorization delays contribute to ED crowding, increased health care costs, resource strain, and clinician burnout, ultimately compromising the quality and timeliness of emergency care; and

WHEREAS, Emergency physicians are uniquely positioned to advocate for system reforms that reduce preventable ED visits, improve care coordination, and support timely access to appropriate outpatient services; therefore be it

RESOLVED, That ACEP support federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in emergency department visits or hospitalizations; and be it further

RESOLVED, That ACEP advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

Background

This resolution asks ACEP to advocate for time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings and advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings

Emergency physicians frequently care for patients whose conditions have worsened due to delayed access to diagnostic tests, specialist evaluations, medications, or procedures requiring prior authorization, which disproportionately affect patients with chronic illnesses, cancer, mental health conditions, and social vulnerabilities.

Prior authorization is a form of utilization management that requires physicians and other providers to obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage. Through Prudent Layperson (PLP) laws have largely eliminated the issue of prior authorization for emergency services, emergency medicine is not immune from the negative effects of overly restrictive prior authorization requirements. Patients are often unable to receive services in other care locations because of prior authorization denials and delays are forced to come to the ED specifically to receive those services. In the 2024 American Medical Association Prior Authorization Physician Survey, 93 percent of physicians surveyed responded that prior authorization sometimes, often, or always results in care delays.

Prior authorization is frequently utilized by Medicare Advantage Organizations (MAOs), but unfortunately, it delays necessary care, instead of preventing unnecessary care. According to the Kaiser Family Foundation, there were 35 million Medicare Advantage (MA) prior authorization requests in 2021. Over two million prior authorization requests were fully or partially denied by MA plans, and 11 percent of those denials were appealed. The vast majority (82 percent) of appeals resulted in fully or partially overturning the initial prior authorization denial. Since MAOs are not required to indicate the reason a denial was issued in the reporting to CMS, it is unclear why claims are being denied. The fact that the majority of prior authorization appeals are fully or partially overturned gives credence to the argument that prior authorization is simply a delay tactic.

Prior authorization also contributes to ED boarding. In a March 2022 American Hospital Association (AHA) letter to the Centers for Medicare & Medicaid Services (CMS), the AHA stated that the use of prior authorization among MA plans is "especially problematic when general acute-care hospital beds have been filled to capacity and while healthcare providers contend with the demands of vaccine distribution and workforce shortages," and "The absence of prior authorization waivers also resulted in unintended consequences for patients who were then forced to stay in acute care settings unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care."

ACEP's Prior Authorization Policy Statement maintains that prior authorization rules instituted by third party payers must not pose a barrier to patients seeking access to timely emergency care, and that an insured patient should be granted the expectation of coverage when seeking emergency care. ACEP further asserts that insurance companies have an obligation to pay for necessary evaluation, stabilizing treatments, and/or appropriate consultation, admission, or transfer.

ACEP's legislative and regulatory priorities include:

- Oppose efforts by insurers to create unnecessary barriers to care, including through use of prior authorization, etc.
- Monitor regulatory changes in Medicare that promote Medicare Advantage and potential increased patient burdens via prior authorization requirements, narrow networks, increased cost-sharing, step therapy, and others.

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 professional.

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 resources for current advocacy initiatives.

Prior Council Action

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 38(19) Standards for Insurance Denials adopted. Directed ACEP to work with legislators to enact legislation that makes it illegal for a payor to engage in automatic denials; allow a physician who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial; patients have the legal right under EMTALA to seek emergency care and that their claims are not denied by payors; and work towards getting an affirmation in writing from payors that they will adopt this as policy.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Amended Resolution 25(87) Prior Authorization Requirements adopted. Directed ACEP to recognize the concept of prior authorization imposes barriers to patient care, reaffirm the principles that patients should receive prompt emergency care regardless of payment source or ability to pay, patient who requests emergency medical care establishes a relationship with the physician, and develop strategies to address the ramifications of prior authorization.

Prior Board Action

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005; revised and approved June 1999 titled "Compensation When Services Are Mandated;" originally approved September 1992.

June 2023, approved the revised policy statement "Prior Authorization;" revised and approved April 2017, April 2010, February 2003; originally approved October 1998.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 38(19) Standards for Insurance Denials adopted.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.
Resolution 43(97) Prudent Layperson Legislation adopted.

Amended Resolution 25(87) Prior Authorization Requirements adopted.

Background Information Prepared by: Jessica Adams
Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 54(25)

SUBMITTED BY: Nevada Chapter

SUBJECT: Reassessment and Potential Restructuring of the HCAHPS Survey and Its Role in Medicare Reimbursement

PURPOSE: Study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to develop recommendations that focus on patient-centered care, physician autonomy, and sustainable health system payment.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and would require a minimum of unbudgeted costs of $30,000 including for staff time, $15,000 for outside consultants (e.g. statistician, survey developer), and $5,000 for development, formatting, and distribution of findings.

WHEREAS, The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey has been a core component of Medicare's Value-Based Purchasing (VBP) program since 2007, influencing up to 25% of a hospital's performance-based reimbursement[1]; and

WHEREAS, The original intent of HCAHPS was to promote patient-centered care through standardized measurement of patient experience, but its integration into payment systems has led to unintended consequences, including administrative burden and potential manipulation or gaming of survey results[2]; and

WHEREAS, The survey includes controversial components, such as questions related to pain management, which have been criticized by the American Medical Association for potentially encouraging opioid overprescription and undermining appropriate clinical judgment[3]; and

WHEREAS, Response rates to the HCAHPS survey have declined over time, and the current design may disadvantage patients with low health literacy and hospitals serving vulnerable populations, potentially exacerbating health disparities[4]; and

WHEREAS, International models of patient experience measurement, such as those used in the United Kingdom and Canada, prioritize quality improvement and public accountability without direct financial penalties or rewards, offering potential lessons for U.S. policy[5]; and

WHEREAS, Proposed cuts to Medicaid will likely lead to hospital closures in rural and underserved areas, which are also the hospitals that are likely to benefit from restructuring of the HCAHPS survey[6]; and

WHEREAS, ACEP has an interest in promoting evidence-based performance measures that do not inadvertently compromise clinical care; therefore be it

RESOLVED, That ACEP study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and specifically its linkage to Medicare reimbursement, with the aim of developing recommendations that better balance the goals of patient-centered care, physician autonomy, and sustainable health system payment.

References

[1] https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey#:~:text=CMS%20implemented%20the%20HCAHPS%20survey,results%20occurred%20in%2 0March%202008.
[2] https://www.who.int/health-topics/integrated-people-centered-care#tab=tab_1

[3]https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/patient-satisfaction-surveys-need-better-address-pain
[4]https://pmc.ncbi.nlm.nih.gov/articles/PMC8478166/#:~:text=Perhaps%20a%20larger%20problem%20with,HCAHPS%20responses%20rates%20after%20TKA.
[5]https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly#:~:text=Goal:%20To%20compare%20the%20performance,children%20and%20working%2Dage%20adults
[6]https://sph.umich.edu/news/2025posts/what-proposed-medicaid-cuts-could-mean-for-rural-communities-hospital-access.html

Background

This resolution asks ACEP to develop a study and offer recommendations for a replacement or restructuring of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

The HCAHPS Survey is a national, standardized, publicly-reported survey of patients' perspectives of hospital care. The 32-item instrument and data collection methodology allow valid comparisons to be made across hospitals. The original survey was nationally implemented in 2006, and public reporting of hospital scores began in 2008. Since 2012, HCAHPS scores have also played a role in hospital payment through the Hospital Value-Based Purchasing (VBP) program.

Beginning January 1, 2025, CMS made several changes to survey administration and content. The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address: 22 questions that ask how often or whether patients experienced a critical aspect of hospital care, 3 screener items that direct patients to relevant questions, and 7 questions to adjust for the mix of patients across hospitals or support Congressionally-mandated reports. Hospitals are permitted to add up to 12 supplemental items; CMS does not review, approve, or receive data from supplemental items. Of note, the updated HCAHPS does not include items related to pain management. It is unlikely that CMS will modify or replace the current HCAHPS in the near future as they very recently revamped the survey and its administration.

In 2012, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. ACEP members were appointed to the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. CMS has decided not to make the ED CAHPS survey mandatory; however, it allows EDs to collect information about their patients' experience of care and identify aspects of care that could be improved. ACEP could work with CMS to utilize the ED CAHPS as a replacement for the HCAHPS in the ED setting.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort and would require a minimum of unbudgeted costs of $30,000 including for staff time, $15,000 for outside consultants (e.g. statistician, survey developer), and $5,000 for development, formatting, and distribution of findings.

Prior Council Action

Resolution 55(24) Patient Experience Reporting not adopted. Directed the College to work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and revise ACEP's "Patient Experience of Care" policy statement to advocate for mean score rather than percentile scores.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted. Directed ACEP to advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy; define standardized inclusion and exclusion criteria for patient experience survey populations; 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 advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores referred to the Board. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non-cancer pain from patient satisfaction surveys; oppose new core measures relating to chronic pain management in the ED; continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and bring patient satisfaction scores and pain management to the AMA for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

January 2025, March 2024, February 2023, and January 2022, approved legislative and regulatory priorities that include advocating for patient experience validity and working with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted.

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016 with the current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Erin Grossmann
Regulatory and External Affairs Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 55(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Reduce Non-Beneficial Regulation by The Joint Commission and other Health Care Regulatory Bodies

PURPOSE: Identify The Joint Commission's and other health care regulatory bodies' mandates and standards that do not improve patient care in the ED setting and advocate for the elimination or modification of such requirements.

FISCAL IMPACT: Budgeted staff resources for ongoing communications with TJC and other regulatory bodies. Potential unbudgeted travel costs of $3,000-5,000 for each in-person meeting with TJC and/or CMS, NQF, or other regulatory bodies. Potential unknown and unbudgeted costs for longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

WHEREAS, The Joint Commission (TJC) is a major accrediting body for hospitals and health care facilities, with its standards intended to improve patient safety, quality of care, and operational efficiency; and

WHEREAS, Regulatory compliance is essential to maintaining high standards of care, but excessive and unnecessary regulations can divert valuable time and resources away from direct patient care; and

WHEREAS, Emergency departments (EDs) face significant operational challenges, including overcrowding, increasing patient volumes, and staff shortages, all of which are exacerbated by excessive regulatory burdens; and

WHEREAS, Many emergency physicians report that compliance with non-beneficial accreditation requirements increases administrative workload, contributes to burnout, and reduces the time available for patient care; and

WHEREAS, Certain TJC standards have been criticized for being overly prescriptive or redundant with existing federal and state regulations, leading to unnecessary duplication of efforts; and

WHEREAS, Studies have shown that administrative burden is a leading cause of physician dissatisfaction and contributes to physician burnout, which is linked to decreased quality of care, increased medical errors, and physician workforce attrition; and

WHEREAS, Some TJC documentation and process requirements do not have strong evidence linking them to improved patient outcomes, yet failure to comply with these mandates can still result in citations or financial penalties; and

WHEREAS, Emergency departments, due to their fast-paced and unpredictable nature, require regulatory flexibility to adapt to emergent situations, and overly rigid standards can interfere with real-time clinical decision-making; and

WHEREAS, Through ACEP's advocacy efforts, emergency departments are now permitted to allow beverages with lids and food to be consumed within the department, promoting a more flexible and supportive work environment for health care staff while maintaining patient safety and infection control standards; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) and other regulatory bodies have recognized the need to reduce administrative burdens in health care and have implemented measures to streamline requirements in various areas; and

WHEREAS, Collaborative efforts between medical organizations and accrediting bodies have successfully led to the revision or removal of overly burdensome requirements in the past, demonstrating the potential impact of physician-led advocacy; and

WHEREAS, ACEP, as the leading organization representing emergency physicians, is uniquely positioned to advocate for the elimination of non-beneficial accreditation requirements (e.g., sedation documentation, pain assessments, etc.) that do not improve patient outcomes but increase administrative burden; therefore be it

RESOLVED, That ACEP conduct a comprehensive review of The Joint Commission and other health care regulatory bodies' regulatory requirements to identify mandates and interpretations of standards that do not demonstrably improve patient care in the emergency department setting; and be it further

RESOLVED, That ACEP collaborate with The Joint Commission and other health care regulatory bodies to advocate for the elimination or modification of such non-beneficial requirements, aiming to streamline processes, reduce administrative burdens on emergency physicians, and allow more time for direct patient care.

Background

This resolution requests the College to review existing mandates and standards promulgated by the Joint Commission (TJC) and other regulatory bodies that do not improve patient care in the emergency department setting and advocate for the elimination of such standards.

The resolution does not reference specific mandates and standards to advocate for appeal and asks for a comprehensive review of all standards. The resolution also does not delineate or define how something "demonstrably improve[s] patient care," which could necessitate longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

Independently, TJC is making efforts to reduce complexities and streamline and simplify requirements. TJC announced on June 30, 2025, significant updates to its standards used by hospitals and critical access hospitals to guide compliance with accreditation requirements and the Centers for Medicare & Medicaid Services' (CMS) Conditions of Participation. This new accreditation process includes an updated Accreditation Manual that more clearly identifies CMS-directed Conditions of Participation, while the remaining requirements and National Patient Safety Goals are being merged into Joint Commission National Performance Goals (NPGs). This includes a reduction of 713 requirements from the hospital accreditation program.

Reducing administrative burden and advocating for the modification or elimination of detrimental policies is at the forefront of the College's regulatory affairs agenda. In May 2025, ACEP responded to a Request for Information (RFI) on deregulation issued by the White House Office of Management and Budget, where we suggested potential repeal or modification of several redundant, clinically inconsistent, or overly burdensome federal regulations including prescription drug monitoring program (PDMP) checking requirement reform, repeal of onerous methadone prescribing regulations, deregulation of the 21st Century Cures Act, removal of barriers to adding codes to the Medicare Telehealth Services List, deregulation of the acute hospital-at-home program requirements, and the repeal of the SEP-1 measure. ACEP again responded in June 2025 to a deregulatory RFI specific to Medicare regulations issued by CMS. ACEP's comments were reiterated in the RFI related to Medicare requirements and also advocated for the modification of critical care time reporting policies, streamlining of Medicare signature requirements, and deregulation of overly complex Merit-based Incentive Payment Systems (MIPS) requirements for qualified clinical data registries.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing communications with TJC and other regulatory bodies. Potential unbudgeted travel costs of $3,000-5,000 for each in-person meeting with TJC and/or CMS, NQF, or other regulatory bodies. Potential unknown and unbudgeted costs for longitudinal studies of all requirements promulgated by TJC and other regulatory bodies and accrediting organizations.

Prior Council Action

Resolution 54 (23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted. Directed ACEP to discuss with TJC ACEP's opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Resolution 33(20) Metrics, Measures, and Pay-for-Performance Programs not adopted. Directed the College to seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements to alleviate administrative burden.

Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards referred to the Board. Called for ACEP to collaborate and build coalitions with non-medical organizations involved in developing quality standards and engage with regulatory entities such as CMS, Joint Commission, and the National Quality Forum.

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Prior Board Action

Resolution 54(23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions adopted.

Amended Resolution 43(15) Required CME Burden adopted.

Background Information Prepared by: Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 56(25)

SUBMITTED BY: Michigan College of Emergency Physicians
New Mexico Chapter

SUBJECT: Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions

PURPOSE: 1) Advocate for state and federal legislation requiring AI-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel; 2) support prohibiting health insurers from relying solely on AI-based algorithms to deny, delay, or modify health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; 3) collaborating with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that AI algorithms used in health care decision-making are transparent, accountable, and subject to oversight.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

WHEREAS, Artificial intelligence (AI) is increasingly utilized by health insurers to automate reimbursement and coverage decisions, including down-coding and prior authorization processes; and

WHEREAS, The use of AI in these contexts can lead to insurers reducing reimbursement rates through the automation of decision-making processes; and

WHEREAS, Companies such as Cotiviti are employed by insurers to implement AI-driven systems for claims processing, often without disclosing the underlying algorithms to health care entities, thereby limiting transparency and understanding of decision-making criteria; and

WHEREAS, The lack of transparency and potential biases in AI algorithms may result in inappropriate down-coding, claim denials, and delays in patient care, adversely affecting both patients and physicians; and

WHEREAS, Multiple states have recognized the risk associated with AI-driven insurer decision-making and have introduced legislation to regulate its use, including:

- Georgia (HB 887, 2023-4), which aimed to prohibit the use of AI in making certain insurance coverage decisions without human oversight; and
- Arizona (HB 2175, 2025-6), which ensures that AI-driven claim denials are subject to human review by licensed medical professionals; and
- Texas (SB 815, 2025-6), which would prohibit the use of AI-based algorithms as the sole basis of utilization review decisions in health care; and
- Florida (SB 794, 2025-6), which would have mandated that claim denials be reviewed by a qualified human professional and prohibited insurer use of AI as the sole basis for denying or adjusting claims; and
- Michigan (HB 4536 and 4537, 2025-6), which would prohibit health insurers and contracted health plans from denying, modifying, or delaying a claim based on a review using artificial intelligence; and

WHEREAS, AI-driven reimbursement and coverage decisions present significant concerns for patient care and physician autonomy, which may lead to delays, denials, and adverse outcomes for patients due to improper or unchecked AI interventions; therefore be it

RESOLVED, That ACEP advocate for legislation at the state and federal levels requiring that artificial intelligence-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel; and be it further

RESOLVED, That ACEP support prohibiting health insurers from relying solely on artificial intelligence-based algorithms to deny, delay, or modify health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

Background

This resolution asks ACEP to advocate for state and federal legislation that will require artificial intelligence-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel by collaborating with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making are transparent, accountable, and subject to oversight.

In recent years, health insurers have turned to AI decision-making tools to make prior authorization determinations with little or no human review. In October 2024, the U.S Senate Permanent Subcommittee on Investigations issued its report, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* which concluded that:

> "The data obtained so far is troubling regardless of whether the decisions reflected in the data were the result of predictive technology or human discretion. It suggests Medicare Advantage insurers are intentionally targeting a costly but critical area of medicine—substituting judgment about medical necessity with a calculation about financial gain."

The version of the 2025 reconciliation bill, also known as the "One Big Beautiful Bill Act," that the U.S. House of Representatives passed on May 22, 2025, initially included language that prohibited states from enforcing any law or regulation governing artificial intelligence (AI) models, systems, or automated decisions systems for a 10-year period. The U.S. Senate removed this language, and the Senate version of the bill was passed on July 3, 2025, leaving AI regulation to the states.

According to the National Conference of State Legislatures, as of 2025 all 50 states, Puerto Rico, the Virgin Islands, and Washington, DC, have introduced legislation to regulate AI. Significant state AI legislation will go into effect in 2026, including:

- California's Artificial Intelligence Training Data Transparency Title 15.2 - Mandates comprehensive transparency of AI training datasets.
- Colorado Consumer Protections for Artificial Intelligence Bill – Allows a consumer to appeal, via human review if technically feasible, an adverse consequential decision from the deployment of a high-risk AI system.
- Texas Responsible AI Governance Act – Provides certain consumer protections, enforcement processes, and created the Artificial Intelligence Council to support innovation and compliance.

ACEP appointed an AI Task Force in June 2024 to determine the current landscape of utilization of AI in emergency medicine practice, to include an assessment of prevalence, practice type, and purpose as well as other objectives to help prepare emergency physicians and their teams for the provision of care using AI. The task force scope of work has evolved and a new Artificial Intelligence Committee will begin its work in September 2025 with the following objectives:

1. Identify relevant opportunities and risks in the application of artificial intelligence in the education and training of emergency medicine for emergency physicians at all career stages. Provide a report to the Board of Directors summarizing these findings.
2. Identify relevant opportunities and risks in the application of artificial intelligence in the practice of emergency medicine for emergency physicians. This scope of work should include activities directly related to clinical practice, including documentation of care, diagnostic testing and evaluation and quality

improvement. Provide a report to the Board of Directors summarizing these findings. The report should advocate for responsible and physician-centric integration of artificial intelligence in emergency care and should support a "human-in-the-loop" model that ensures AI augments rather than replaces physician judgement.

3. Identify relevant opportunities and risks in the application of artificial intelligence in the practice of emergency medicine for emergency physicians related to the operational and administrative practice of emergency medicine including revenue cycle management and risk management. Provide a report to the Board of Directors summarizing these findings including best practices such as safeguards and protective measures for health care professionals who choose to use AI.
4. Identify relevant opportunities and risks in the application of artificial intelligence in the operations and management of the College including identification of opportunities to improve communication with members and other member-facing operations. Provide a report to the Board of Directors summarizing these findings.

Additionally, ACEP is hosting an AI Summit October 21-22, 2025, and will bring together representatives from all major emergency medicine organizations to explore and align on the role of AI in emergency medicine. The summit will focus on three key areas:

- Education – Discussing approaches to the use of AI in the education of emergency physicians across the career spectrum, including AI in formal medical education, research, and publishing.
- Clinical Care – Establishing consensus on how AI should be used in emergency care delivery, including appropriate applications and necessary safeguards.
- Practice Administration / EM Group Management – Identifying the use of AI in administrative and business aspects such as quality improvement, documentation/coding, revenue cycle management, risk management, and more.

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 professional.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

Prior Council Action

The Council has discussed and adopted many resolutions pertaining to reimbursement and coverage decisions, although none that are specific to regulating artificial intelligence in health insurance reimbursement and coverage decisions.

Resolution 42(19) Augmented Intelligence in Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to convene an Emergency Medicine Augmented Intelligence (EMAI) Summit and/or a task force to produce an information paper on the issues and concerns surrounding augmented intelligence and make recommendations for the College. Advised the Board of Directors to consider updating the College's Strategic Plan to include augmented intelligence and be include a presentation/session on augmented intelligence in emergency medicine at LAC20 or ACEP20.

Prior Board Action

January 2025, approved the revised policy statement "Medical Services Coding;" revised and approved January 2019;

reaffirmed June 2013; revised and approved April 2006 with the current title; reaffirmed June 1999; originally approved September 1986 titled "Coding Reform."

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, and June 2007 with current title; revised and approved July 2000, January 1999, and March 1993 titled "Managed Health Care Organizations and Emergency Care;"" originally approved September 1987 titled "Managed Health Care Plans and Emergency Care."

July 2019, hosted the "HIT SUMMIT: *Evolving Emergency Care with Technology*" in Dallas, TX, attended by 100 participants from a broad spectrum of Health Information Technology stakeholders, with a breakout session dedicated to Artificial (Augmented) Intelligence (AI) and Clinical Decision Support. The event proceedings resulted in a comprehensive Vision Paper, including a section on AI with seven related detailed recommendations.

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

April 2014, revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted. A report was distributed at the 2001 Leadership/ Legislative Issues Conference.

Background Information Prepared by: Jessica Adams
Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 57(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Repeal Certificate of Need Laws to Expand Access and Improve Patient Care

PURPOSE: Advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist, develop a toolkit to support legislative action aimed at eliminating these laws, and collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of CON laws.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

WHEREAS, Certificate of Need (CON) laws were originally enacted in the 1970s to control health care costs, manage the supply of health care resources, and ensure access to care; and

WHEREAS, CON laws often result in limited health care access, especially in underserved and rural areas, by restricting the ability of health care providers to expand services or facilities based on demand; and

WHEREAS, CON laws create artificial barriers to entry for new health care providers, limiting competition and preventing the development of essential services, such as diagnostic equipment and inpatient beds, which could reduce wait times and improve patient access to care; and

WHEREAS, CON laws contribute to inefficiencies in health care delivery, including overcrowding and longer wait times in emergency departments (EDs), as well as delays in patient care due to a lack of available inpatient beds; and

WHEREAS, The repeal of CON laws can foster competition among health care providers, encouraging innovation, improving efficiency, and expanding patient access to high-quality care; and

WHEREAS, Many states that have reformed or eliminated CON laws have experienced improvements in health care access, competition, and lower health care costs, without compromising the quality of care; and

WHEREAS, ACEP recognizes the critical role that timely access to diagnostic services and inpatient beds plays in improving emergency care outcomes, including reducing patient morbidity and mortality; and

WHEREAS, ACEP advocates for a health care system that promotes timely access to care, reduces regulatory burdens that impede effective care delivery, and ensures that patients receive the appropriate services when needed; therefore be it

RESOLVED, That ACEP advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist and develop a toolkit to support legislative action aimed at eliminating these laws, including evidence-based arguments and strategies for engaging policymakers; and be it further

RESOLVED, That ACEP collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of Certificate of Need (CON) laws on patient access to emergency care, including overcrowding, boarding, and limited capacity, and advocate for the removal of these regulatory barriers to improve patient flow and health care access.

Background

This resolution calls ACEP to advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist, and develop a toolkit to support legislative action aimed at eliminating these laws, and to collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of CON laws.

Certificate of need, or CON, laws require a health agency or entity to approve the creation of a new health facility, or the expansion of an existing facility. The goal of CON laws are to control health care costs by restricting duplicative services.[1] As of January 2025, 35 states and Washington, DC have CON programs/laws.

ACEP's Physicians' Guide to State Legislation, Fourth Edition, most recently updated in 2012, states, "Traditionally, the health-related activities of state and local government are public health, including health monitoring, sanitation, and disease control; the financing and delivery of health services, including Medicaid, mental health, and direct delivery through public hospitals and health departments; environmental protection, including protection against manmade environmental and occupational hazards; and the regulation of the providers of medical care, through certificate-of-need, state rate-setting, and licensing functions."

ACEP's Freestanding Emergency Centers (FEC) Section has had previous discussions regarding certificate of need designation.

A 2020 empirical investigation on emergency departments found that CON programs "have a statistically significant impact on increasing the median wait time for medical examination, pain medication administration, hospital admittance, and hospital discharge."[2]

A 2007-2009 national study found that Emergency Departments in CON states have reduced length of stays. The study also found that stringency surrounding equipment expenditure lessens the positive impacts CON laws have on ED length of stay[3].

Background References

1. National Conference of State Legislatures. (2025, April 29). Certificate of Need State Laws. https://www.ncsl.org/health/certificate-of-need-state-laws
2. Myers, M. S., & Sheehan, K. M. (2020). The impact of certificate of need laws on emergency department wait times. *Journal of Private Enterprise*, *35*(1), 59-75.
3. Paul, J. A., Ni, H., & Bagchi, A. (2014). Effect of certificate of need law on emergency department length of stay. *The Journal of Emergency Medicine*, *47*(4), 453-461.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other advocacy work to support this effort.

Prior Council Action

Amended Resolution 32(24) Preventing Harmful Health Care Deals adopted. Directed ACEP to advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions – including but not limited to sale-leaseback agreements, purchases or sales of health system facilities or real estate, dividend recapitalization, private practice rollups, and changes in majority owner equity stakes – to protect the integrity of health systems and maintain competitive markets.

Prior Board Action

Amended Resolution 32(24) Preventing Harmful Health Care Deals adopted.

Background Information Prepared by: Brianna Hanson, MPH
Reimbursement and State Legislative Manager

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 58(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Nicole E. Exeni McAmis, MD
Gus M. Garmel, MD, FACEP
California Chapter
Colorado Chapter
Montana Chapter
Ohio Chapter

SUBJECT: Role of EDs in Interactions with U.S. Immigration and Customs Enforcement

PURPOSE: 1) Acknowledge ACEP's prior guidance on ICE in the ED and recognize the continuing potential impact of ICE enforcement actions within EDs on patient care and public health. 2) Advocate for development and dissemination of guidelines and training programs for ED staff to manage interactions with ICE officials, ensuring the protection of patient rights and the provision of uncompromised medical care. 3) Support collaboration with legal experts, hospital administrations, and community organizations to establish policies delineating the role of EDs in relation to ICE activities, emphasizing the importance of patient trust, safety, and confidentiality.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Hospitals and emergency departments (EDs) have traditionally been considered places of refuge, providing medical care to all individuals regardless of immigration status; and

WHEREAS, Recent changes in U.S. immigration enforcement policies have led to increased instances of Immigration and Customs Enforcement (ICE) officials entering hospitals to conduct enforcement actions, including the detention of patients[1]; and

WHEREAS, Such enforcement actions within healthcare settings can deter individuals from seeking necessary medical care due to fear of deportation, thereby compromising public health and patient safety[2]; and

WHEREAS, Emergency department personnel may lack clear guidelines on how to respond to ICE presence while upholding patient confidentiality, legal obligations, and institutional policies[3]; and

WHEREAS, The American College of Emergency Physicians (ACEP) has previously issued guidance titled "Navigating Immigration Enforcement in the Emergency Department[4]" which offers a foundational framework for EDs in responding to ICE activities, but many hospitals have yet to adopt or operationalize this guidance into formal policies; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) has developed resources[5,6] to assist health care providers in navigating interactions with ICE, including guidelines and sample institutional policies; therefore be it

RESOLVED, That ACEP acknowledge its prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the emergency department as a valuable foundation, and recognize the continuing potential impact of ICE enforcement actions within emergency departments on patient care and public health; and be it further

RESOLVED, That ACEP advocate for the development and dissemination of clear guidelines and training programs for emergency department staff to manage interactions with U.S. Immigration and Customs Enforcement officials, ensuring the protection of patient rights and the provision of uncompromised medical care; and be it further

RESOLVED, That ACEP support collaboration with legal experts, hospital administrations, and community organizations to establish policies that delineate the role of emergency departments in relation to U.S. Immigration and Customs Enforcement activities, emphasizing the importance of patient trust, safety, and confidentiality.

Resolution References

1. Exeni McAmis N. Responding to ICE in Emergency Departments: Protecting Patients and Navigating Legal Obligations. EM Resident. February 11, 2025.
2. American Civil Liberties Union (ACLU). Know Your Rights: What to Do if ICE Comes to Your Workplace, Home, or Public Space.
3. National Immigration Law Center. Protecting Access to Health Care: Guidelines for Medical Providers. Available at: https://www.nilc.org/health-care-access. Accessed 2/18/25.
4. American College of Emergency Physicians. Navigating Immigration Enforcement in the Emergency Department.
5. Emergency Medicine Residents' Association. Responding to ICE in the Emergency Department [Flyer]. Available at: https://www.emra.org/siteassets/emresident/documents/emra---ice-flyer---2025-final.pdf. Accessed 2/18/25.
6. Emergency Medicine Residents' Association. Managing ICE Interactions in Emergency Departments: Sample Institutional Policy. Available at: https://www.emra.org/siteassets/emresident/images/articles/2025/02-feb/ice---sample-policy.pdf. Accessed 2/18/25. Exeni McAmis N.

Background

This resolution calls for ACEP to: 1) Acknowledge it's prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the ED and recognize the continuing potential impact of ICE enforcement actions within EDs on patient care and public health. 2) Advocate for development and dissemination of guidelines and training programs for ED staff to manage interactions with ICE officials, ensuring the protection of patient rights and the provision of uncompromised medical care. 3) Support collaboration with legal experts, hospital administrations, and community organizations to establish policies delineating the role of EDs in relation to ICE activities, emphasizing the importance of patient trust, safety, and confidentiality

In 2021, the director of ICE issued an internal memo directing ICE officers to generally avoid conducting enforcement activities (such as arrests, interviews, searches, and surveillance) at protected areas, including hospitals, churches, and schools. Housed under the Department of Homeland Security (DHS), ICE is the federal agency responsible for identifying and eliminating border, economic, transportation, and infrastructure security vulnerabilities. On January 20, 2025, this internal ICE policy was rescinded by DHS. Therefore, ICE officers are no longer discouraged from conducting enforcement activities in these areas, and the change has led to increased instances of officials entering hospitals to conduct enforcement actions, including the detention of patients.

As a result, ACEP developed the resource "Navigating Immigration Enforcement in the Emergency Department" detailing what this change means for emergency departments and guidance on what emergency physicians or other ED staff should do if ICE officers present themselves in the ED. ACEP consulted with outside legal experts with a background in hospital-specific issues, as well as other impacted stakeholders, to inform the development of this resource. As the ACEP resource notes, while ICE officers are no longer discouraged from conducting enforcement activities at protected areas including hospitals, how a hospital responds to ICE should be no different today than it was previously. Hospitals should already have policies and procedures in place for interacting with ICE officials as well as sufficient staff training to ensure they are appropriately followed.

ACEP has heard reports of hospitals that either lack such clear policies or guidelines or (to similar effect) have not trained ED and other relevant staff about the policies/guidelines or made them aware of their existence. ACEP's resource encourages emergency physicians to request such guidance from their hospital as well as training for all staff on several specific areas, including:

- How to inform immigration or other law enforcement officers that only the designated authorized staff member(s) is authorized to review a warrant or to consent to their entry into private areas.
- Declining to answer questions agents pose about a patient unless authorized to do so by the designated staff member.
- Avoiding any action that could be interpreted as consent by an officer.
- Being cautious of what is in "public view".

Development of further guidance via collaboration with legal experts, hospital administrations, and community organizations can be useful, although it is complicated by the fact that state and local laws (for example, Florida and

Texas[1] require hospitals to ask patients about their immigration status for aggregate reporting of amounts of uncompensated care provided to undocumented patients) can vary, so national-level guidance must be appropriately caveated and can therefore potentially be limited in level of specificity.

The State Legislative/Regulatory Committee, in collaboration with the Diversity, Equity, & Inclusion Committee (now Access, Belonging, & Community Committee) developed the toolkit "Law Enforcement Presence in the Emergency Department" to assist with navigating encounters with law enforcement personnel beyond ICE.

ACEP's policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department" states:

- No legal or law enforcement process should interfere with patient care in the ED absent immediate safety threats or specific applicable laws.

Background Reference

[1]Potential Impacts of New Requirements in Florida and Texas for Hospitals to Request Patient Immigration Status

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 professional.

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

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted. Directed ACEP to support the research, development, and adoption of best practices regarding law enforcement and security personnel presence in the hospital environment, including but not limited to the ED and collaborate with other interested organizations to create easily accessible transparent toolkits outlining state-specific policies and laws regarding law enforcement presence in the hospital environment, including but not limited to the ED.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Required revisions to the existing policy statement on "Law Enforcement Information Gathering in the Emergency Department" to reflect the recent relevant court decisions regarding consent for searches with or without a warrant to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

Resolution 35(18) ACEP Policy Related to Immigration referred to the Board of Directors. The resolution sought for ACEP to affirm the right for all patients to receive emergency medical care; encourage establishment of policies of non-collaboration between hospital staff and immigration authorities, unless required by warrant; and oppose modifications to U.S. public charge policies, referred.

Resolution 33(17) Immigrant and Non-Citizen Access to Care referred to the Board of Directors. The resolution requested that ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy statement for physicians to access and present to their hospital systems for implementation and make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physician can ensure the policy is communicated in the language most relevant to their patient populations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Directed ACEP to develop a paper addressing the impact of foreign nationals on the American health care safety net and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in U.S. emergency departments.

Prior Board Action

September 2024, reaffirmed the policy statement "Delivery of Care to Undocumented Persons;" revised and approved June 2018; reaffirmed February 2018, April 2012, October 2005, July 2000; originally approved January 1995.

September 2024, approved the policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department."

June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2010; originally approved September 2003.

February 2022, Reviewed the Policy Resource & Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department: Legal and Ethical Background and Practical Approaches."

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted.

June 2019, approved the Medical-Legal Committee's recommendation to take no further action on Resolution 35(18) ACEP Policy Related to Immigration. The committee noted that policies already exist throughout the health care community to protect patient information, unless disclosure is required by law, and creating additional policy specific to providing information to immigration authorities would essentially be superfluous. Further, the committee noted the Fourth Amendment provides patients with a reasonable expectation of privacy and protects against unreasonable search and HIPAA requires patient information to be protected unless by a court order or in special circumstances not relevant to this issue. The U.S. Immigration and Customs Enforcement Agency also has policy stating that hospitals are included in the definition of "sensitive zones" where access by immigration officials is severely limited except in extraordinary circumstances.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

Background Information Prepared by: Laura Wooster, MPH
Associate Exec Director, Advocacy & Practice Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 59(25)

SUBMITTED BY: Michigan College of Emergency Physicians
New Mexico Chapter

SUBJECT: Support Interstate Telemedicine Practice for Physicians with Permanent Licensure

PURPOSE: Advocate for regulatory changes at both federal and state levels to allow physicians with a permanent, unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure; work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's successful telehealth registration system to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

FISCAL IMPACT: Budgeted resources for current advocacy initiatives.

WHEREAS, Current state-based medical licensure requirements create barriers to telemedicine by restricting physicians from providing care across state lines unless they obtain multiple state licenses; and

WHEREAS, Telemedicine has proven to be an effective and efficient way to expand access to emergency and acute care, particularly in underserved and rural areas, and to reduce unnecessary emergency department visits; and

WHEREAS, State licensure barriers prevent patients from accessing timely care from qualified physicians, especially in cases where specialists or emergency physicians could provide critical virtual consultation or ongoing care management; and

WHEREAS, The COVID-19 pandemic demonstrated the necessity and feasibility of interstate telemedicine, with temporary waivers allowing physicians to practice across state lines improving healthcare access and outcomes; and

WHEREAS, The Interstate Medical Licensure Compact (IMLC) was created to streamline the licensure process for physicians across state lines, but remains burdensome to complete, requiring substantial paperwork, time, and effort for physicians; and

WHEREAS, Despite the intent to simplify licensure, the IMLC continues to involve significant costs for both the states and the physicians, undermining its intended purpose of reducing barriers to medical practice across state lines; and

WHEREAS, Many states still face difficulties in efficiently implementing and maintaining the IMLC, resulting in delays and complications for physicians who wish to practice across multiple states; and

WHEREAS, The IMLC has not yet achieved widespread adoption or effectiveness in alleviating the challenges associated with state-by-state medical licensure processes; and

WHEREAS, Unlike the Interstate Medical Licensure Compact, which still imposes significant costs, administrative burdens, and delays, driver's licenses are universally recognized and accepted across state lines without such barriers, serving as a more efficient model for multi-state credentialing; and

WHEREAS, The current system requiring physicians to obtain multiple state licenses is burdensome, costly, and does not improve patient safety, as U.S. physicians undergo standardized medical education, residency training, and board certification processes; and

WHEREAS, Florida has implemented a streamlined telemedicine registration process that allows out-of-state physicians with a permanent license in another state to provide telemedicine services without requiring full licensure in Florida, thus improving access to care while maintaining patient safety and regulatory oversight; and

WHEREAS, The Florida telehealth model has demonstrated that such licensure reforms can increase patient access to care without compromising quality, and similar approaches could be adopted nationwide; and

WHEREAS, The current patchwork of state regulations disproportionately impacts vulnerable populations, including those with mobility limitations, patients in rural or physician shortage areas, and those seeking follow-up care with out-of-state specialists; and

WHEREAS, Allowing physicians with a permanent and unrestricted medical license in one U.S. state to provide telemedicine services nationwide would improve healthcare access while maintaining high standards of care and medical accountability; therefore be it

RESOLVED, That ACEP support and advocate for federal and state legislative efforts to allow physicians with a permanent and unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure; and be it further

RESOLVED, That ACEP work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's successful telehealth registration system; and be it further

RESOLVED, That ACEP advocate for permanent regulatory changes at both federal and state levels to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

Background

This resolution calls for the College to support and advocate at the federal and state levels for legislative to allow physicians with a permanent, unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure, and work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's telehealth registration system to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

The Interstate Medical Licensure Compact is an agreement among participating U.S. states and territories to work together to streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify and enables states to share investigative and disciplinary information. As of July 2025, the Compact includes 40 states, the District of Columbia and the Territory of Guam. Applicants are charged a non-refundable $700 fee when requesting to participate in the Compact and must submit fingerprints to the designated criminal justice agency in their State of Principal License for a criminal background check.

In 2019, Florida passed into law section 456.47, Florida Statutes, which established standards of practice for telehealth services and authorized out-of-state health care practitioners to perform telehealth services for patients in Florida. Out-of-state physicians must register with the Florida Department of Health to perform telehealth services for patients in Florida. Telehealth providers must practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice for in-person health care services to patients in Florida.

ACEP has advocated for both regulatory and legislative changes to advance the use of telehealth in emergency medicine and implement more consistent payment policies. Even before the COVID-19 public health emergency (PHE) began, ACEP sent a letter to the Centers for Medicare & Medicaid Services (CMS) formally requesting that CMS add the five emergency department (ED) evaluation and management (E/M) codes to the list of approved Medicare telehealth services. During the PHE, CMS temporarily added many codes, including all five ED E/M codes, to the list of approved telehealth services and allowed emergency physicians to perform medical screening exams – a component of the Emergency Medical Treatment and Labor Act (EMTALA) – a via telehealth. CMS also used its

unique "1135" waiver authority that only exists during a national emergency to temporarily waive two existing telehealth restrictions in Medicare: the originating site requirement (which mandates that Medicare beneficiaries receive a telehealth service from a certain type of health care facility and not from any location like their home) and the geographic requirement (which restricts telehealth in Medicare to only rural areas). Waiving these requirements during the PHE allows clinicians to perform telehealth services regardless of where they or their patient are located, in both urban and rural areas.

However, CMS does not have the legal authority to permanently waive the originating site and geographic restrictions. Eliminating these telehealth restrictions requires legislation from Congress. ACEP sent a letter calling on Congress to take action immediately. Specifically, ACEP called on Congress to enact S.2741, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. This vital legislation sets the stage for permanent reforms to telehealth that would advance care delivery, improve preparedness and capacity, and improve patient outcomes. In the letter to Congress and in a separate opinion article, ACEP also called on state Medicaid programs and health plans to embrace telehealth with the same enthusiasm as Medicare and align their telehealth policies with Medicare's to ensure consistent regulation, licensure, billing, and coding for emergency telehealth services. Different billing rules and state regulations make reimbursement inconsistent and adds administrative challenges that hinder the sustainability of these new and vital telehealth programs.

ACEP's "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth" states, "Emergency physicians are uniquely qualified to leverage acute care medical decision making via telehealth, unscheduled or scheduled, to provide medical care across the spectrum of conditions and severity." The Guidance also supports national telemedicine licensure framework:

> "ACEP's Emergency Telehealth Section supports a national licensing standard that would allow physicians to practice in all 50 states and all US territories which would ease the burden qualified and willing EPs and NEPs face in order to provide telehealth services. Such a licensing standard would increase access to specialty care and help provide emergency telehealth services from board-certified physicians to residents of rural areas and other underserved communities that currently are unable to receive such services in a timely manner, if at all."

A Telehealth Task Force was appointed in 2021 to define a vision for the impact of telehealth on emergency medicine and identify ACEP resources necessary to position emergency physicians to be the leaders in acute unscheduled telehealth. Substitute Resolution 36(20) Telehealth Free Choice, which was referred to the Board, called on ACEP to address a wide variety of issues in Emergency Telehealth including who should provide emergency care. The Taskforce recommended that ACEP take the position that emergency medicine and board-certified emergency physicians are appropriate and well suited to practice acute unscheduled telehealth, while recognizing that other specialties practice within certain care models (Direct-to-Consumer, remote home monitoring, etc.); and that ACEP advocate that the practice of emergency telehealth is an extension (via an additional modality) of emergency medicine and clinical practice within the scope of a Board-Certified Emergency Physician.

ACEP remains engaged in advancing the use of telehealth in emergency medicine. In accordance with ACEP's policy statement "Emergency Medicine Telehealth," ACEP supports, "the development of interstate medical licenses, which would be offered based on reciprocity among the states. As interstate licenses evolve, ACEP further supports the development of uniform rules governing the practice of medicine, physician discipline, and laws concerning malpractice throughout the United States to provide uniform, safe, and quality urgent and emergent patient care."

The Legislative and Regulatory Priorities for First Session of 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, include the following initiatives regarding telehealth:

- Encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.
- Track private sector, Medicare, and Medicaid coverage of telehealth initiatives.

- Monitor regulations regarding telehealth in which CMS has extended waivers through the end of 2025 through the CY 2025 Physician Fee Schedule.

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 professional.

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 resources for current advocacy initiatives.

Prior Council Action

Resolution 40(24) Telehealth Emergency Physician Standards referred to the Board of Directors. Requested the College to affirm that physicians providing telehealth emergency medicine or urgent care services be board certified or board eligible in emergency medicine.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Amended Resolution 51(19) Stimulating Telemedicine Researchers and Programs adopted. Directed ACEP to advocate for telehealth research in emergency medicine.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

January 2025, approved the Legislative and Regulatory Priorities for First Session of 119th Congress.

September 2022 approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth."

June 2022 reviewed the reimbursement recommendations from the Telehealth Task Force report, and approved the recommendations except for number 4, number 8, and number 12.

January 2022, approved the revised policy statement "Ethical Use of Telehealth in Emergency Care;" originally approved June 2016, titled "Ethical Use of Telehealth in Emergency Care."

January 2022 reviewed the recommendations from the Telehealth Task Force Report and referred the reimbursement recommendation to the Coding & Nomenclature Advisory Committee and the Reimbursement Committee to provide further analysis and submit their recommendations to the Board on appropriate advocacy action regarding telehealth reimbursement.

October 2021 filed the Telehealth Task Force Report and assigned subgroups of the Board to review each of the recommendations contained in the report and provide their analysis to the Board.

April 2021 approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

January 2021 approved the policy statement "Telehealth Inclusion."

May 2020 reviewed the information paper "COVID-19: Rapid Application of Technology for Emergency Department Tele-Triage."

Amended Resolution 52 (19) Telehealth Emergency Physician Inclusion adopted.

Amended Resolution 51 (19) Stimulating Telemedicine Researchers and Programs adopted.

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015 approved the revised policy statement "Definition of Emergency Medicine;" revised April 2008 and April 2001; reaffirmed October 1998; revised April 1994 with current title; originally approved March 1986 as "Definition of Emergency Medicine and the Emergency Physician."

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Background Information Prepared by: Jessica Adams
Reimbursement Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 60(25)

SUBMITTED BY: Minnesota Chapter

SUBJECT: Tele-Emergency Medicine Oversight of Non-Board-Certified/Board-Eligible Emergency Medicine EDs

PURPOSE: 1) Engage with chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report. 2) Provide clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized EDs are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, ACEP believes that all patients who present to emergency department (EDs) should have access to high-quality, patient-centered care delivered by Board Certified/Board Eligible (BC/BE) EM physician-led care teams; and

WHEREAS, ACEP Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments (as amended) was referred to the Board, calling for critical access and rural emergency hospitals to have "a qualified, state-licensed (MD/DO/MBBS) physician be required to be immediately available for on-site and available for care of emergency department patients at all times", regardless of their specialty; and

WHEREAS, Recent advocacy initiatives have led to state legislation mandating on-site and on-duty physician coverage at all EDs, regardless of volume, without a requirement of BC/BE status; therefore be it

RESOLVED, That ACEP engage with state chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report; and be it further

RESOLVED, That ACEP provide clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized emergency departments are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

Background

The resolution calls for ACEP to engage with state chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report. Additionally, the resolution seeks clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized emergency departments are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency medicine physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments, as adopted by the Council and the Board of Directors:

> RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further
>
> RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

The resolution was assigned as an objective to the State Legislative/Regulatory Committee (SLRC) to "Monitor legislative and regulatory efforts by nurse practitioners and physician assistants to expand their scope of practice in emergency medicine in a way that is inconsistent with ACEP policy and develop resources to assist state chapter advocacy on this issue." The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation (HOUSE BILL No. 1199) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider.

The second resolved of Amended Resolution 42(23) was assigned to ACEP's communications staff to include in ongoing communications regarding ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." The policy statement was most recently revised in October 2024, in response to other resolutions submitted to the 2024 Council seeking revisions to the policy statement. The policy states:

> "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."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. 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."

The ACEP Rural Emergency Care Task Force 2020 Report made several recommendations to address the needs of ACEP's rural members, including the development of a model for onboarding for physician assistants (PAs) and nurse practitioners (NPs) practicing without emergency medicine (EM) board-certified emergency physician presence in rural EDs, to include EM specific knowledge and procedural skills training, and to facilitate the use of telemedicine in rural sites to enable supervision by EM board-certified physicians for initial onboarding supervision of PAs and NPs, as well as ongoing telemedicine availability.

ACEP has consistently advocated for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy & Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services (CMS) as well as Health and Human Services and the U.S. Congress.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "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."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP's current "Emergency Medicine Telehealth" policy statement addresses this with respect to supervision requirements for nurse practitioners (NPs) and physician assistants (PAs):

> "Physician assistants (PAs) and nurse practitioners (NPs) can serve an integral role as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. With the aim of ensuring that all patients seeking telehealth services receive high quality care, the American College of Emergency Physicians (ACEP) endorses the utilization of PAs and/or NPs who are supervised by an American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine (ABEM/AOBEM) board-certified or board-eligible emergency physician according to ACEP guidelines."

ACEP's policy statement "Rural Emergency Medical Care" states:

> "As rural emergency departments (EDs) provide a safety net for some of the country's most vulnerable and underserved communities, the American College of Emergency Physicians (ACEP) believes that all emergency care should be provided, directed, and/or supervised by a board-certified/board-eligible (BC/BE) emergency physician."

These principles are also widely affirmed throughout other ACEP policy statements, such as "Role of the Emergency Physician in the Care of Trauma Patients," which states that "…patients presenting for care in an emergency department are best served by receiving care from board-eligible or board-certified emergency physicians…"

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 professional.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 40(24) Telehealth Emergency Physician Standards referred to the Board of Directors. The resolution sought to affirm that physicians providing telehealth emergency medicine or urgent care services be board-certified or board-eligible.

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board of Directors. The resolution sought to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified,

state-licensed (MD/DO/MBBS) physician be required to be on-site and available for care of emergency department patients at all times.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an ED is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to 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.

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.

Substitute Resolution 36(20) Telehealth referred to the Board of Directors. Called for ACEP to support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, and cost; that ACEP, in collaboration with other medical organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and, oppose restrictions to tele-health care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

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 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 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

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and 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."

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

September 2022, approved the revised policy statement "Emergency Medicine Telehealth;" revised and approved February 2020 with the current title; originally approved January 2016 titled "Emergency Medicine Telehealth."

June 2022, approved the revise policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

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, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

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 the policy statement "Role of the Emergency Physician in the Care of Trauma Patients."

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: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2025 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 61-80

Angela P. Cornelius, MD, FACEP (TX) – Chair
Greg Gafni-Pappas, DO, FACEP (MI)
Puneet Gupta, MD, FACEP (CA)
Amanda Irish, MD, MPH, MS (IA)
Jeffrey F. Linzer, MD, FACEP (GA)
Aaron Snyder, MD (NM)

Travis Schulz, MLS, AHIP
George Solomon, MHS, FP-C, CCP-C, TP-C

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 61(25)

SUBMITTED BY: Juliana Chang, MD
Gayle Galletta, MD, FACEP
Hillary Irons, MD, FACEP
Emily Sbiroli, MD, FACEP
Tushara Surapanemi, MD
Massachusetts College of Emergency Physicians

SUBJECT: Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers

PURPOSE: 1) Acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; 2) encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes; the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and 3) support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, Climate change has been recognized by leading health organizations as a public health emergency, with the United States healthcare sector contributing approximately 8.5% of domestic greenhouse gas (GHG) emissions; and one quarter of global health care GHG emissions[1]; and

WHEREAS, Metered-dose inhalers (MDIs), commonly used in emergency medicine for acute asthma and chronic obstructive pulmonary disease (COPD), contain hydrofluoroalkane (HFA) propellants, which are potent hydrofluorocarbon (HFC) greenhouse gases with global warming potentials (GWPs) thousands of times that of carbon dioxide[2]; and

WHEREAS, There are varying canister weights of MDIs on the market – each containing an equivalent amount of medication but varying amounts of HFA propellant – resulting in significantly different environmental impacts[3]; and

WHEREAS, Dry powder inhalers (DPIs) are a clinically effective alternative to MDIs for many patients and are associated with significantly lower carbon footprints because DPIs do not use propellants, making them a more environmentally sustainable treatment option;[4,5]; and

WHEREAS, MDIs are often disposed of in general waste streams despite containing recyclable materials such as aluminum and residual HFA propellants that can only be deactivated by incineration[6]; and

WHEREAS, Education of emergency physicians, allied health professionals, pharmacists, and patients regarding environmentally sustainable prescribing practices, inhaler choice, and proper disposal methods can reduce environmental harm without compromising patient care; and

WHEREAS, Other nations such as the United Kingdom have taken substantial steps to reduce the environmental impact of healthcare delivery, including the establishment of the *Greener NHS* initiative and the

GreenED (Green Emergency Departments) program, a model for environmental sustainability in emergency medicine,[7,8]; therefore be it

RESOLVED, That ACEP acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; and be it further

RESOLVED, That ACEP encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding:

- the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes;
- the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and
- proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and be it further

RESOLVED, That ACEP support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

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2. Woodcock A, Beeh KM, Sagara H, Aumônier S, Addo-Yobo E, Khan J, Vestbo J, Tope H. The environmental impact of inhaled therapy: making informed treatment choices. *Eur Respir J*. 2022 Jul 21;60(1):2102106. doi: 10.1183/13993003.02106-2021.
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4. British Thoracic Society. *Position Statement on the Environment and Lung Health*. 2020.
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6. Pharmaceutical Services Negotiating Committee (PSNC). *Guidance on the disposal of inhalers*. Available from: https://psnc.org.uk (Accessed May 2025).
7. NHS England. *Delivering a Net Zero National Health Service*. 2020. Available at: [https://www.england.nhs.uk/greenernhs].
8. Royal College of Emergency Medicine Green ED. https://greened.rcem.ac.uk (Accessed May 2025).

Background

This resolution directs ACEP to: 1) acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; 2) encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes; the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and 3) support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

Climate change has been formally recognized as a public health emergency by leading health bodies, and the United States health care sector plays a significant role in this crisis by accounting for approximately 8.5% of national greenhouse gas emissions and nearly 25% of the global healthcare sector's emissions. Notably, Scope 3 emissions, generated by the health care supply chain – including pharmaceuticals, medical devices, and energy usage – comprise over 80% of the sector's carbon footprint. Moreover, these emissions have increased by 6% between 2010 and 2018, underscoring the urgent need for decarbonization efforts. The health care sector's substantial contribution to carbon emissions mandates urgent mitigation, particularly in emergency care where metered-dose inhalers (MDIs) are used routinely. Transitioning toward dry powder inhaler (DPI) use when appropriate, adopting education on inhaler carbon footprints, and implementing sustainable prescribing and disposal practices are critical steps. Coupled with broader commitment from institutions and policymakers, these efforts support climate resilience, public health, and cost-effective care.

In the context of emergency medicine, MDIs are frequently used to manage acute asthma and COPD exacerbations and have significant environmental impact. MDIs utilize hydrofluoroalkane (HFA) propellants, which are potent greenhouse gases with global warming potentials (GWPs) thousands of times greater than CO_2. Even the lowest-emission MDI may produce approximately 10 kg CO_2-equivalent over its lifetime, while the highest emit over 36 kg CO_2-equivalent. By contrast, DPIs, which do not rely on propellants, typically produce only 1.5–6 kg CO_2-equivalent per use. Improper disposal of MDIs further exacerbates environmental harm. Many devices are discarded in general waste, despite containing recyclable materials (e.g., aluminum) and residual HFAs that require incineration for safe deactivation.

Medical professionals can play a pivotal role in mitigating this environmental burden through education and practice transformation. Strategies include selecting DPIs when clinically appropriate, prescribing MDIs with lower environmental impact where necessary, instituting safe disposal and recycling protocols, and engaging colleagues, pharmacists, and patients on sustainable inhaler use. Such measures enable reductions in carbon emissions without compromising patient care.

International analogues offer instructive models. The United Kingdom's Greener NHS and Green Emergency Departments (GreenED) programs have systematically integrated sustainability into healthcare operations. The NHS aims to achieve net-zero emissions by 2045 and has successfully phased out high-GWP anesthetics like desflurane. Many U.S. health systems have followed suit and realizing substantial cost savings and emission reductions by eliminating desflurane and other volatile anesthetics. Collective efforts are also underway in the U.S.: in 2022, more than 650 hospitals and health sector organizations signed the HHS Health Sector Climate Pledge, committing to reduce greenhouse gas emissions by 50% by 2030 and reach net-zero by 2050. Academia, policy groups, and the National Academy of Medicine are collaborating to establish decarbonization metrics, standardized reporting, and scalable solutions for healthcare sustainability.

Currently, in the U.S., dry powder inhalers, particularly brand name products, are more expensive.

The use of MDIs has limited scope within emergency medicine and aligning and supporting efforts led by broader agencies and organization such as the National Academy of Medicine and the American Medical Association would have greater impact on addressing the problem.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

Prior Council Action

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 62(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Promoting Environmental Sustainability and Waste Reduction in the ED

PURPOSE: 1) Support efforts to reduce unnecessary waste and carbon emissions in EDs through education, policy development, and support for sustainable clinical practices. 2) Encourage hospitals and EDs to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate. 3) Develop resources to help emergency physicians and EDs achieve the aim of reducing waste and carbon emissions from the ED.

FISCAL IMPACT: Budgeted committee and staff resources to continue working on a similar resolution from 2024.

WHEREAS, The health care sector contributes approximately 8–10% of greenhouse gas emissions in the United States, with a significant portion attributed to wasteful practices and energy use in hospital and emergency department (ED) settings; and

WHEREAS, EDs generate large volumes of waste, including improperly sorted biohazard and sharps materials, which unnecessarily increase both environmental impact and disposal costs; and

WHEREAS, The use of disposable and single-use medical products – while often clinically necessary – can contribute to excessive resource use when not employed judiciously, and opportunities exist to reduce low-value or unnecessary interventions without compromising patient safety; and

WHEREAS, Board certification through the ABEM or ABOEM ensures that physicians have met rigorous standards of competency and excellence in emergency care; and

WHEREAS, Environmentally sustainable practices such as implementing recycling programs, proper waste segregation, minimizing overuse of disposable supplies, and substituting sterile water or saline with tap water for wound cleaning (when clinically appropriate) have been shown to reduce waste, lower carbon emissions, and save costs; and

WHEREAS, As stewards of both public health and health system resources, emergency physicians are uniquely positioned to lead and model environmental responsibility in acute care settings; therefore be it

RESOLVED, That ACEP support efforts to reduce unnecessary waste and carbon emissions in emergency departments (EDs) through education, policy development, and support for sustainable clinical practices; and be it further

RESOLVED, That ACEP encourage hospitals and emergency departments to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and be it further

RESOLVED, That ACEP develop resources to help emergency physicians and emergency departments achieve the aim of reducing waste and carbon emissions form the emergency department.

Background

This resolution calls for ACEP to support efforts to reduce unnecessary waste and carbon emissions in emergency departments (EDs) through education, policy development, and support for sustainable clinical practices; encourage hospitals and EDs to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and develop resources to help emergency physicians and EDs achieve the aim of reducing waste and carbon emissions from the ED.

The Council and the Board of Directors adopted Amended Resolution 58(24) Reducing Waste in Our Emergency Departments last year. The resolution directed ACEP to encourage and support comprehensive research efforts to facilitate data collection of the measurements of ED waste and energy consumption and work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste. The resolution was assigned to the Public Health Committee for implementation. The committee recently updated the policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" and is working on a policy resource and education paper (PREP) as an adjunct to the updated policy statement. Additionally, the committee is working to develop on a policy statement highlighting the importance to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, biohazard/medical waste, as well as advocating for a transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change.

The U.S. health care sector continues to be a major contributor to environmental degradation through its substantial waste generation, heavy use of single-use devices, pharmaceuticals, and energy-intensive operations. American hospitals produce approximately 29 pounds of waste per bed per day, equating to roughly 5 million tons annually, with the operating rooms alone responsible for 70% of that waste. Health care operations account for 8-8.5% of U.S. greenhouse gas emissions, surpassing many national emitters and resulting in an estimated 655 million metric tons.

Single-use medical devices represent approximately 80% of the sector's carbon footprint, given their entire lifecycle from manufacture to disposal. However, initiatives like reusable textiles and device reprocessing demonstrate substantial environmental and economic benefits. Reusable gowns can reduce energy use by up to 64%, cut greenhouse gas emissions by 66%, and reduce solid waste generation by 84% compared to disposables. Additionally, FDA-regulated reprocessing of single-use devices can divert thousands of pounds from landfills and save hospitals up to $462 million annually across the U.S., while lowering device purchase costs by 60–75%

Adopting broad climate-smart health care practices, such as low-carbon procurement, energy and water efficiency, waste minimization, and climate resilience strategies, can yield significant financial savings. Energy efficiency and renewable energy transitions have already reduced emissions by over 95% in some systems (e.g., Gundersen Health) and saved hundreds of thousands of dollars annually in operating costs. Nationwide, comprehensive sustainability efforts could save health care institutions up to $15 billion over ten years, with up to $5.4 billion saved in five years through waste reduction and operational efficiency measures.

Clinical inefficiencies and waste represent a major economic burden as well and account for 5.4% to 15.7% of U.S. health care spending, or approximately $760 to $935 billion annually, with potential savings of $191 to $282 billion per year if addressed through low-value care reduction and improved coordination. These data underscore the urgent need for the health care sector, including emergency departments, to prioritize sustainable supply chains, waste reduction, decarbonization, and resilience strategies—not only to reduce environmental harm but to improve public health and reduce costs.

In 2022, ACEP joined the Medical Society Consortium on Climate and Health, aligning with 25 state networks and 56 major medical societies (representing over one million health professionals) to advocate for public and policy awareness of climate change as a health threat and promote sustainable health practices.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff and committee resources to continue working on a similar resolution from 2024.

Prior Council Action

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

Background Information Prepared by: Sam Shahid, MD, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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RESOLUTION: 63(25)

SUBMITTED BY: Michael J. Bresler, MD, FACEP
Gus M. Garmel, MD, FACEP
Nicole E. Exeni McAmis, MD
Colorado Chapter
Montana Chapter

SUBJECT: Addressing Bullying in the ED – Role of Emergency Physicians in Identification and Intervention

PURPOSE: 1) Recognize the critical role of emergency physicians in identifying and addressing victims of bullying; 2) advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and 3) support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Bullying is a pervasive issue that affects individuals of all ages, leading to significant physical, psychological, and emotional harm[1]; and

WHEREAS, Victims of bullying often present to emergency departments (EDs) with both acute and chronic physical injuries, as well as mental health concerns including depression, anxiety, and suicidal ideation[2]; and

WHEREAS, Emergency medicine physicians are uniquely positioned to identify victims of bullying due to their role in treating a diverse patient population, including children, adolescents, and adults who may not otherwise seek help[3]; and

WHEREAS, Early identification and intervention by emergency medicine physicians can help mitigate the long-term health consequences of bullying through appropriate screening, counseling, and referrals to mental health and social support services[4]; and

WHEREAS, There is a growing need for increased education and training among emergency medicine providers to recognize the signs of bullying and provide trauma-informed care to affected individuals[5]; therefore be it

RESOLVED, That ACEP recognize the critical role of emergency medicine physicians in identifying and addressing victims of bullying; and be it further

RESOLVED, That ACEP advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and be it further

RESOLVED, That ACEP support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

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7. American Psychological Association. Understanding and Preventing Bullying. Available at: https://www.apa.org/topics/bullying. Accessed 2/18/25.
8. U.S. Department of Education. Protecting Students from Harassment and Bullying. Available at: https://www2.ed.gov/about/offices/list/ocr/letters/colleague-bullying-201010.html. Accessed 2/18/25.

Background

This resolution calls for ACEP to recognize the critical role of emergency medicine physicians in identifying and addressing victims of bullying; advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources and referrals; and support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

Bullying continues to be a significant public health concern in the United States, impacting individuals across a wide range of age groups and social settings. Victims of bullying may suffer from both physical injuries and psychological effects, including anxiety, depression, post-traumatic stress, and, in severe cases, suicidal ideation or self-harm. Emergency physicians could play a vital role in the identification, management, and prevention of the health consequences associated with bullying. Emergency departments often serve as the initial point of contact for individuals experiencing acute physical or emotional distress related to bullying. Emergency physicians may be uniquely positioned to recognize clinical and behavioral signs of victimization, provide timely medical and psychological care, and facilitate referrals to appropriate mental health and social support services. Through interdisciplinary collaboration with schools, behavioral health professionals, and community organizations, emergency medicine can contribute to a broader, coordinated response aimed at early intervention, prevention, and the reduction of bullying-related harm.

ACEPs policy, "Emergency Department Triage" states, "Screening information may be best obtained after the initial prioritization process is complete and should not delay timely access to the medical screening exam and stabilizing treatment." ACEPs policy, "Screening for Disease and Risk Factors in the Emergency Department" and related Policy Resource and Education Paper, "Principles of Screening for Disease and Health Risk Factors in the Emergency Department" state that "screening should rely on evidence-based strategies drawn from the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention, peer-reviewed emergency medicine literature, and other trusted sources." The Screening policy also states that "Screening with inadequate or inappropriate follow-up systems available for the targeted disease or risk factor may lead to unintentional harm."

ACEP's policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies" highlights strategies, resources, and recommendations for improving emergency care delivery for pediatric mental and behavioral health emergencies, including presentations related to bullying.

Additionally, the Pediatric Emergency Medicine Committee has developed multiple resources addressing this topic, including information papers: "Role of Emergency Physicians in Identifying Bullying in the Emergency Department," and "Suicide Contagion in Adolescents: The Role of the Emergency Department".

The Pediatric Emergency Medicine Committee is currently developing a point-of-care tool addressing suicide in the pediatric population, as well as a policy statement on trauma informed care.

The tenets of this resolution have been met by prior and ongoing work.

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 professional.

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

None

Prior Board Action

January 2025, approved the revised policy statement, "Emergency Department Triage;" revised and approved June 2024, June 2023 with the current title, January 2017, and October 2010; originally approved September 2023 titled "Triage Scale Standardization."

January 2022, approved the revised ACEP/AAP/ENA joint policy statement "The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies;" revised and approved September 2018 titled "Pediatric Mental Health Emergencies in the Emergency Department;" reaffirmed April 2012; originally approved April 2006 titled "Pediatric Mental Health Emergencies in the Emergency Medical Services System."

April 2021, approved the policy statement, "Screening for Disease and Risk Factors in the Emergency Department."

April 2021, reviewed the Policy Resource and Education Paper (PREP), "Principles of Screening for Disease and Health Risk Factors in the Emergency Department."

October 2015, reviewed the information paper "Role of Emergency Physicians in Identifying Bullying in the Emergency Department."

February 2019, reviewed the information paper "Suicide Contagion in Adolescents: The Role of the Emergency Department."

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 64(25)

SUBMITTED BY: Juliana Chang, MD, NY ACEP
Gayle Galletta, MD, FACEP, MA ACEP
Hillary Irons, MD, FACEP, MA ACEP
Tushara Surapaneni, MD, CT ACEP
Massachusetts College of Emergency Physicians
New Jersey Chapter

SUBJECT: Endorsement of Electronic Discharge Instructions for Patients with Electronic Medical Records

PURPOSE: Endorse and promote the use of electronic discharge instructions for patients with access to electronic medical records and communication tools, leveraging the widespread adoption of EMRs in hospitals and EDs to transition from paper-based to more efficient and secure electronic processes.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The majority of hospitals and emergency departments in the United States have implemented electronic medical records (EMRs)[1]; and

WHEREAS, The use of printed discharge instructions consumes significant amounts of paper and ink, contributing to environmental waste[2]; and

WHEREAS, Electronic discharge instructions can be securely delivered to patients via patient portals, email, or text message, enabling faster discharge processes and improving ED throughput and operational efficiency[3]; and

WHEREAS, Electronic discharge instructions reduce costs associated with printing materials, maintenance of printers, and staff time spent printing, collating, and distributing physical documents[4]; and

WHEREAS, The manual distribution of paper instructions poses a risk of human error, including the possibility of handing a patient another patient's discharge summary, thereby violating the Health Insurance Portability and Accountability Act (HIPAA)[5]; and

WHEREAS, Electronic delivery mechanisms tied to unique patient identifiers reduce the risk of such privacy breaches and enhance the accuracy and safety of information delivery[6]; therefore be it

RESOLVED, That ACEP endorse the use of electronic discharge instructions for patients with access to electronic medical records and electronic communication capabilities; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt policies and technologies that support the secure, timely, and environmentally responsible electronic delivery of discharge instructions in compliance with HIPAA regulations and best practices.

References

1. Office of the National Coordinator for Health Information Technology. *Non-federal Acute Care Hospital Electronic Health Record Adoption*. HealthIT.gov. 2021. https://www.healthit.gov/data/quickstats/non-federal-acute-care-hospital-ehr-adoption
2. Environmental Paper Network. *State of the Global Paper Industry Report*. 2018. https://environmentalpaper.org
3. Liu, B., et al. *Improving Emergency Department Discharge Process with an EMR-Based Solution*. AMIA Annu Symp Proc. 2019;2019:1138–1147.

4. Kruse, C. S., et al. *The Impact of Electronic Health Records on Healthcare Quality: A Systematic Review and Meta-analysis*. JMIR Med Inform. 2018;6(2):e10234.
5. U.S. Department of Health & Human Services. *Health Information Privacy: HIPAA Violations*. https://www.hhs.gov/hipaa/for-professionals/privacy/index.html
6. Patel, V. & Johnson, C. *Individuals' Access and Use of Patient Portals and Smartphone Health Apps, 2020*. ONC Data Brief, No. 56. The Office of the National Coordinator for Health IT. May 2021.

Background

This resolution asks the College to endorse and encourage the use of electronic discharge instructions for patients who have access to electronic medical records and electronic communication capabilities.

The widespread adoption of electronic medical records (EMRs) in the majority of hospitals and emergency departments across the United States has created an opportunity to transition from traditional paper-based discharge processes to more efficient and secure electronic methods. The current reliance on printed discharge instructions contributes to significant paper and ink consumption, impacting environmental sustainability. In contrast, electronic discharge instructions can be delivered securely through various digital channels, including patient portals, email, or text messages. This electronic delivery facilitates faster discharge processes, which in turn improves emergency department throughput and overall operational efficiency.

A critical advantage of electronic delivery is the reduction of human error inherent in manual distribution, such as the risk of inadvertently providing a patient with another patient's discharge summary, which constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA). Electronic mechanisms, by being tied to unique patient identifiers, significantly reduce the risk of such privacy breaches and enhance the accuracy and safety of information dissemination. Furthermore, electronic discharge instructions offer substantial cost reductions by minimizing expenses associated with printing materials, printer maintenance, and the staff time traditionally allocated to printing, collating, and distributing physical documents.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.
- Identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.
- Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Budgeted committee and staff resources. The primary activities involved would include developing and disseminating advocacy statements, creating communication materials to encourage adoption, and potentially collaborating with relevant committees or sections to provide guidance and best practices.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Dhruv Sharma, MS
Lead Data Scientist

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 65(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter

SUBJECT: Emergency Physicians and Collaborative Practice Agreements

PURPOSE: Develop a policy statement regarding collaborative practice agreements that provides protection for emergency physicians.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement.

WHEREAS, Emergency physicians are frequently required to supervise non-physician practitioners (NPPs) as a condition of employment; and

WHEREAS, Emergency physicians are often excluded from the credentialing, hiring, privileging, or training processes of the nonphysician practitioners they are assigned to supervise; and

WHEREAS, Physicians are sometimes asked to sign blanket authorization forms – occasionally with the names of NPPs left blank – granting their employer, hospital, or contract medical group the authority to enter into collaborative practice agreements (CPAs) on their behalf; and

WHEREAS, Some physicians have discovered that CPAs have been established or maintained under their medical license without their explicit knowledge or consent; and

WHEREAS, In certain cases, CPAs may have been initially authorized but later:

- Automatically renewed for years without the physician's awareness;
- Continued without proper reauthorization;
- Remained in effect even after the physician had changed jobs or had not worked with the NPP in many years; and

WHEREAS, The collaborative relationship defined in a CPA represents a legal and professional obligation designed to ensure patient safety and must not be treated as a mere administrative formality; and

WHEREAS, CPAs can expose physicians to professional and legal liability; therefore be it

RESOLVED, That ACEP develop a policy statement opposing the following practices:

- the establishment of collaborative practice agreements without the specific and informed authorization of the supervising physician;
- the execution of collaborative practice agreements by employers, hospitals, or contract groups on behalf of emergency physicians;
- the imposition of collaborative practice agreements as a mandatory condition of employment for emergency physicians.

Background

This resolution asks that ACEP develop a policy statement regarding collaborative practice agreements that provides protection for emergency physicians by opposing: establishing collaborative practice agreements without the specific and informed authorization of the supervising physician; the execution of collaborative practice agreements by

employers, hospitals, or contract groups on behalf of emergency physicians; and the imposition of collaborative practice agreements as a mandatory condition of employment for emergency physicians.

When physicians work with non-physician practitioners, most states require a practice agreement outlining the relationship. Traditionally, these practice agreements were called supervision agreements, which delineate the scope of practice, level of supervision required, and roles and responsibilities. Some states have shifted from a supervision model to collaborative practice models, allowing for non-physician practitioners to operate with less supervision and oversight. CPAs are more commonly associated with nurse practitioners and in states that have expanded their scope of practice and independence.

Physicians who enter collaborative practice agreements face potential risks including liability for the actions of those they supervise, challenges in maintaining adequate oversight, and legal and compliance issues. These agreements can also lead to increased administrative burden and potential conflicts within the collaborative relationship.

Risks and Concerns for Physicians:

- **Liability Exposure:** Physicians can be held liable for the actions of NPs and PAs working under a CPA, even if they were not directly involved in the specific case. This liability can stem from malpractice claims or board complaints.
- **Maintaining Adequate Oversight:** Providing sufficient oversight and guidance to multiple NPPs can be challenging, especially in busy or complex settings. This is particularly true when collaborating with a large number of NPPs, when the collaborative agreement involves complex cases, or don't build in appropriate oversight processes.
- **Legal and Compliance Issues:** Collaborative practice agreements must comply with state laws and regulations, including scope of practice, prescribing authority, and other requirements. Failure to comply with these regulations can result in legal and financial consequences, especially if the physicians don't have input into the agreements
- **Administrative Burden:** Managing collaborative agreements, including record-keeping, communication, and oversight activities, can add to the administrative workload for physicians.
- **Potential for Conflict:** Disagreements may arise between the physician and the supervisee regarding treatment plans, patient care, or other aspects of the collaborative relationship. This can be especially challenging if the physician does not have clear and defined supervision responsibilities./
- **Difficulty Defending Claims:** If a lawsuit arises, it may be difficult for the physician to defend against claims if they did not have direct involvement in the case or if there are discrepancies in documentation or communication.

The CPAs are often standardized by employers across multiple types of relationships, roles, and types of NPPs. Employed physicians may not have the autonomy to provide input and determine the terms of the CPAs based on the relationship with the NPPs.

ACEP is actively engaged in addressing scope of practice issues to protect physician-led care in emergency medicine by advocating for policies that prioritize emergency physician-led teams at both the state and federal levels. ACEP has developed a toolkit with model state legislation and best practices for scope of practice, while simultaneously fighting against legislation that would expand the scope of non-physician practitioners.

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 professional**.**

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement.

Prior Council Action

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

Amended Resolution 72(21) Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision adopted. The amended resolution directed ACEP to support emergency physicians being fairly compensated to supervise ABEM/AOBEM board certified/eligible physician led teams.

Prior Board Action

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and 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" and 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.

June 2023, approved the policy statement "Fair Compensation to Emergency Physicians to Supervise ABEM/AOBEM Board Certified/Board Eligible Led Teams."

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Amended Resolution 72(21) Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision adopted.

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

April 2020, approved the policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships."

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 66(25)

SUBMITTED BY: Sean Vanlandingham, MD, MBA, FACEP
Alabama Chapter

SUBJECT: Endorsing a Realistic Door-to-Doctor Standard

PURPOSE: Endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability and oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Timely care is a core principle of emergency medicine, and a door-to-doctor benchmark has historically helped balance patient flow, staffing, and safety; and

WHEREAS, Until recently the long-standing industry standard for door-to-doctor time had been 30 minutes, providing a realistic target that accounted for variability in patient volume and workforce limitations; and

WHEREAS, Some health systems and staffing companies are now enforcing artificially aggressive door-to-doctor targets while neglecting to strengthen the core staffing, systems, and processes that enable safe emergency care; and

WHEREAS, These reduced targets often serve financial incentives (e.g., to ensure patients are billed) rather than improving patient outcomes, and may contribute to physician burnout, resource overuse, and fragmented care; and

WHEREAS, Physician-in-triage (PIT) models used to achieve these metrics frequently involve brief, superficial encounters that increase diagnostic testing, cloud subsequent decision-making, and introduce risks of diagnostic anchoring, communication failures, and medical error; and

WHEREAS, Studies have shown that PIT models are minimally effective in addressing the root causes of the ED boarding crisis; and

WHEREAS, Nursing led triage processes (without PIT) are sufficient to identify patients requiring immediate care utilizing proven protocols for Stroke, STEMI, and the Emergency Severity Index (ESI) model; therefore be it

RESOLVED, That ACEP endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability; and be it further

RESOLVED, That ACEP oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care.

References

- Franklin BJ, Li KY, Somand DM, Kocher KE, Kronick SL, Parekh VI, Goralnick E, Nix AT, Haas NL. Emergency department provider in triage: assessing site-specific rationale, operational feasibility, and financial impact. *J Am Coll Emerg Physicians Open.* 2021 May 24;2(3):e12450. doi: 10.1002/emp2.12450. PMID: 34085053; PMCID: PMC8144283.vhttps://pmc.ncbi.nlm.nih.gov/articles/PMC8144283/
- Kelen GD, Wolfe R, D'Onofrio G, Mills AM, Diercks D, Stern SA, Wadman MC, Sokolove PE. Emergency department crowding: the canary in the health care system. *NEJM Catalyst Innov Care Deliv.* 2021 Sep 28;2(5). doi: 10.1056/CAT.21.0217.vhttps://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217

- Marshall ADA, Diercks DB, McGeorge NM, Meurer WJ, Sharp SC. The effect of a physician in triage on number of orders placed. *Ann Emerg Med.* 2019 Oct;74(4 Suppl):S47.https://www.annemergmed.com/article/S0196-0644(19)30794-2/fulltext

Background

The resolution calls for ACEP to endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability and oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care. The median door-to-doctor time was once part of the CMS quality reporting requirements for Timely and Effective Care in the Emergency Department and it was removed several years ago; however, it is still used in many benchmarking processes.

ACEPs policy statement, "Standards for Measuring and Reporting Emergency Department Wait Times*" recommends standard terms for reporting of ED patient waiting times for initial evaluation. The policy states:

- ED patient "wait time" should be defined as "door to provider contact time." [1,2]
- Provider is defined as physician (MD, DO), advanced practice nurse, or physician assistant (PA).
- Measurement of the "door to provider contact time" should be the sole metric used in public advertising to describe ED patient "wait time."
- Provider contact time is defined by either the face-to-face evaluation of the patient by the provider or the initiation by the provider of specific diagnostic and/or therapeutic orders.
- The calculation of wait time should be the longest amount of time that a patient is currently waiting to see a provider.
- Public advertising of ED patient "wait time" should include a time stamp of the last moment the metric was updated or refreshed.
- Ideally, advertised times should be accurate and reflect real-time waits. However, posted wait times should be updated at least hourly to be meaningful to patients.

**Note: This policy is undergoing review in the 2025-26 committee year as part of ACEP's Policy Sunset Review Process. One change to the policy will be to remove the word "provider."*

ACEP's policy statement "Patient Experience of Care Surveys" reviews the methodological and statistical issues with existing patient experience surveys. It states that many factors that lead to poor patient experience scores, such as wait times and boarding, are beyond the control of the individual emergency physician. The policy specifically states that patient experience of care survey scores should not be used for credentialing, contract renewal, or incentive bonus programs, and that rank-ordered percentiles should be abandoned.

Quality metrics are used as a means to measure "quality." While every attempt is made to make these metrics as fair as possible, often there are ways to "game" the measure. Additionally, there can be obstacles outside of the physician's control that interfere with the ability to meet a metric, such as boarding.

A December 2023 article in *ACEPNow*, A Sobering Year for Emergency Departments and Their Patients, included data from the Emergency Department Benchmarking Alliance (EDBA) 2022 report on data from 938 EDs reflecting 46 million patient visits which was roughly one-third of all patients seen in US EDs in 2022. Compared to data from the previous year, "Patient intake remained steady with median "Door to Bed" time decreasing to about eight minutes and "Door to Doctor" time to about 20 minutes."

Door-to-doctor time is a commonly tracked emergency department (ED) metric intended to evaluate the timeliness of patient assessment. For many years, the standard benchmark for this metric had been set arbitrarily at 30 minutes. This timeframe acknowledged that emergency departments operated under unpredictable and variable volumes, often with constrained staffing and limited physical space.

Recently, some hospital systems and contract management groups have sought to reduce door-to-doctor times, using PIT models where a physician or advanced practitioner briefly evaluates the patient in triage. While marketed as

patient-centered, this practice is often driven by financial motivations – ensuring patients are "seen" before they can leave – and does not necessarily improve care quality.

The PIT model leads to several downstream challenges:

- **Fragmented care**: Patients are seen by multiple physicians, NPs, or PAs, sometimes with inconsistent or duplicative evaluations and limited communication.
- **Increased costs**: Hasty workups in triage can result in over-testing and overuse of resources.
- **Clinical risk**: The initial impression based on a quick and limited history may bias the second physician's decisions, introducing cognitive errors.
- **Physician dissatisfaction**: Many emergency physicians find these systems inefficient, demoralizing, and operationally disruptive.
- **Educational**: In residency settings, having patients pre-worked can have a significant impact on learners.

Studies suggest that PIT models, while effective at reducing door-to-doctor time, do little to resolve emergency department crowding and may introduce unintended negative consequences.

- PIT models have been shown to **increase laboratory and imaging orders** for ESI 3 and 4 patients (Marshall et al. 2019)
- PIT models **do not reduce overall length of stay for admitted patients** (Franklin et al. 2021)
- PIT models have been found to be **ineffective in alleviating the ED crowding crisis** (Kelen et al. 2021)

Physicians, NPs, and PAs in triage are often underutilized and relegated to observing the triage nurse, jotting down brief notes, and initiating a few orders, all while practicing far below their level of capability. Despite the added expense of staffing these clinicians in triage, health systems deem it worthwhile because of the increased revenue from early billing capture. The result is that many patients are effectively seen by two "half" doctors instead of one fully engaged physician, which is a model that, as previously outlined, undermines continuity, inflates costs, and compromises the quality and efficiency of care.

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 professional.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 50(23) Metric Shaming referred to the Board of Directors. The referred resolution requested ACEP to develop practices and policies to prevent the public or external publication, transmission, and/or release unblinded metric-related information about individual emergency physician performance..

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non-evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Amended Resolution 19(09) Defining Boarding Time in the Nation's Emergency Departments adopted. Directed development of policy statement to define "boarded patient" and continue involvement with national organizations

developing measurements on patient through-put.

Amended Resolution 25(06) : Redefining the Front End Process to Optimize Emergency Department & Hospital Flow adopted. This resolution called for ACEP to develop a position paper defining optimal emergency care related to the "Front End" processing of ED patients and specifying that individuals with clinical expertise are the first personnel to interact with ED patients.

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. The resolution called for ACEP to endorse the concept of inpatient nurse staffing assigned to care for patients that been admitted but are classified as "boarders" in the ED and develop a relevant policy to which ED medical directors and hospital administrators may refer.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. Directed 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

June 2024, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department." Previously revised September 2018; originally approved January 2012.

February 2023, approved the revised policy statement, "Patient Experience of Care Surveys." Previously revised June 2016; originally approved September 2010 with the title, "Patient Satisfaction Surveys"

February 2023, approved the revised policy statement, "Boarding of Admitted and Intensive Care Patients in the Emergency Department," revised June 2017, April 2011, April 2008, and January 2007; originally approved October 2000.

September 2018, reaffirmed the policy statement, "Standards for Measuring and Reporting Emergency Department Wait Times;" originally approved October 2012.

May 2016, reviewed the report, "Emergency Department Crowding: High Impact Solutions."

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

Amended Resolution 19(09) Defining Boarding Time in the Nation's Emergency Departments adopted.

January 2008, reviewed the information paper, "Optimizing Emergency Department Front-End Operations."

Amended Resolution 25(06) Redefining the Front End Process to Optimize Emergency Department & Hospital Flow adopted.

June 2006, approved adopting a quality measure requiring hospitals to report the time of presentation to the ED to the time of disposition (admission or leaving the ED) within six hours for all patients.

Substitute Resolution 18(04) Caring for Emergency Department "Boarders" adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 67(25)

SUBMITTED BY: Forensic Medicine Section
Illinois College of Emergency Physicians

SUBJECT: Forensic Programs in Trauma Centers

PURPOSE: Work with other organizations to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as resources to provide support for collaborative work with external stakeholders.

WHEREAS, Traumatic injuries are a frequent cause of Emergency Department visits and they affect all patient populations and include injuries from multiple causes such as gunshot wounds, motor vehicle accidents, pedestrians injured by vehicles, assaults, sexual assault, strangulation, intimate partner and domestic violence, assaults, child and elder abuse, and human trafficking; and

WHEREAS, A significant fraction of those visits will prompt law enforcement investigation and subsequent court proceedings and this process will rely on medical records for the documentation of injuries and the physical evidence collected during the initial patient visit; and

WHEREAS, Medical treatment always takes precedence over forensic aspects of care, and trauma and emergency physicians providing lifesaving care may not be able to provide comprehensive forensic documentation; and

WHEREAS, Detailed description and photographic documentation of pattern injuries, gunshot wounds, evidence of abuse, patient's appearance and clothing, and trace evidence can determine the outcome of a court case; and

WHEREAS, Medical providers are often not familiar with the correct process of evidence collection and preserving chain of custody, putting the evidence at risk of being dismissed in court; and

WHEREAS, Forensic nurses have specialized training that would allow them to collect photos and evidence during medical evaluation and comply with legal requirements; therefore be it

RESOLVED, That ACEP work with stakeholders including the Forensic Medicine Section, American College of Surgeons – Committee on Trauma (ACS-COT), International Association of Forensic Nursing (IAFN), Academy of Forensic Nursing (AFN), and Emergency Nurses Association (ENA), to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

Resources

1. International Association of Forensic Nurses: SANEs in Level 1 and 2 Trauma Centers Policy Paper https://forensicnurses.org/wp-content/uploads/2021/11/sanes_in_trauma_centers_poli.pdf
2. 24/7 Forensic Trauma Nurses: How we Did It And What We Learned. An interview with Heather DeVore, MD, ACEP Now September 18, 2017 https://www.acep.org/forensicmedicine/newsroom/fm-newsroom-articles/sept2017/247-forensic-trauma-nurses-how-we-did-it-and-what-we-learned

Background

This resolution calls for the College to work with stakeholders including ACEP's Forensic Medicine Section, American College of Surgeons-Committee on Trauma (ACS-COT), International Association of Forensic Nursing (IAFN), Academy of Forensic Nursing (AFN), and the Emergency Nurses Association (ENA) to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

The ACS-COT establishes and verifies trauma center criteria. ACEP has a long history of working with ACS on trauma issues that affect emergency medicine, but ACEP does not set the criteria.

The College has historically been involved in various aspects of evidence collection within the emergency department, primarily around patients in police custody, requests from law enforcement, and sexual assault. However, this resolution seeks to require forensic programs be incorporated into Level 1 and Level 2 trauma criteria.

A forensic program within a trauma center plays a crucial role in providing comprehensive and specialized care to patients who have experienced trauma, particularly when those injuries may be related to violence, abuse, or other criminal activity. The purpose of such a program is to address the unique needs that arise at the intersection of health care and the legal system. Care in forensic programs is generally delivered at the bedside by specially trained and dedicated nurses whose primary role is to care for victims of violence and other crimes.

Key elements and functions of a forensic program at a trauma center include:

- Bridging health care and the legal system: Forensic programs aim to provide specialized medical care to those affected by trauma while also collecting and preserving crucial evidence that can be used in legal investigations.
- Trauma-informed care: Prioritize a trauma-informed approach, ensuring patients feel safe, respected, and supported throughout the process. This includes being sensitive to the emotional and psychological impact of trauma and providing appropriate referrals for ongoing support.
- Specialized care: Provide specialized care for victims of sexual assault, domestic violence, child abuse, elder abuse, and other forms of interpersonal violence. This includes both physical and emotional support, as well as addressing immediate and long-term health consequences of the trauma.
- Forensic medical examinations and evidence collection: Conduct meticulous examinations to document injuries and collect potential evidence such as DNA, hair, fibers, and other trace materials. Proper documentation, photography, and adherence to chain-of-custody protocols are essential to ensure the evidence's admissibility in court.
- Collaboration with law enforcement and the legal system: Working with police, attorneys, and other legal professionals, which may include providing expert testimony in court
- Advocacy and support: Providing emotional and psychological support to patients and connecting them with victim services and community resources.
- Education and training: Forensic programs often contribute to the education and training of other healthcare professionals on forensic principles, trauma-informed care, and the proper handling of forensic evidence in order to ensure all staff are familiar with best practices.
- Violence prevention and public health: By identifying patterns of violence and collaborating with community partners, forensic programs contribute to violence prevention efforts and promoting public health and safety.

A standardized training program focusing on forensic training for trauma centers does not currently exist. ACEP would need to work with ACS-COT to develop a curriculum to incorporate a forensic program into all trauma centers. Once such a curriculum was developed, dissemination of the material by either online or in person instruction would need to be developed.

ACEP's policy statement "Sexual Assault Nurse Examiner Programs and Facilities" supports the collection of forensic evidence (performance of evidentiary examinations) by specially educated and clinically trained personnel development and funding of additional Sexual Assault Nurse Examiner (SANE)/Sexual Assault Response Team (SART) programs and facilities.

ACEP's policy statement *"*Law Enforcement Information Gathering in the Emergency Department*"* specifies that evidence collection for law enforcement purposes must occur only with patient consent, under a legal mandate, or pursuant to a court order, and must never delay or interfere with the provision of medical care. The Policy Resource and Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department – Legal and Ethical Background and Practical Approaches," was developed as an adjunct to the policy statement and provides detailed legal and ethical background with practical approaches to balancing clinical care and forensic responsibilities.

The "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department" policy statement recommends that ED staff receive training to properly preserve physical evidence and maintain the chain of custody when caring for incarcerated patients. The PREP "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department" provides additional guidance.

Additionally, ACEP disseminated the e-book "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, 2nd edition," developed by the Forensic Medicine Section, in June 2016. This resource provides standardized recommendations for forensic evaluation and evidence collection for sexual assault victims.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as resources to provide support for collaborative work with external stakeholders

Prior Council Action

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Directed ACEP to expand the "Law Enforcement Information Gathering in the Emergency Department" policy statement to reflect recent relevant course decisions regarding consent for searches with or without a warrant, providing clarification and guidance to emergency physicians on their ethical and legal obligations in this issue.

Resolution 22(16) Court-Ordered Forensic Evidence Collection in the ED adopted. Directed ACEP to study the ethical and moral implications for emergency physicians acting in compliance with court orders that require the collection of evidence from a patient in the absence of consent, and to develop a policy statement addressing the issue.

Amended Resolution 30(14) Sexual Assault Victims' DNA Bill of Rights adopted. Directed ACEP to encourage members to be familiar with and comply with all local laws, policies, and procedures regarding the collection and submission of DNA evidence to law enforcement agencies and support state legislative "Sexual Assault Victims' DNA Bill of Rights" and other initiatives regarding the timely submission and processing of DNA evidence.

Amended Resolution 36(11) Sexual Assault Training in Emergency Medicine Residency adopted. Directed ACEP to work with the Council of Emergency Medicine Residency Directors and other organizations to develop sexual assault examination curricular tools that can be adopted by emergency medicine programs and practicing emergency physicians.

Amended Resolution 21(06) Selective Triage for Victims of Sexual Assault to Designated Exam Facilities adopted. Directed ACEP to support the collection of forensic evidence by specially educated and clinically trained personnel when available and appropriate and the development and funding of additional SANE/Sexual Assault Response Team (SART) programs.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Directed the College to amend the policy statement, "Management of the Patient with the Complaint of Sexual Assault.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Directed 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. Directed 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. Directed 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. Directed 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

August 2023, approved the policy statement "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department."

August 2023, reviewed the Policy Resource & Education Paper (PREP) "Best Practice Guidelines for Evaluating Patients in Custody in the Emergency Department."

April 2024, approved the revised policy statement "Sexual Assault Nurse Examiner Programs and Facilities;" reaffirmed February 2018 and April 2012; originally approved October 2006 titled "Selective Triage for Victims of Sexual Assault to Designated Exam Facilities."

June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2010; originally approved September 2003.

June 2023, reviewed the Policy Resource & Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department – Legal and Ethical Background and Practical Approaches"

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed February 2020, April 2014 and October 28; revised and approved October 2002; reaffirmed June 1999; revised and approved December 1994; originally approved January 1992.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

Resolution 22(16) Court-Ordered Forensic Evidence Collection in the ED adopted.

Amended Resolution 30(14) Sexual Assault Victims' DNA Bill of Rights adopted.

Amended Resolution 36(11) Sexual Assault Training in Emergency Medicine Residency adopted.

Amended Resolution 21(06) Selective Triage for Victims of Sexual Assault to Designated Exam Facilities adopted.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

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: George Solomon, MHS, FP-C, CCP-C, TP-C, LSSBB
Director of EMS, Disaster Medicine, and Accreditation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 68(25)

SUBMITTED BY: Halleh Akbarnia, MD, MPH, FACEP
Kristen Donaldson, MD, MPH, FACEP
Illinois College of Emergency Physicians

SUBJECT: Integrating Firearm Safety Counseling into Emergency Medicine Education and Practice

PURPOSE: 1) Amend ACEP's policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs. 2) Develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling.

FISCAL IMPACT: Budgeted committee and staff resources for current and ongoing initiatives.

WHEREAS, Firearm violence remains the leading cause of death for children and teens in the United States, affecting hundreds of lives daily – including the 327 people shot each day – and emergency physicians, as front-line responders, have both the responsibility and privilege to care for victims and to advocate for prevention, consistent with ACEP's established policies supporting a public health approach to firearm injury prevention; and

WHEREAS, Emergency physicians are often the first and only point of contact in high-risk encounters such as suicidal ideation, domestic violence, or pediatric injury, yet most residency programs and continuing medical education (CME) offerings lack standardized training on firearm safety counseling and education; and

WHEREAS, ACEP's 2020 policy on "The Role of the Emergency Physician in Injury Prevention and Control" and the 2019 policy on "Violence Free Society" affirm that emergency physicians have both the right and responsibility to provide injury prevention counseling and education to patients and families, and emphasize the need to teach the next generation of physicians about injury prevention through formal education and leadership development; and

WHEREAS, Studies show that firearm safety counseling is underutilized despite patient risk, and a 2024 study by Ladines-Lim et al. conducted in primary care clinics found no documentation of firearm safety counseling even when patients reported access to firearms and had psychiatric risk factors; and

WHEREAS, Brief, nonjudgmental counseling about safe firearm storage has been shown to increase the use of secure storage practices, which reduces the risk of suicide, unintentional injury - particularly among youth - and limits unauthorized access, including firearm theft and diversion to community violence (Carter and Cunningham, 2024); and

WHEREAS, A 2022 study by Pallin et al. found that fewer than half of medical trainees asked patients about firearm access, stating barriers exist such as lack of training, time, and confidence; yet over 90% expressed interest in receiving firearm injury prevention education, and those who had prior training were significantly more likely to engage in counseling behavior; therefore be it

RESOLVED, That ACEP amend its policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs; and be it further

RESOLVED, That ACEP develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling, particularly for high-risk patients, alongside both printable and digital format, evidence-based patient handouts suitable for emergency

department use, potentially leveraging existing materials and partnerships where appropriate and consistent with ACEP's firearm safety policies.

Related ACEP Policies/Resolutions
Firearm Safety and Injury Prevention Policy (Policy revised June 2024)
Declaring Firearm Violence a Public Health Crisis (2023 Council Resolution 35)
Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients (Policy revised June 2020)
Violence-Free Society (Policy 2019)

References
1. Carter PM, Cunningham RM. Clinical Approaches to the Prevention of Firearm-Related Injury. N Engl J Med. 2024;391(10):926-940. doi:10.1056/NEJMra2306867
2. Ladines-Lim J, Secrest K, Pu A, et al. Firearm Screening and Counseling in General Medicine Primary Care Clinics at an Academic Medical Center. *J Gen Intern Med.* 2024;39(1):147-149. doi:10.1007/s11606-023-08379-x
3. Pallin R, Teasdale S, Agnoli A, et al. Talking about firearm injury prevention with patients: a survey of medical residents. *BMC Med Educ.* 2022;22(1):7. doi:10.1186/s12909-021-03024-9

Background

This resolution calls for ACEP to amend its policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs; and that ACEP develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling - particularly for high-risk patients - alongside both printable and digital format, evidence-based patient handouts suitable for emergency department use, potentially leveraging existing materials and partnerships where appropriate and consistent with ACEP's firearm safety policies.

In 2023, firearms remained the leading cause of death among U.S. youth, surpassing motor vehicle crashes and other causes. Among children and adolescents aged 0–17, there were approximately 2,581 firearm-related deaths, reflecting a 50% increase since 2019; this equates to nearly four deaths per 100,000 children. Nationwide, total firearm fatalities reached 46,728 in 2023, an average of 14.0 deaths per 100,000 people—including 27,300 firearm suicides (8.2 per 100,000) and 17,927 firearm homicides. Among youth firearm deaths in 2023, 63% were homicides, 29% suicides, and 5% attributed to unintentional incidents. Firearm suicides remain particularly urgent: firearms were involved in 47% of all youth suicides, and across all ages, 55% of suicides utilized firearms. This data underscores the vital importance of prevention strategies. Evidence strongly links access to firearms, especially unsecured weapons in the home, with increased risk of both suicide and homicide. Research shows that approximately 80% of youth firearm suicides involve a firearm from the home, and nearly 40% of households with children store at least one weapon loaded and unlocked.

Safe firearm storage is a critical and evidence-based strategy for reducing gun-related injuries and deaths, with broad support from researchers, healthcare professionals, and many firearm owners. Studies have consistently shown that storing firearms securely, unloaded, locked, and separate from ammunition, significantly reduces the risk of suicide, particularly among adolescents, and helps prevent unintentional injuries and deaths. In addition, secure storage decreases the likelihood that firearms will be stolen, diverted into illegal markets, or used in criminal activity. Child-protective firearm safety practices include a range of security measures, such as lockboxes and safes for handguns and long guns, trigger and cable locks, and separate locked containers for ammunition. A growing body of research supports the effectiveness of safe storage laws and policies, which have been associated with meaningful reductions in firearm suicides, accidental shootings, and homicides, including among youth and young adults.

Lethal means safety counseling in the emergency department (ED) is a crucial evidence-based suicide prevention intervention aimed at reducing the risk of suicide and self-harm among patients. This recommended practice involves healthcare providers assessing patients' access to means that could be used for self-injury, such as firearms, medications, or other harmful substances, with the goal is to create a supportive environment that helps patients develop coping strategies and access mental health resources, ultimately minimizing the risk of suicide. Effective lethal means safety counseling not only addresses immediate safety concerns but also contributes to long-term mental health support and recovery.

Unfortunately, earlier studies involving emergency physician self-reports found that lethal means assessment was not routine; less than 50% of providers 'almost always' or 'often' ask about suicidal patients' access to firearms, even though more than half thought that this assessment is important. Additionally, it is not uniformly implemented across all facilities, and its frequency can vary based on several factors, including institutional policies, physician training, and the specific protocols of the ED. Training programs and guidelines that emphasize the importance of this counseling can increase its implementation. However, not all EDs may have comprehensive training or resources available. Overall, while there is growing recognition of the importance of lethal means safety counseling, its frequency of implementation in EDs varies, and efforts are ongoing to standardize and improve its application across different healthcare settings.

Various studies have shown a strong correlation between firearm safety instruction to children and a reduction in dangerous interactions with firearms. A study published July 2023 in JAMA Pediatrics found that children ages 8-12 were three times more likely to avoid touching a discovered firearm when they had been shown a single one-minute firearm safety video a week prior. They were also three times more likely to tell an adult.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements. Two firearms-related resolutions were adopted by the Council and the Board of Directors last year:

- Amended Resolution 61(24) Safe Storage of Firearms directed ACEP to create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, prevent theft, and prevent access by unauthorized users who may pose a danger to themselves or others; and encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage. The Public Health Committee is developing strategies to address this resolution.

- Amended Resolution 60(24) Lethal Means Firearm Safety Counseling directed ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training. The Public Health Committee is investigating available resources and enhance their availability to ACEP members.

The 2023 Council and the Board of Directors adopted Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems directing ACEP to support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems. ACEP's policy statement "Firearm Safety and Injury Prevention" was revised in June 2024 in response to Resolution 36(23) Mandatory Waiting Period for Firearm Purchases and Resolution 35(23) Declaring Firearm Violence a Public Health Crisis.

The provisions of the "Firearm Safety and Injury Prevention" policy statement include:

- ACEP supports legislative and regulatory efforts that:
  - Actively support both private and public funding into firearm safety and injury prevention research.
  - Protect the duty of physicians to discuss firearm safety with patients.
- ACEP supports public health and health care efforts that:
  - Provide health care providers with information on the most effective ways to counsel patients and families on proper firearm safety, emphasizing evidence-based methods that are shown to reduce intentional and unintentional injuries.
  - Support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior.

The policy statement "Violence-Free Society" 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." The Public Health Committee (PHC) is currently revising and updating this policy statement.

The PHC 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. Additionally, the PHC is developing a patient centered resource addressing gun safety and providing information on best practices and available resources. The Pediatric Emergency Medicine Committee is developing an information paper on Safety Planning for Youth in the Emergency Department who have Suicide Risk, and this paper addresses firearms and provides guidance on evidence based best practices related to firearms.

In addition to the College's own specific efforts, ACEP member representatives and staff also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research.

ACEP Strategic Plan Reference

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Career Fulfillment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients

Fiscal Impact

Budgeted committee and staff resources for current and ongoing initiatives.

Prior Council Action

Amended Resolution 61(24) Safe Storage of Firearms adopted. Directed ACEP to create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, prevent theft, and prevent access by unauthorized users who may pose a danger to themselves or others; and encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage.

Amended Resolution 60(24) Lethal Means Firearm Safety Counseling adopted. Directed ACEP to develop resources to provide evidence-based firearm-related lethal means safety counseling to at risk youth and work with other organizations to develop training for health care providers in firearm-related lethal means safety training.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted. Directed that ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted. Directed ACEP to declare firearm violence to be a public health crisis in the United States.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Prior Board Action

Amended Resolution 61(24) Safe Storage of Firearms adopted.

Amended Resolution 60(24) Lethal Means Firearm Safety Counseling adopted.

June 2024, approved the revised policy statement "Firearm Safety and Injury Prevention;" revised and approved October 2019; revised and 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.

Amended Resolution 37(23) Support for Child-Protective Safety Firearm Safety and Storage Systems adopted.

Resolution 35(23) Declaring Firearm Violence a Public Health Crisis adopted.

June 2020, approved the revised policy statement "Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients;" reaffirmed April 2014; revised and approved June 2008, replacing rescinded policy statement "Role of Emergency Physicians in the Prevention of Pediatric Injury;" reaffirmed October 2002; originally approved March 1998 titled "The Role of the Emergency Physician in Injury Prevention and Control."

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 69(25)

SUBMITTED BY: Kansas Chapter

SUBJECT: Investigating Best Practices and Policy Solutions for Direct Communication When Referring Patients to the ED

PURPOSE: Investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Unknown and unbudgeted costs for external resources could also be required.

WHEREAS, Emergency departments (EDs) often receive patients referred from urgent care centers, primary care providers, telehealth services, and other outpatient settings without accompanying documentation or direct communication; and

WHEREAS, The lack of direct communication between referring clinicians and emergency physicians can result in incomplete clinical information, unnecessary diagnostic duplication, delayed treatment, and potential patient harm; and

WHEREAS, Emergency physicians are frequently left to reconstruct the clinical reasoning, treatments already administered, or the urgency of the referral, particularly in cases where patients are unable to accurately relay relevant medical history; and

WHEREAS, Direct communication – whether through phone call, secure messaging, or electronic health record transmission – between the referring provider and the emergency physician could improve care coordination, reduce inefficiencies, and enhance patient safety; and

WHEREAS, Poor communication is a leading cause of patient harm, patient safety events and malpractice claims; and,

WHEREAS, While operational and logistical challenges exist, models in certain health systems have demonstrated the feasibility and benefit of streamlined referral communication protocols; therefore be it

RESOLVED, That ACEP investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

Background

This resolution calls on ACEP investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

The prevalence of chronic and behavioral health conditions is rising as the U.S. population ages and people often have multiple, complex underlying conditions. Half of adult Americans have at least one chronic condition and more than two-thirds of Medicare patients have two or more. People with complex, chronic, and behavioral health conditions

contribute to higher health care costs and account for more than 90%t of the nation's $3.3 trillion in health care spending. Patients with serious illness often have a lack of understanding of their disease process and prognosis. Patients are even sent to the ED after critical test results without being informed of the result or diagnosis.

Patient handoffs or transitions of care are dangerous primarily due to communication errors, which can lead to adverse events, delays in treatment, and even death. These errors often stem from missing, incomplete, or inaccurate information during the handoff process, as well as differing perspectives among caregivers. Communication errors have been identified as the root cause in about 70% of sentinel events. Additionally, up to 84% of treatment delays can be attributed to miscommunication.[1]

The risk to patient safety from handoffs is a well-known problem in medicine. Many organizations have taken steps to address the risks of handoffs, including the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, and The Joint Commission. Structured communication, the use of standardized tools, and a supportive environment is necessary to improve patient safety during handoffs along with prioritizing face-to-face communication, minimizing distractions, and ensuring adequate time for information exchange and questions. Implementing tools such as SBAR (Situation, Background, Assessment, Recommendation) or I-PASS (Illness severity, Patient summary, Action list, Situation awareness, Synthesis by receiver) can help ensure all critical information is conveyed. ACEP has developed resources to improve handoffs in the ED and a Rapid Integration of Care Toolkit. These tools have been primarily applied in the hospital setting.

Background Reference

1. Cheung DS, Kelly JJ, Beach C, Berkeley RP, Bitterman RA, Broida RI, Dalsey WC, Farley HL, Fuller DC, Garvey DJ, Klauer KM, McCullough LB, Patterson ES, Pham JC, Phelan MP, Pines JM, Schenkel SM, Tomolo A, Turbiak TW, Vozenilek JA, Wears RL, White ML; Section of Quality Improvement and Patient Safety, American College of Emergency Physicians. Improving handoffs in the emergency department. Ann Emerg Med. 2010 Feb;55(2):171-80. doi: 10.1016/j.annemergmed.2009.07.016. Epub 2009 Oct 2. PMID: 19800711.

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

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. Unknown and unbudgeted costs for external resources could also be required.

Prior Council Action

Amended Resolution 50(24) Communication to Established Patients Being Referred to the Emergency Department adopted. The resolution directed ACEP to work with the other stakeholders to develop a strategy to address the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so.

Adopted Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed ACEP to rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to: 1) define the role of emergency medicine in transitions of care for emergency medicine patients; 2) participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed

standards for emergency medicine transitions of care; 3) monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and 4) identify resources and educational materials to improve transitions of care for emergency patients.

Prior Board Action

January 2015, reviewed the Rapid Integration of Care Toolkit

Adopted Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 70(25)

SUBMITTED BY: Colorado Chapter
District of Columbia Chapter
New York Chapter
North Carolina College of Emergency Physicians
Wellness Section

SUBJECT: Mandated Reporting of ED Violence

PURPOSE: Partner with other organizations to develop an ED violence reporting system and facilitate collection of violence prevention initiatives implemented by hospitals and health systems and develop best practices.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives. Unbudgeted costs for creation of a national centralized reporting portal, likely in excess of $100,000, and considerable staff resources to create, analyze, and maintain the data. Collecting violence prevention initiatives from hospitals and health systems to address ED violence and develop best practices is not a current initiative of the College and would require diverting committee and staff resources to address this initiative.

WHEREAS, Violence against physicians in the ED is an epidemic; and

WHEREAS, There is a paucity of data of the occurrence of violence against physicians in the ED; and

WHEREAS, Once we know the true occurrence of this violence, it can be tracked and health systems can be held accountable; therefore be it

RESOLVED, That ACEP work with likeminded organizations, such as the Emergency Nurses Association and the Lorna Breen Foundation, to develop an emergency department violence reporting system; and be it further

RESOLVED, That ACEP facilitate the collection of violence prevention initiatives that hospitals and health systems have implemented to address emergency department violence and develop best practices.

Background

This resolution calls for ACEP to partner with other organizations to develop an ED violence reporting system and facilitate collection of violence prevention initiatives implemented by hospitals and health systems and develop best practices.

ACEP has taken a leading role in addressing the growing problem of violence in emergency departments. Surveys conducted by ACEP in 2024, 2022, and 2018 reveal an alarming and escalating trend: nearly half of emergency physicians reported being physically assaulted at work in 2018, with 91% indicating in 2024 that they or a colleague had experienced violence within the past year. Many physicians believe hospitals can do more to enhance safety through increased security measures, such as deploying security personnel, installing surveillance systems, and implementing stricter visitor screening protocols. In response, ACEP has collected more than 800 personal accounts from emergency physicians detailing workplace violence and has advocated for improved local reporting mechanisms. ACEP has advocated for local reporting of violence in the ED. While the development of a national database on emergency department violence could offer valuable insights, ACEP recognizes the significant logistical challenges involved, including the need for standardized terminology, consistent data submission across institutions, and dedicated analytic resources – challenges similar to those encountered with collecting data for the Clinical Emergency Data Registry. ACEP has learned from the implementation of the Clinical Emergency Data Registry, and

even with the CDC, hospitals are reluctant to provide such data outside of state or federal requirements. Despite these barriers, ACEP continues to promote data-driven approaches to reduce violence and protect emergency care teams. Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and has been featured as one of the key advocacy priorities during several ACEP Leadership & Advocacy Conference (LAC) meetings in Washington, DC, including as recently as 2024.

ACEP's Legislative & Regulatory Priorities for the First Session of the 119th Congress include:

- Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions.(Legislative)
- Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department. (Regulatory)
- Support legislation and identify new opportunities to promote comprehensive violence prevention and intervention efforts, such as hospital-based violence intervention programs, increased community-specific resources, research funding, and educational initiatives.(Legislative)

ACEP helped inform and continues to support the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2531/S.1232), introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI). This legislation would compel the Occupational Safety and Health Administration (OSHA) to issue federal standards to require health care and social service employers to create and implement workplace violence prevention plans. ACEP was the first physician organization to ever endorse this legislation and has worked closely with the sponsors for several Congresses. Among the provisions of this bill are:

- The OSHA standard mandates that employers shall investigate each incident of workplace violence as soon as practicable, document the findings, and take corrective measures.
- The OSHA standard requires that employers must record workplace violence incidents in a Violent Incident Log ("Log"). An annual summary of the Log shall be posted in the workplace in the same manner as the posting of the OSHA Annual Summary of Injuries and Illnesses, and similarly shall be transmitted to OSHA. Employers shall maintain records related to the Plan, and employees are provided the right to examine and make copies of the Plan, the Log and related Plan documents, with appropriate protections for patient and worker privacy. Patient names and personal identifying information will be excluded from the Violent Incident Log.
- The OSHA standard prohibits retaliation against a covered employee for reporting a workplace violence incident, threat, or concern to an employer, law enforcement, local emergency services, or a government agency. A violation of this prohibition shall be enforceable as a violation of an OSHA standard.

ACEP has also worked directly with OSHA for many years as they have attempted to develop and issue regulations on this front, efforts that have been in progress since 2015. The agency had hoped to release a proposed rule for a workplace violence prevention in health care and social service facilities in December 2024, however the agency ultimately did not release the proposed rule prior to the end of President Joe Biden's term.

ACEP also helped inform and supports the bipartisan, "Save Healthcare Workers Act" (H.R. 3178/S.1600), previously known as the "Safety from Violence for Healthcare Employees (SAVE) Act" (H.R. 2584/S.2768) in previous Congresses. This bipartisan, bicameral legislation was introduced by Madeleine Dean (D-PA) and Reps. Mariannette Miller-Meeks (R-IA), and Sens. Cindy Hyde-Smith (R-MS) and Angus King (I-ME). This legislation would establish federal criminal penalties for violence against health care workers, similar to those in place for airline and airport workers. ACEP President Alison Haddock, MD, FACEP, was quoted in the press release when the legislation was introduced.

Last year, the Council and the Board of Directors adopted Amended Resolution 41(24) Workplace Violence Data Collection. The resolution directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem. This tenets of this resolution are addressed in the proposed

"Save Healthcare Workers Act" (H.R. 3178/S.1600).

In early 2024, ACEP co-hosted a congressional briefing on health care workplace violence and the SAVE Act with the American Hospital Association (AHA). ACEP, along with the with the Emergency Nurses Association (ENA) and the American Nurses Association (ANA), hosted another congressional briefing on workplace violence in March 2024. And in July 2024, ACEP and AHA hosted another congressional briefing focused on the Senate, with Senator Joe Manchin (D-WV) attending to deliver remarks to the audience as well. ACEP has also established and leads a coalition of other medical specialties to further amplify these advocacy efforts on Capitol Hill.

ACEP also provided input on The Joint Commission's "Workplace Violence Prevention" project in 2021 and, as a result of that work, TJC announced 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.

ACEP began a partnership with ENA in 2019 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 and ENA hosted a similar press conference on Capitol Hill after LAC2023, and continue closely partnering on related efforts.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of 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" and the "How Safe is Your Workplace" sample checklist.

The Public Health Committee is currently working on a one-page/signage template for emergency departments using the "Emergency Department Patient Rights and Responsibilities" policy statement to educate patients that clearly defines acceptable behavior and states that non-medical aggression may result in immediate removal.

ACEP's State Legislative/Regulatory Committee (SLRC) has a work group assigned to address workplace violence issues. Part of their work involves discussions with the law enforcement community to ensure that convictions for workplace violence are not dismissed by district attorney offices. Additionally, the SLRC has advocated for mandatory reporting of workplace violence, similar to legislation in North Carolina, which requires hospitals to track and report such incidents.

ACEP Strategic Plan Reference

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.

Advocacy: ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives. Unbudgeted costs for creation of a national centralized reporting portal, likely in excess of $100,000, and considerable staff resources to create, analyze, and maintain the data. Collecting violence prevention initiatives from hospitals and health systems to address ED violence and develop best practices is not a current initiative of the College and would require diverting committee and staff resources to address this initiative.

Prior Council Action

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted. Directed ACEP to develop and adopt a universal code of conduct for patients and visitors in the emergency department.

Amended Resolution 41(24) Workplace Violence Data Collection adopted. Directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

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 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on violence prevention issue and encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research.

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

Approved as legislative and regulatory priorities in January 2025, March 2024, February 2023, and January 2022 to continue advocating for reintroduction or passage of bills to address violence against health care workforce and for increased safety measures in the ED. Additionally, continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department.

Substitute Resolution 56(24) Patient and Visitor Code of Conduct adopted.

Amended Resolution 41(24) Workplace Violence Data Collection adopted.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

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.

Resolution 55(17) Workplace Violence adopted.

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 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 71(25)

SUBMITTED BY: Louisiana Chapter
Pennsylvania College of Emergency Physicians
Vermont Chapter
New Mexico Chapter
Texas College of Emergency Physicians
Emergency Medicine Workforce Section

SUBJECT: Maintenance of Malpractice Tail Coverage in the Setting of Employer Bankruptcy

PURPOSE: Curate educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and a member-accessible hub that is easily identifiable on the ACEP website.

FISCAL IMPACT: Budgeted committee and staff resources. Members and staff are currently working on providing additional resources to members affected by employer bankruptcy and making the resources available in a centralized area of the website.

WHEREAS, Emergency physicians frequently practice under employment agreements with contract management groups (CMGs) and other private entities that are responsible for securing and maintaining malpractice insurance coverage, including tail coverage upon separation or corporate dissolution; and

WHEREAS, Recent high-profile bankruptcies of emergency medicine practice groups, including NES Health and American Physicians Partners, have disrupted the continuity of malpractice insurance coverage for many emergency medicine physicians, placing them at personal financial and legal risk;[1,2] and

WHEREAS, The sudden collapse of such entities can leave physicians without critical malpractice tail coverage, particularly when employer policies do not guarantee or adequately fund tail insurance upon insolvency; and

WHEREAS, ACEP has a vested interest in advocating for the financial security and legal protection of its members, and in equipping emergency medicine physicians with the knowledge and tools necessary to navigate employer-related insurance gaps;[3] and

WHEREAS, Easily accessible educational resources and guidance from ACEP would empower emergency medicine physicians to proactively protect themselves against such vulnerabilities in future employment contracts; and

WHEREAS, ACEP already has various resources available in its Career Center, other locations on the ACEP website, and within the NES Health Discussion Member Interest Group;[4,5,6] therefore be it

RESOLVED, That ACEP curate existing and future educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions, and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and member-accessible hub that is easily identifiable on the ACEP website.

References

1. https://www.acepnow.com/article/another-failed-physician-mgmt-company-leaves-ed-staff-dangling/

2. https://www.beckershospitalreview.com/legal-regulatory-issues/physician-staffing-firm-files-for-bankruptcy/
3. https://www.acep.org/news/acep-newsroom-articles/acep-calls-for-stronger-physician-protections-when-employers-break-contracts
4. https://www.acep.org/life-as-a-physician/career-center
5. https://www.acep.org/careertransitionsupport
6. https://engaged.acep.org/communities/community-home?CommunityKey=36175b5e-1ad5-4e56-a03f-0192eadd604b

Background

This resolution calls for ACEP to curate educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions and responding to employer insolvency and have these resources available in an organized, user-friendly, centralized and a member-accessible hub that is easily identifiable on the ACEP website.

Several prominent emergency physician groups have undergone financial reorganization or bankruptcy recently without always honoring their commitment to provide tail malpractice coverage for their employed physicians. These bankruptcies have exposed emergency physicians to long-term legal and financial risks. Many were faced with the prospect of personally funding expensive tail policies or assuming open-ended legal liability for their prior clinical work having been unaware that their tail coverage was not guaranteed in the event of corporate bankruptcy.

ACEP has multiple resources in various locations on the website to assist members, including the Career Center. Other areas of the website include resources on employment contracts, medical-legal resources, and the Town Hall session on Resources for Physicians Affected by NES Health. Additionally, ACEP in conjunction with EMRA, offers a comprehensive course "Practice Essentials" that is free to EMRA and ACEP members. The course covers many of the topics called for in this resolution including negotiation, contracts, malpractice fundamentals, personal finance, etc.

ACEP President Alison Haddock, MD, FACEP, has appointed a workgroup of members who have been impacted by recent employer groups dissolving, national ACEP Board members, and staff to assist with strategies to pursue and developing resources to assist members. The strategies being discussed include: 1) help prepare physicians by giving them the skills and knowledge needed to best protect themselves up front; 2) consolidate more resources to be able to help immediately when new situations occur; and 3) advocate at both the state and national level for better protections for emergency physicians and patients when employer groups are at risk of dissolution.

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 professional.

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. Members and staff are currently working on providing additional resources to members affected by employer bankruptcy and making the resources available in a centralized area of the website

Prior Council Action

The Council has discussed and approved many resolutions related to contracts and providing resources to members. Prior resolutions have not been submitted that are specific to curating the resources in a centralized area of the website.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. Directed ACEP to adopt a policy statement addressing continuity of fair compensation including monetary payments and malpractice coverage during times of contract transitions.

Prior Board Action

The Boad has discussed and approved many policy statements and other resources related to contracts and providing resources to members.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. The resolution was formatted as the policy statement "Protecting Emergency Physicians During Contract Transitions."

Background Information Prepared by: Adam Krushinskie, MPA
Senior Director, State Legislative & Reimbursement

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 72(25)

SUBMITTED BY:

Stephen H. Anderson MD, FACEP	Donald Stader, MD, FACEP
John Bibb, MD, FACEP	Jessica Wall, MD, MPH, FACEP
Nida Degesys, MD, FACEP	Scott Weiner, MD, FACEP
Ramnik Dhaliwal, MD, JD	California Chapter
Alicia Gonzalez, MD, FACEP	Missouri Chapter
Alexis LaPietra, DO, FACEP	New Mexico Chapter
Aimee Moulin, MD, FACEP	Pain Management & Addiction Medicine Section
Evan Schwarz, MD, FACEP	Toxicology Section

SUBJECT: Naloxone Access and Education in Public Schools

PURPOSE: ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

FISCAL IMPACT: Budgeted resources to endorse the work of other organizations in supporting naloxone-related initiatives in educational settings.

WHEREAS, The number one cause of accidental deaths ages 13-55 in America in 2024 remains overdose deaths; and

WHEREAS, The overdose death rate increased 300% among adolescents aged 13-17 from 2019 to 2022, however, the good news is the number of deaths overall decreased 27% from 2023 to 2024 primarily through restricting fentanyl in our communities and access to naloxone; and

WHEREAS, We can reverse opioid overdoses with rapidly administered naloxone one person at a time, but to change the overdose trajectory into the next generation requires education of that generation and studies show adolescents are receptive to this, and modules already exist; and

WHEREAS, Youth targeted harm reduction strategies already exist for other scenarios and we already have AED's, tourniquets, and fire extinguishers in our schools for public safety and the likelihood of an overdose death far exceeds those events; and

WHEREAS, In 2024, only 13 states have naloxone legislatively mandated on campus, and only 7 states required mandatory training on the topic of opioids, overdose and addiction and as recently as May 2024 template legislation has passed in states such as Colorado to assure this; and

WHEREAS, Other visible organizations have already endorsed these campaigns (i.e., the AMA, the White House Office of National Drug Control Policy, the prior U.S. Secretary of Education, and SAMHSA to name a few), but to engage other policy makers and influential organizations ACEP's endorsement is highly valued; and

WHEREAS, Emergency medicine is often the gurney on which these individuals land, and we now have programs and medications to promote rehabilitation and these are OUR patients along their journeys; therefore be it

RESOLVED, That ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

Background

This resolution calls for ACEP to endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

The ongoing surge in synthetic opioid use, particularly fentanyl, which has driven a steep rise in overdose fatalities, has elevated naloxone (and other opiate reversal agents approved by the FDA) to a critical role in emergency response. Provisional data from the CDC reveal that U.S. drug overdose deaths declined nearly 27% from approximately 110,000 in 2023 to around 80,400 in 2024, the lowest figure since 2019. Much of this decline is attributed to the significant drop in synthetic opioid deaths, especially fentanyl, by about one-third in the year ending October 2024, linked to expanded naloxone distribution and broader access to medications for opioid use disorder. With its rapid onset of action and excellent safety profile, naloxone remains indispensable for emergency physicians, EMS providers, and frontline clinicians managing acute opioid toxicity, especially since many overdoses occur outside hospital settings.

Efforts to expand naloxone access have seen substantial progress. Since April 2023, at least two nasal spray formulations, including Narcan®,have been approved for over the counter (OTC) sale. Pharmacy availability has increased accordingly: same-day OTC access rose from 42% to nearly 58% post-OTC approval, and over 2.1 million naloxone prescriptions were dispensed in retail pharmacies in 2023, raising the national dispensing rate from 0.3 to 0.6 per 100 persons since 2019. Additionally, statewide standing orders and community-based distribution programs now operate in every U.S. state, with naloxone dispensing mandates and co-prescribing initiatives embedded in laws in states such as New York and Massachusetts.

For clinicians, integrating naloxone into routine care through targeted risk assessments, patient and caregiver education, and naloxone prescribing or dispensing is essential. Regularly co-prescribing naloxone alongside high-dose opioids or in patients with other overdose risk factors aligns with CDC guidelines and enhances safety nets. Moreover, naloxone distribution in emergency settings, including vending machines and public access points, such as the initiative in Nashville, TN which dispensed over 2,200 doses within five weeks, demonstrates how EDs and health systems can lead community harm-reduction efforts.

Expanding naloxone access and education in schools is a critical public health strategy to combat the growing opioid crisis among youth and adolescents. With the increasing presence of fentanyl and other synthetic opioids in the illicit drug supply, even a single exposure can be fatal and often without the individual knowing they are ingesting an opioid. Equipping school staff, students, and communities with the knowledge to recognize opioid overdose symptoms and administer naloxone can save lives and reduce response time in emergencies. The inclusion of naloxone in school emergency preparedness plans, along with appropriate training, helps destigmatize its use and reinforces its role as a life-saving tool, similar to AEDs or EpiPens. Moreover, integrating substance use education with harm reduction principles fosters early awareness, resilience, and responsible behavior among students, ultimately contributing to safer and more informed school environments.

There are organizations that are working on initiatives and are actively supporting naloxone-related initiatives in educational settings, such as the American Association of School Administrators and the National Association of School Nurses (NASN). For example, NASN has taken a formal leadership role in advocating naloxone access in schools. Its revised position statement asserts that schools should maintain naloxone on-site and that professional school nurses are essential in developing and implementing overdose response protocols and NASN’s toolkit and guidance align with federal recommendations. In 2023, the U.S. Department of Education and the Office of National Drug Control Policy, issued a joint letter encouraging all U.S. schools to maintain naloxone and educate staff and students in its use. This resolution calls for ACEP to potentially work with such organizations and others to endorse these efforts.

ACEP Strategic Plan Reference

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

Fiscal Impact

Budgeted resources to endorse the work of other organizations in supporting naloxone-related initiatives in educational settings.

Prior Council Action

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 in EDs; 2) seek to increase the distribution of naloxone from the ED by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; 3) 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 to increase the number of Take-Home Naloxone programs in EDs; 4) advocate for regulatory and payment reform to facilitate reimbursement from public and private payers, to hospitals and EDs for naloxone dispensed directly to patients as part of Take-Home Naloxone programs; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with the 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.

Resolution 30(18) Naloxone Layperson Training adopted. Directed ACEP to support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted. Directed ACEP to advocate and support training and equipping all first responders to use injectable and nasal spray Naloxone and advocate and support that appropriately trained pharmacists be able to dispense Naloxone without prescription, and develop a comprehensive policy statement on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

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 review solutions to decrease the death rate from prescription drug overdoses and create a document offering best practice solutions.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution sought for ACEP to support and advises emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to lawfully prescribe Naloxone explicitly for potential future opiate overdose through legislative or regulatory advocacy at the local, state, and national levels.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

Prior Board Action

February 2023, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" revised and approved June 2016; originally approved October 2015.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments 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 47(18) Supporting Medication for Opioid Use Disorder adopted.

Resolution 30(18) Naloxone Layperson Training adopted.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 73(25)

SUBMITTED BY: Stephen Anderson, MD, FACEP
John Bibb, MD, FACEP
Christine Collins, MD, FACEP
Fred Dennis, MD, MBA, FACEP
Anthony Furiato, DO, EJD, FACEP
California Chapter
Pain Management & Addiction Medicine Section

SUBJECT: Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation

PURPOSE: 1) Develop a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; 2) Potentially work with other organizations such as the AMA, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and 3) Provide a report to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment and any progress made on the goals of the plan.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, For the first time in over 30 years the overdose death rate in 2024 in United States dropped (from 112,000 to 84,000), but still remained the #1 cause of accidental deaths in America; and

WHEREAS, There are over 170,000 US deaths due to alcohol use disorder according to the CDC; and

WHEREAS, Only 15% of people in the U.S. with substance use disorder (SUD) obtained any treatment for their disease in the last year; and

WHEREAS, These people are our patients, family and friends; and

WHEREAS, There is a wealth of information on treating substance use disorder including E-QUAL, etc.; and

WHEREAS, Initiation of medication for opioid use disorder has been shown to reduce mortality; and

WHEREAS, Only 2% of written prescriptions for naloxone from the emergency department are ever filled; and

WHEREAS, Maryland, California, New York and others have found ways to fund the treatment of substance use disorder from federal, state and private resources; and

WHEREAS, There is evidence for the cost effectiveness of comprehensive substance use disorder treatment programs initiated in the ED benefitting hospitals, health care systems, local communities, and all society; and

WHEREAS, ACEP's own Pain and Addiction Care in the ED (PACED) and other organizations largely composed of ACEP physicians, such as Bridge to Treatment, and MATTERS have worked successfully to improve

SUD treatment in the ED and beyond; therefore be it

RESOLVED, That ACEP develop a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; and be it further

RESOLVED, That ACEP potentially work with other organizations such as the American Medical Association, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and be it further

RESOLVED, That ACEP report back to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment and any progress made on the goals of the plan.

References

- Bridge to Treatment
- Cost Effectiveness of Emergency Department-Initiated Treatment for Opioid Dependence
- Emergency department screening and interventions for substance use disorders
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet].US Department of Health and Human Services; 2016 Nov.
- E-Qual Opioid Network Initiative
- State Investment in Emergency Department Buprenorphine Pays Off Gail D'Onofrio, MD, MS[1,2]; Jon B. Cole, MD[3,4,5]; Jeanmarie Perrone, MD[6] JAMA.2025;333(14):1209-1211. doi:10.1001/jama.2025.0609
- EDAP, www.acep.org/EDAP
- Maryland Department of Public Health Funding
- MATTERS
- Model Legislation: Legislative Analysis and Public Policy Association
- Washington Post editorial https://www.washingtonpost.com/opinions/2025/05/22/opioids-europe-philadelphia-drugs/

Background

This resolution calls for ACEP to: 1) Develop a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; 2) Potentially work with other organizations such as the AMA, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and 3) Provide a report to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment and any progress made on the goals of the plan.

ACEP has helped develop original federal legislation and supports a number of federal legislative advocacy efforts to facilitate access to opioid use disorder (OUD) and substance use disorder (SUD) treatment. For example, in 2018, ACEP was able to secure the inclusion of two ACEP-led and -developed bills, the "Alternatives to Opioids (ALTO) in the Emergency Department Act" and the "Preventing Overdoses While in Emergency Rooms (POWER) Act" as part of the comprehensive opioid crisis response legislation, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271).

- The Alternatives to Opioids (ALTO) in the Emergency Department Act created a demonstration program to implement non-opioid evidence-based pain management protocols, such as nitrous oxide, trigger point injections, nerve blocks, and other pain management options in hospitals across the country, based on the successful and proven ALTO program developed in New Jersey. In 2022, ACEP helped secure a 5-year reauthorization of this program, changing it from a demonstration program to a full permanent program and increasing its appropriation to a total of $8 million (a $2 million increase from FY22 levels).

- The Preventing Overdoses While in Emergency Rooms (POWER) Act established a grant program to implement policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department. It also would provide education and additional resources to help implementation of MAT in the emergency department, as well as develop best practices to provide a "warm handoff" to appropriate community resources and providers to keep patients engaged in treatment. Unlike ALTO, the POWER Act was authorized but never appropriated. The SUPPORT Act reauthorization effort in the current 119th Congress is a streamlined version of the original law and does not extend programs that were authorized but never appropriated, like the POWER Act. As a result, the POWER Act's authorization has expired and ACEP continues looking for potential new legislative champions to reintroduce the bill or related text.

In the 118th Congress, ACEP also supported the "Hospitals as Naloxone Distribution Sites (HANDS) Act" that would provide no-cost coverage under Medicare, Medicaid, and Tricare for preventive distribution of opioid overdose reversal agents, such as naloxone.

Substance use and substance use disorders (SUDs) remain a pervasive public health crisis in the United States, contributing to significant morbidity, mortality, and health care utilization. More than 109,000 people died from drug overdoses in 2023, the vast majority of which involved opioids and particularly synthetic opioids such as fentanyl. Alcohol use also remains a leading preventable cause of death, contributing to approximately 140,000 deaths annually. These figures highlight the ongoing and escalating burden of substance-related harm across communities, exacerbated by the increasing complexity of polysubstance use and co-occurring mental health disorders.

Emergency departments (EDs) serve as critical access points for individuals affected by substance use. Patients may present with acute intoxication, withdrawal symptoms, overdose, or complications from chronic substance use, such as infections, injuries, or psychiatric crises. According to the Centers for Disease Control and Prevention (CDC), ED visits for opioid-related overdoses have increased significantly over the past decade, with notable spikes during and after the COVID-19 pandemic. EDs are also seeing rising numbers of visits associated with methamphetamines, cocaine, xylazine-adulterated opioids, and synthetic cannabinoids, reflecting shifting patterns in drug use and supply.

Emergency physicians are uniquely positioned to intervene in the cycle of addiction. The ED provides a vital opportunity for screening, brief intervention, and referral to treatment (SBIRT), as well as for the initiation of evidence-based medications for opioid use disorder (MOUD), such as buprenorphine. Despite time and resource constraints, emergency medicine is increasingly integrating addiction medicine principles, harm reduction strategies (e.g., naloxone, and other opiate reversal agents, distribution), and linkage to outpatient care into routine practice. These efforts have been supported by evolving legislation and policy changes, including the removal of the federal X-waiver requirement to prescribe buprenorphine.

The impact of substance use on emergency care also extends to provider and system-level challenges. ED crowding, repeat utilization, complex medical and psychiatric needs, and violence associated with intoxicated states can strain resources and staff. Moreover, stigma remains a persistent barrier to effective care and follow-up. As the epidemic evolves, emergency medicine will continue to play a central role, not only in responding to the immediate consequences of substance use, but also in advancing upstream, compassionate, and evidence-based approaches to prevention, treatment, and recovery support.

ACEP has developed a significant number of resources, education, policies and information papers addressing the opioid epidemic and substance use disorders, along with numerous initiatives and partnerships targeted at this issue. In addition to ACEP's clinical policy on "Opioids", there are multiple policy statements on issues related to substance use, including but not limited to:

- Addressing Nicotine Use
- Alcohol Advertising
- Care of Pregnant Individuals with Substance Use Disorder
- Drug Take Back Programs
- Electronic Prescription Drug Monitoring Programs

- Medical Cannabis
- Naloxone Access and Utilization for Suspected Opioid Overdoses
- Physician Reporting of Potentially Impaired Drivers
- Optimizing the Treatment of Acute Pain in the Emergency Department
- Overdose Prevention Centers
- Screening for Disease and Risk Factors in the Emergency Department
- Social Services and Care Coordination in the Emergency Department

ACEP committees have also developed multiple publications on issues related to substance use such as:

- Sandelich S, Hooley G, Hsu G, et al. Acute opioid overdose in pediatric patients. *J Am Coll Emerg Physicians Open*. 2024;5(2):e13134. Published 2024 Mar 7. doi:10.1002/emp2.13134
- Hawk K, Hoppe J, Ketcham E, et al. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Ann Emerg Med. 2021;78(3):434-442. doi:10.1016/j.annemergmed.2021.04.023
- Taylor A, Kinsman J, Hawk K, et al. Development and testing of data infrastructure in the American College of Emergency Physicians' Clinical Emergency Data Registry for opioid-related research. *J Am Coll Emerg Physicians Open*. 2022;3(5):e12816. Published 2022 Oct 25. doi:10.1002/emp2.12816
- Schwarz ES, Dietrich AM, Sandelich S, et al. Emergency department management of opioid use disorder in pediatric patients. *J Am Coll Emerg Physicians Open*. 2024;5(5):e13265. Published 2024 Aug 25. doi:10.1002/emp2.13265
- Chang CD, Saidinejad M, Atanelov Z, et al. Emergency department strategies to combat the opioid crisis in children and adolescents. *J Am Coll Emerg Physicians Open*. 2021;2(4):e12512. Published 2021 Jul 21. doi:10.1002/emp2.12512
- Duber HC, Barata IA, Cioè-Peña E, et al. Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department. *Ann Emerg Med*. 2018;72(4):420-431. doi:10.1016/j.annemergmed.2018.04.007
- Hawk KF, Weiner SG, Rothenberg C, et al. Leveraging a Learning Collaborative Model to Develop and Pilot Quality Measures to Improve Opioid Prescribing in the Emergency Department. *Ann Emerg Med*. 2024;83(3):225-234. doi:10.1016/j.annemergmed.2023.08.490
- Models for Addressing Transitions of Care for Patients with Opioid Use Disorder
- Stoner MJ, Dietrich A, Lam SH, Wall JJ, Sulton C, Rose E. Marijuana use in children: An update focusing on pediatric tetrahydrocannabinol and cannabidiol use. J Am Coll Emerg Physicians Open. 2022;3(4):e12770. Published 2022 Jul 5. doi:10.1002/emp2.12770

ACEP has worked with multiple organizations over many years such as the American Academy of Addiction Psychiatry, American Society of Addiction Medicine, Foundation for Opioid Response Efforts, and others, including federal partners and agencies such as the Center for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration and the Food and Drug Administration, to develop education, tools, resources and initiatives to address the substance use epidemic, including but not limited to in person educational trainings and conferences, publications, policies, clinical point of care tools, webinars, and podcasts.

ACEP launched the EM Opioid Advisory Network in 2022. This initiative was formed by leaders and experts from the Pain Management & Addiction Medicine Section and the Pain & Addiction Care in the Emergency Department (PACED) accreditation program. This program 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 available to emergency health care professionals.

ACEP convened a summit, Addressing the Opioid Stigma in the Emergency Department, on January 23, 2020. 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 OUD.

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**
- 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

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

Prior Council Action

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted. Directed ACEP to create a policy statement based on the concepts of the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

Amended Resolution 43(22) Endorsing ED Resident Competency in Buprenorphine Initiation adopted. Directed 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 to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.

Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder adopted. Directed ACEP to 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.

Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED adopted. Directed ACEP to advocate for the FDA adding buprenorphine to its list of essential medications and that EDs stock buprenorphine and medications for opioid use disorder. Directed ACEP to 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 support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

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 in EDs; 2) seek to increase the distribution of naloxone from the ED by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; 3) 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 to increase the number of Take-Home Naloxone programs in EDs; 4) advocate for regulatory and payment reform to facilitate reimbursement from public and private payers, to hospitals and EDs for naloxone dispensed directly to patients as part of Take-Home Naloxone programs; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

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.

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 the 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.

Resolution 30(18) Naloxone Layperson Training adopted. Directed ACEP to support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

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 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted. Directed ACEP to advocate and support training and equipping all first responders to use injectable and nasal spray Naloxone and advocate and support that appropriately trained pharmacists be able to dispense Naloxone without prescription, and develop a comprehensive policy statement on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

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 develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

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 39(14) Naloxone Prescriptions by Emergency Physicians adopted. Directed ACEP to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone.

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.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution sought for ACEP to support and advises emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to lawfully prescribe Naloxone explicitly for potential future opiate overdose through legislative or regulatory advocacy at the local, state, and national levels.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

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.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. Directed ACEP to provide guidance to states and chapters to respond to issues related to psychiatric and substance abuse patients in the ED.

Prior Board Action

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted.

February 2023, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" revised and approved June 2016; originally approved October 2015.

Amended Resolution 43(22) Endorsing ED Resident Competency in Buprenorphine Initiation adopted.

Resolution 33(22) Telehealth Bridge Model for the Treatment of Opioid Use Disorder adopted.

Resolution 29(22) Buprenorphine is an Essential Medicine and Should be Stocked in Every ED adopted.

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.

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.

June 2020, approved the Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

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.

Resolution 30(18) Naloxone Layperson Training adopted.

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

October 2014, approved the Public Health & Injury Prevention Committee's recommendation for ACEP to advocate for further research into ED-specific interventions to address prescription drug overdose deaths with the goal of reducing mortality while treating pain for patients seen in the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 74(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Medical Directors Section
Quality Improvement & Patient Safety Section
Rural Emergency Medicine Section

SUBJECT: Necessary Facility-Provided Medications from Emergency Departments

PURPOSE: Identify a list of key medications that should be dispensed at the time of discharge and establish this practice as a standard of care and coordinate legislative resources to assist chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

WHEREAS, Patients continue to have care needs during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Emergency departments may be the only source of health care available to patients during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Many emergency departments may be lacking in local pharmacies open during off hours, such as overnights, weekends, and holidays; and

WHEREAS, Not all local pharmacies may stock relevant medications to be filled by patients upon discharge from their local emergency department; and

WHEREAS, It contributes to increased medical waste to utilize a facility-provided medication only used once or a few times during an ED visit which then must be disposed of upon completion of patient care; and

WHEREAS, It contributes to both increased patient costs and health care costs in general to utilize a facility-provided medication in the ED, dispose of that medication, and then prescribe that same medication for a patient to fill upon discharge from the ED; and

WHEREAS, Multi-use medications would otherwise be used in the emergency department and subsequently disposed of if not dispensed with the patient; and

WHEREAS, Some states are now debating the legality of emergency departments from performing the common practice of sending patients home with select medications upon discharge ("facility-provided medication")[1]; and

WHEREAS, Legislation in different states has already been implemented to ensure that practitioners are authorized to provide the remaining unused portion of select facility-provided medications to a patient upon discharge[2,3]; and

WHEREAS, In different states where legislation has been implemented to preserve the dispensing of facility-provided medications, emergency departments are specifically mentioned, where "the prescriber is responsible for counseling the patient on its proper use and administration and the requirement of pharmacist counseling is waived"[3]; therefore be it

RESOLVED, That ACEP acknowledge there is a standard of care for certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available for continued care after discharge from the emergency department, and that deviation from this established standard of care may put a patient's organ function or life at risk; and be it further

RESOLVED, That ACEP develop a list of key classes of medications that patients could receive as facility-provided medications upon discharge from the emergency department; and be it further

RESOLVED, That ACEP coordinate legislative resources to assist state chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

Resolution References

1. Pennsylvania General Assembly, Session of 2025. House Bill 446: An Act Amending the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act. ttps://www.palegis.us/legislation/bills/2025/hb446
2. Delaware 152nd General Assembly. Senate Bill 148: An Act to Amend Title 24 of the Delaware Code Relating to the Topical Medical Waste Reduction Act. https://legis.delaware.gov/BillDetail/140458#:~:text=Original%20Synopsis:,the%20Delaware%20Legislative%20Drafting%20Manual.
3. Illinois 102nd General Assembly. Senate Bill 0579: Facility-Provided Medications. https://www.ilga.gov/legislation/BillStatus.asp?GA=102&DocTypeID=SB&DocNum=579&GAID=16&SessionID=110&LegID=133175

Background

This resolution requests ACEP to identify a list of key medications that should be dispensed at the time of discharge and establish this practice as a standard of care and coordinate legislative resources to assist chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

A 2023 report in Pediatrics[1] highlights the benefits of dispensing medications from the ED:

> "Approximately one-third of patients fail to obtain priority medications from a pharmacy after discharge from an ED. The option of judiciously dispensing medications at ED discharge from the outpatient pharmacy within the health care facility is a major convenience that helps to overcome this obstacle, improving the likelihood of medication adherence."

Emergency departments (EDs) are typically not set up to dispense medications like traditional pharmacies due to a combination of factors, including regulatory limitations, logistical challenges, and patient safety concerns.

1. Regulatory limitations
   - State and Federal Regulations: Laws governing the dispensing of medications vary by state and are often quite stringent. These regulations may limit the types and quantities of medications that can be dispensed from an ED, especially controlled substances. For example, in many states, only a pharmacist or an individual under the direct supervision of a pharmacist can dispense medications for use beyond the immediate needs of the patient.
   - Controlled Substances: Rules surrounding controlled substances are particularly strict. Emergency supplies of certain controlled drugs may be restricted or require follow-up prescriptions within a specific timeframe.

2. Logistical challenges
   - Staffing: Hiring pharmacists for dedicated ED roles can be expensive, especially in smaller departments with lower patient volume.
   - Inventory Management: Maintaining a comprehensive medication inventory, similar to a pharmacy, can be challenging in an ED setting, especially with issues like drug shortages and space constraints.
   - Patient Flow: Dispensing medications can add to the time patients spend in the ED, potentially hindering efficient patient flow and creating backlogs.
   - Costs: Operating a pharmacy within an ED, or providing medications free of charge, can incur significant costs for the hospital system.

3. Patient safety
    - Medication Reconciliation: Ensuring accurate and complete medication histories in the fast-paced ED environment can be challenging, increasing the risk of medication errors.
    - Dispensing Accuracy: Without dedicated pharmacy staff and systems, the risk of dispensing errors can increase, particularly when dealing with large volumes of patients and time pressure.
    - Patient Education: Providing comprehensive medication education to patients in a busy ED setting can be difficult, potentially leading to non-adherence and adverse outcomes.

4. Financial Barriers
    - Medication Cost: Many patients, especially those with limited financial resources or without insurance, may struggle to afford medications, even with insurance coverage. Unlike a pharmacy, the ED is not set up for patients to pay for medications at the time they are dispensed. Hospitals may have to absorb the cost when dispensing medications in-house.
    - Insurance Coverage: Insurance companies may deny payment for outpatient medications dispensed by an inpatient pharmacy, particularly if the medication is typically covered under an outpatient benefit. This lack of coverage can create a financial disincentive for hospitals to dispense medications directly to patients. Insurers also have formularies, which can increase the number of drugs needing to be stocked in the ED, and add to the complexity of the prescribing and dispensing process. Prior authorizations represent another challenge.

Despite these challenges, some EDs are exploring or implementing programs to facilitate medication dispensing, especially for patients who might face barriers to accessing medications after discharge, such as transportation or cost. These programs often focus on providing short-term supplies of essential medications and prioritizing patient education and follow-up.

Background Reference

1. Suzan S. Mazor, Michelle C. Barrett, Corinne Shubin, Shannon Manzi, COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE; Dispensing Medications at the Hospital Upon Discharge From an Emergency Department. *Pediatrics* June 2023; 151 (6): e2023062144. 10.1542/peds.2023-062144

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 professional

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort.

Prior Council Action

Resolution 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team adopted. This resolution calls for the College to develop a policy statement in support of clinical pharmacy services in the emergency department (ED), collaborate with emergency medicine providers to promote safe, effective, and evidence-based medication practices, conduct emergency medicine related clinical research, and foster support for pharmacy residency training in emergency medicine.

Prior Board Action

January 2021, ,approved the revised policy statement "Clinical Pharmacist Services in the Emergency Department;" originally approved June 2015.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 75(25)

SUBMITTED BY: Louisiana Chapter
Maine Chapter
New Jersey Chapter
Vermont Chapter

SUBJECT: Protecting the Term "Emergency Department" in Critical Access Hospitals

PURPOSE: 1) Develop a policy to ensure the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours. 2) Develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the ED, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy statement. Unbudgeted additional resources to develop and advocate for regulation for Critical Access Hospitals to adopt alternative terminology to inform the public that physician-level medical care is not continuously available on-site.

WHEREAS, Recent data indicate that 1 in 13 emergency departments operate at times without a physician physically on-site and on duty; and

WHEREAS, The American College of Emergency Physicians (ACEP) affirms that, regardless of geographic location, all patients who present to emergency departments (EDs) deserve access to high-quality, patient-centered care delivered by emergency physician-led teams; and

WHEREAS, The ACEP Emergency Department Accreditation Program promotes transparency to help patients make informed decisions when seeking emergency care; and

WHEREAS, The general public reasonably expects that a visit to an "Emergency Department" will involve being evaluated by a physician; and

WHEREAS, A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency; and

WHEREAS, Per the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F regarding "Conditions of participation: Critical Access Hospitals (CAHs)" do not require an "Emergency Department" as a condition of participation, but must be able to provide emergency care necessary to meet the needs of its inpatients and outpatients; therefore be it

RESOLVED, That ACEP develop a policy to ensure that the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours; and be it further

RESOLVED, That in the interest of public transparency, ACEP develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the emergency department while it is open, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

Background

This resolution calls for ACEP to develop a policy to ensure the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours. Additionally, the resolution requests ACEP to develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the ED, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

ACEP believes that every patient deserves to have their care overseen by a board-certified emergency physician and advocates for physician-led care teams in emergency departments, emphasizing that while physician assistants (PAs) and nurse practitioners (NPs) are valuable members of the team, they do not possess the same level of training and expertise as emergency physicians.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "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."

Federal regulations, like those governing Critical Access Hospitals (CAHs), stipulate that a physician, PA, NP, or clinical nurse specialist with emergency care training must be available, but not necessarily on-site at all times. They must be immediately available by phone or radio for consultation. Most states do not have regulations requiring an onsite physician in the ED. This has been a major state-level advocacy effort for both ACEP and the American Medical Association.[1,2] Some states have moved towards requiring on-site physician presence in emergency departments. In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing a law requiring all hospitals with emergency departments to have at least one physician physically onsite while the ED is open. Both Virginia and South Carolina chapters were able to use model legislation and receive direct support from ACEP's State Legislative team, including assistance with drafting the legislation, and providing expert-level support during the legislative process.

Ensuring adequate physician coverage, especially in rural areas, presents a challenge for some states. The unique needs of rural emergency departments are often considered when determining the applicability of any exceptions to on-site physician requirements, and some state laws have exceptions for rural settings.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered. ACEP worked with ABEM to pilot a campaign promoting the value of board certification in three markets (urban, suburban, and rural) that included billboards and other environmental ads, a digital campaign, and pre- and post-campaign surveys. Enduring materials for the campaign are available to diplomates and the public on the ABEM website, which includes video content provided by ACEP.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. 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."

ACEP developed an information paper that defines the use of the term "Free Standing Emergency Department" and "Urgent Care Center." Additionally, ACEP's policy statement "Urgent Care Centers" states:

> "The American College of Emergency Physicians (ACEP) believes that any facility that does not meet the definition of an ED or freestanding ED as defined by ACEP and that advertises itself as providing unscheduled care should:
>
> - Not use the word "emergency" or "ER" in its name in any way.
> - Not use the word "emergency" or "ER" in any advertisements, claims of service, or to describe the type or level of care provided or as an alternative to an ED. Doing so may be considered a deceptive trade practice, as defined by federal or applicable state law."

However, ACEP does not currently have a specific policy statement defining the term "Emergency Department." While ACEP could develop a policy statement, ensuring the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours would require changes to federal and state regulations.

Background References

1. https://www.ama-assn.org/practice-management/scope-practice/having-physician-site-best-way-deliver-emergency-care#:~:text=%E2%80%9CWithout%20the%20availability%20of%20a,emergency%20department%20at%20all%20times.
2. https://emworkforce.substack.com/p/48-states-and-the-feds-dont-require?triedRedirect=true

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 professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources to develop a policy statement. Unbudgeted additional resources to develop and advocate for regulation for Critical Access Hospitals to adopt alternative terminology to inform the public that physician-level medical care is not continuously available on-site.

Prior Council Action

Resolution 69(24) Updating ACEP's Position on PA and NP Supervision in the ED referred to the Board of Directors. The resolution sought to amend the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove reference to workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "offsite" by telehealth means for Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs).

Resolution 39(24) Urgent Care Transparency on Available Resources and Credentials adopted. Directed ACEP to advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing resources that are or are not available; and advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board. Requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician is immediately available for on-site care of emergency department patients at all times.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

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.

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted. Directed ACEP to create a policy statement defining an urgent care center to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and costs to make informed decisions when seeking care; and consider working with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

Prior Board Action

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and 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" and 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(24) Urgent Care Transparency on Available Resources and Credentials adopted.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

January 2022, approved the revised policy statement "Urgent Care Centers;" originally approved October 2016.

April 2020, approved the revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

Amended Resolution 33(15) Defining and Transparency in Urgent Care Centers adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 76(25)

SUBMITTED BY: Puneet Gupta, MD, FACEP
Scott Pasichow, MD, FACEP
California Chapter
New Jersey Chapter
Social Emergency Medicine Section

SUBJECT: Protection and National Standardization of Transgender Care in Emergency Medicine

PURPOSE: Support the development and publication of nationally recognized guidelines for transgender care in emergency medicine and advocate for the protection and of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians are on the front lines of providing critical and lifesaving care to all individuals regardless of gender identity; and

WHEREAS, Transgender and gender-diverse individuals face significant barriers in accessing appropriate medical care, including emergency services; and

WHEREAS, Evidence-based transgender health care is an important and growing facet of emergency medicine that requires clear, standardized, and scientifically driven guidelines; and

WHEREAS, The practice of medicine should be governed by scientific evidence and professional standards rather than legislative, judicial, or executive actions that may interfere with the physician-patient relationship; and

WHEREAS, Ensuring the safety and dignity of transgender patients in emergency settings is essential to upholding the ethical principles of medical care, including beneficence, nonmaleficence, and justice; and

WHEREAS, National guidelines for transgender care in emergency medicine will aid physicians in delivering consistent, equitable, and high-quality medical services; therefore be it

RESOLVED, That ACEP support the development and publication of nationally recognized guidelines for transgender care in emergency medicine; and be it further

RESOLVED, That ACEP advocate for the protection of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

Background

This resolution calls for ACEP to support the development and publication of nationally recognized guidelines for transgender care in emergency medicine and advocate for the protection and of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities

Emergency physicians frequently treat transgender and gender-diverse (TGD) patients who often encounter significant delays or avoidance of care because of systemic barriers and prior negative experiences. Surveys indicate that approximately 33% of transgender individuals have delayed or avoided medical care because of fear of mistreatment, and nearly 16.8% report experiencing discrimination in emergency department (ED) settings

specifically. TGD patients seen in EDs are disproportionately likely to present with complex chronic medical conditions or mental health comorbidities – 58% and 29% respectively – compared to cisgender counterparts, contributing to higher admission rates (over 52% vs. 17%) following ED visits.

Standardized, evidence-based clinical guidelines tailored to TGD emergency care can and would improve the quality of care and patient outcomes for this patent population. Although the World Professional Association for Transgender Health (WPATH) Standards of Care (Version 8, 2022) offer an international framework, they are not ED-specific and local adaptations remain scarce. Emergency care must be guided by scientific evidence and professional ethics rather than politicized mandates, to ensure equity, dignity, and patient-centered practice. Professional societies including ACEP and the Emergency Medicine Residents' Association (EMRA) have developed policy statements and training materials, however, more rigorous clinical practice guidelines could be beneficial in unifying care standards across emergency settings.

National advocacy organizations, such as the National Center for Transgender Equality (NCTE), continue to call for policies that protect the rights of transgender individuals in health care settings. Establishing and implementing targeted ED guidelines and promoting culturally competent training would help to ensure that transgender and gender-diverse patients receive consistent, affirming, and high-quality care.

ACEP's policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department" states "ACEP believes that:

- Gender-affirming care is supported by evidence and by the medical community. TGD patients should have access to comprehensive gender-affirming health care that is provided in a safe and inclusive clinical setting.
- Emergency physicians need to be knowledgeable and aware of the unique needs and best practices related to care of TGD patients of all ages in the ED. Emergency physicians, patients, and their support structure should engage in shared-decision making based on scientific evidence and best practices regarding appropriate medical care.
- EDs should foster and develop practices, policies, and accessible resources that provide a supportive and inclusive environment for TGD patients, including removing structural barriers to care.
- Hospitals should provide ongoing education, training, and resources to all emergency physicians and ED staff related to best practices and the care of TGD patients.
- Emergency physicians must be able to practice high quality, objective evidence-based emergency medical care without legislative, regulatory, or judicial interference in the physician-patient relationship."

The Public Health Committee developed the Policy Resource & Education Paper (PREP) "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department" as an adjunct to the policy statement.

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 professional.

Practice Innovation: Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department adopted.

Directed ACEP to promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED and compile information on the unique needs and best practices related to care of said patients. The resolution also directed ACEP to encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients, in addition to encouraging EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

Resolution 21(21) Diversity, Equity, and Inclusion adopted. 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 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and continue to create and advertise free, CME-eligible, online training related to implicit bias.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. This resolution directed ACEP to oppose all forms of discrimination against patients and employees in emergency medicine on the basis of gender, race, creed, color, national or ethnic origin, religion, disability, or sexual orientation.

Prior Board Action

September 2024, approved the policy statement "Diversity, Equity, and Inclusion."

April 2023, reviewed the Policy Resource & Education Paper "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

June 2022, approved the policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department."

Resolution 44(21) Caring for Transgender and Gender Diverse Patients in the Emergency Department 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; approved April 2008 with the current title' originally approved October 2001 titled "Cultural Competence and Emergency Care."

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.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 77(25)

SUBMITTED BY: New York Chapter
North Carolina College of Emergency Physicians
Ohio Chapter
Texas College of Emergency Physicians

SUBJECT: Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation

PURPOSE: Support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of NPs and PAs in states with independent practice authority and use the findings of the study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The cost of a study on practice patterns could range between $300,000 and $500,000 to capture a large enough sample to examine geographic and practice patterns.

WHEREAS, There is limited national data regarding the subsequent practice locations, settings (e.g., rural vs urban), or specialties chosen by NPs and PAs following the granting of independent practice rights; and

WHEREAS, Understanding the real-world impact of these laws on healthcare delivery, workforce distribution, and patient access is critical for shaping evidence-based workforce policy; and

WHEREAS, Such data may inform ACEP advocacy, workforce planning, and public health policy in the context of emergency care, therefore be it resolved

RESOLVED That ACEP support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of nurse practitioners and physician assistants in states with independent practice authority and use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

Background

This resolution requests ACEP to conduct or commission a study to investigate the geographic distribution and fields of practice of NPs and PAs before and after states grant independent practice authority use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

The American Medical Association Advocacy Resource Center is studying each of the states that granted independent practice authority to NPs, although this is not a formal academic study and does not include PAs. The study is tracking metrics for quality and patient safety and watching for information demonstrating why a physician-led team would have potentially had a better outcome.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states that:

> "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…. 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."

Proponents of expanding the scope of practice of non-physicians to allow for unsupervised practice claim that in to improve patient access to care. Currently, there is a shortages of physicians in U.S. and the shortage is worse in rural and underserved areas. Non-physician practitioners (NPPs) have long claimed that expansion of their scope of practice will result in increased access to care in rural and underserved areas and will help fill the gaps in primary care. Despite these promises, however, the evidence demonstrates nurse practitioners tend to practice in the same areas of the state as physicians, even in states where nurse practitioners have had independent practice for decades. The AMA has looked into where NPs practice and found that regardless of scope of practice laws, nurse practitioners tend to practice in the same areas of the state as physicians, and do not expand access in rural settings.[1] Data from several states demonstrate this trend. In Wyoming, for example, which has allowed nurse practitioners to practice independently since 2007, there were 382 nurse practitioners in the state compared with 441 primary care physicians in 2018. Over time, the number of nurse practitioners has increased, but the data shows they are practicing in the same areas that physicians are. In West Virginia, which enacted legislation in 2017, that permits nurse practitioners to diagnose and treat patients without physician involvement, but requires them to have a collaborative relationship with a physician for three years to be able to write prescriptions. While the state saw an increase in the overall number of nurse practitioners in the state, again those new professionals continued to practice in the same area as the state's physicians. In Georgia, nurse practitioners must practice pursuant to a protocol agreement with physician supervision and delegation. As is the case in Wyoming, West Virginia and pretty much across the country, there has been tremendous growth in the number of nurse practitioners. There were 10,291 nurse practitioners in 2020, up from 4,275 in 2013. NPs practice with physicians in urban and rural areas of the state, demonstrating "that changes in nurse practitioner scope of practice laws are not the sole reason for growth of nurse practitioners in a state or where they practice," In Oregon, which allows independent practice by NPs, there has been an overall increase in the number of nurse practitioners, but there has been no measurable shift of nurse practitioners to rural areas.[2]

Another argument often advanced for expanding nurse practitioners' scope of practice is that doing so would help address primary care physician shortages, which are severe and expected to worsen dramatically as more physicians retire and the U.S. population ages and becomes sicker. Research actually shows that, in addition to setting up practice in the same geographic locations as physicians, many nurse practitioners are also opting to pursue non-primary care specialties. For example, the Oregon Center for Nursing found that just 25% of nurse practitioners practiced in primary care. A study by researchers from the State University of New York, Albany, School of Public Health Center of Health Workforce Studies found that newly graduated nurse practitioners in the Empire State were more likely to enter a specialty or subspecialty than they were to pursue primary care.

Background References

1. https://www.ama-assn.org/practice-management/scope-practice/are-nurse-practitioners-easing-shortages-underserved-areas
2. https://www.ama-assn.org/practice-management/scope-practice/3-big-reasons-why-letting-nps-practice-independently-bad-idea
3. https://www.chwsny.org/our-work/reports-briefs/a-profile-of-new-york-state-nurse-practitioners-2017/

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 professional.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort. The cost of a study on practice patterns could range between $300,000 and $500,000 to capture a large enough sample to examine geographic and practice patterns.

Prior Council Action

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Amended Resolution 45(22) Offsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP 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.

Resolution 44(22) Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants not adopted. Requested that ACEP: 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 and reimbursement purposes.

Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine adopted. The resolution calls for the College 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.

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.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted. Directed that ACEP publish 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 and support the standard that board certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

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 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.

Prior Board Action

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners"

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and 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" and 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 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, rescinded the motion approved at the October 28, 2021, meeting to adopt the second resolved and to overrule it. The Board also adopted a motion "that ACEP work with the American Medical Association and other stakeholders to 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."

Resolution 46(22) Safe Staffing for Nurse Practitioner and Physician Assistant Supervision adopted.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

Amended Resolution 74(21) Regulation by State Medical Boards of All Who Engage in Practice of Medicine adopted.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted.

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, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

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.

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.

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships."
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.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 78(25)

SUBMITTED BY: Gregory Gafni-Pappas, MD, FACEP
Antony Hsu, MD, FACEP
James Mitchiner, MD, FACEP

SUBJECT: Standardized Emergency Medicine Post-Graduate Training for Advanced Practice Providers

PURPOSE: 1) Reaffirm commitment to physician-led EM teams and oppose the independent practice of PAs and NPs in the ED. 2) Collaborate with other organizations to establish new standards for training and accrediting NPs and PAs as a prerequisite for clinical practice in EDs.

FISCAL IMPACT: Budgeted committee and staff resources to reaffirm commitment to physician-led emergency medicine teams and opposing independent practice of NPs and PAs. Developing standards and accrediting training programs is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort, as well as engage external subject matter experts.

WHEREAS, The scope of practice for Advanced Practice Providers (APPs), including Physician Assistants (PAs) and Nurse Practitioners (NPs), in emergency medicine varies widely across states and hospital systems, leading to inconsistent levels of training and patient care; and

WHEREAS, There is a growing reliance on APPs in emergency departments, yet no standardized, required postgraduate training program exists to ensure competency in emergency medicine; and

WHEREAS, Some institutions and emergency medicine groups have implemented emergency medicine postgraduate training for APPs successfully; and

WHEREAS, APPs with formal postgraduate training in emergency medicine could demonstrate improved clinical competency, reduced medical errors, and increased efficiency in patient care compared to those without such training; and

WHEREAS, Multiple professional organizations, including the Society of Emergency Medicine Physician Assistants (SEMPA) and the American Academy of Emergency Nurse Practitioners (AAENP), support the implementation of structured training programs for APPs in emergency medicine; and

WHEREAS, A standardized emergency medicine training program for APPs would provide critical hands-on experience, procedural training, and supervised clinical education, ensuring that APPs working in emergency departments meet established competency standards; therefore be it

RESOLVED, That ACEP reaffirm its commitment to physician-led emergency medicine teams and opposes independent practice by advanced practice providers (APPs) in emergency departments, while supporting structured training and supervised clinical practice as a means to enhance APP competency within team-based care models; and be it further

RESOLVED, That ACEP work with the Society of Emergency Medicine Physician Assistants (SEMPA) and the American Academy of Emergency Nurse Practitioners (AAENP), and other relevant stakeholders to develop and advocate for the implementation of a standardized, accredited emergency medicine training program for advanced practice providers as a prerequisite for clinical practice in emergency departments, with a legacy process for experienced advanced practice providers based on documented experience and continuing education.

Background

This resolution calls for the College to reaffirm its stance opposing independent practice by advanced practice practitioners in emergency departments (EDs) and to develop and advocate for the implementation of a standardized, accredited emergency medicine training program for advanced practice providers as a prerequisite for clinical practice in EDs.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states (excerpted):

> "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.
>
> 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.
>
> PAs and NPs should not perform independent, unsupervised care in the ED.
>
> 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."

In September 2006, the ACEP Board of Directors reviewed a report from the ACEP 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. The Emergency Nurses Association (ENA) and Society of Emergency Medicine Physician Assistants (SEMPA) expressed their willingness to work with ACEP on this project. In January 2007, NCCPA sent a letter to ACEP and SEMPA advising of their desire to create 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. NCCPA advised they would contact the workgroup representatives regarding next steps.

NCCPA launched the Emergency Medicine CAQ, which has structured requirements for certification including an emergency medicine exam. NCCPA offers 11 CAQs, with geriatric medicine coming soon. The Content Blueprint of the EM CAQ was developed using data gathered from the most recent PA Practice Analysis conducted by NCCPA.

The American Academy of Nurse Practitioners (AANP) has a program for certification of Emergency Nurse Practitioners (ENPs).

The Accreditation Commission for Education in Nursing (ACEN) and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) have partnered to offer nurse practitioner and physician assistant Residency Program Accreditation. This program provides overall accreditation to training programs but is not specialty-specific.

SEMPA has developed the Emergency Medicine Physician Assistant Postgraduate Education Program Standards to be aligned with the Accreditation Council for Graduate Medical Education (ACGME) guidelines and Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) Clinical Postgraduate Standards.

AAENP has also developed a core curriculum, ENP competencies, and Scope and Standards to facilitate ENP program development.

While both AAENP and SEMPA advocate for specialized education and knowledge for NPs and PAs working in emergency departments, neither organization explicitly requires advanced training programs or certification as prerequisites to work in the emergency department.

ACEP Strategic Plan Reference

Career Fulfilment: Position ACEP as the standard bearer for emergency medicine workplaces to increase career satisfaction for all emergency physicians and improve access and outcomes for patients.

Fiscal Impact

Budgeted committee and staff resources to reaffirm commitment to physician-led emergency medicine teams and opposing independent practice of NPs and PAs. Developing standards and accrediting training programs is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort, as well as engage external subject matter experts

Prior Council Action

Amended Resolution 47(22) Independent Agency Report for Nurse Practitioner Schools adopted. Directed ACEP to work with the American Medical Association to provide recommendations for nurse practitioner education reform to improve the quality and standards of nurse practitioner training for the purpose of improving physician-led patient care.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. Called for ACEP to 1.) Create and disseminate a policy explicitly stating that all patients presenting to an ED deserve to be assessed by an emergency physician and all patients have the right to have an emergency physician directly oversee their care in-person; and 2.) Reaffirm that ACEP is a professional medical association dedicated to promoting the role of emergency physicians and instruct ACEP staff and officers promote the role of emergency physicians over all other models of care.

Resolution 25(14) CME for Nurse Practitioners and Physician Assistants not adopted. Called for ACEP to develop a policy statement recommending that NPs and PAs working in emergency department 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 and survey states and hospitals on where independent practice by NPs is permitted.

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 to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Prior Board Action

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and 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" and 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.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" revised and approved April 2017; originally approved June 2011.

Amended Resolution 47(22) Independent Agency Report for Nurse Practitioner Schools adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, and June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

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.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, June 2004; reaffirmed October 1999; revised and approved September 1995; originally approved April 1985 titled "Guidelines for Delineation of Clinical Privileges 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.

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. 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.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Interim Associate Executive Director, Clinical Affairs

Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 79(25)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Standards for the Safe and Appropriate Transport of Patients to Psychiatric Facilities

PURPOSE: Work collaboratively with the American Psychiatric Association to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians frequently coordinate the transfer of patients experiencing psychiatric emergencies to inpatient psychiatric facilities; and

WHEREAS, The current variability in transport requirements, such as mandated use of medically trained transports, indiscriminate use of restraints, or ALS-level transport, may not be evidence-based and can lead to unnecessary delays, stigmatization, escalation of patient distress, increased cost and resource burden on both hospitals and EMS systems; and

WHEREAS, There is often discordance between emergency medicine and psychiatry regarding criteria for safe interfacility transfer behavioral stability, and level of transport required; and

WHEREAS, The American Psychiatric Association statement Transportation during the commitment process shall be provided by medically trained persons in the least restrictive manner appropriate, avoiding the use of restraints and physically coercive measures whenever possible[3]; and

WHEREAS, It is at the discretion of the transferring physician as to the mode of transport, need for associated equipment during transport, and personnel with the patient[1,2]; therefore be it

RESOLVED, That ACEP work collaboratively with the American Psychiatric Association to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

References

1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf
2. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-15-EMTALA.pdf
3. Council on Psychiatry and Law. Position Statement on Voluntary and Involuntary Hospitalization of Adults with Mental Illness. APA Official Actions. July 2020. Accessed June 3, 2025. https://www.psychiatry.org/getattachment/46011d52-de5d-4738-a132-f5aaa249efb5/Position-Voluntary-Involuntary-Hospitalization-Adults.pdf

Background

This resolution calls for ACEP to work collaboratively with the American Psychiatric Association (APA) to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

Emergency physicians frequently coordinate the transfer of patients experiencing psychiatric emergencies to inpatient psychiatric facilities; however, current transport protocols, such as mandatory use of medically trained transport teams, automatic use of restraints, and ALS-level transport, can sometimes be based on custom and common practice rather than evidence. These requirements can sometimes lead to avoidable delays, stigmatization, escalation of patient distress, and increased costs for both hospitals and EMS systems. Additionally, potential discrepancies between emergency medicine and psychiatry in defining behavioral stability and appropriate transport levels further complicate transfers. While the American Psychiatric Association (APA) advocates for medically trained personnel and the least restrictive transport methods, avoiding restraints and coercive measures whenever possible, the decision about transport mode, equipment, and personnel ultimately rests with the transferring physician, underscoring the need for clinical discretion and interdisciplinary collaboration.

Evidence suggests that overly restrictive transport protocols can potentially do more harm than good. A *JACEP Open* study "Interfacility ambulance transport of mental health patients" noted frequent injuries to both patients and EMS personnel during psychiatric transfers and highlighted the lack of standardized guidelines, with institutional policies often conflicting and confusing. Prehospital research further indicates that indiscriminate use of physical restraints can traumatize patients, increase agitation, and elevate the risk of adverse events. These findings reinforce the importance of advocating for the least restrictive, medically supervised transport and highlight the pressing need for harmonized criteria to guide determining transport mode and restraint use.

For emergency physicians, ensuring safe interfacility transfers requires balancing patient safety, patient dignity, and resource stewardship. Incorporating psychiatric consultation in the ED to assess behavioral stability can align transport decisions with clinical rather than administrative criteria. Instituting clear protocols for restraint use and developing pre-transfer checklists can reduce variability and promote transparency. Training ED staff and EMS in de-escalation techniques, mental health first aid, and trauma-informed communication can lower reliance on coercive methods.

At the systems level, institutions should collaborate with psychiatric facilities and EMS medical directors to co-create regional guidelines based on best available evidence and ethical principles. Embedding standardized transport pathways including clear handoff processes, decision tools for transport mode selection, and documentation standards, can decrease delays, improve patient experience, and optimize resource utilization. Future advocacy, education, and research should focus on evaluating outcomes of such guidelines in terms of patient safety, timeliness of psychiatric admission, EMS and ED burden, and staff/patient satisfaction, propelling emergency psychiatry toward more humane, effective, and efficient interfacility transport practices.

The ACEP Board approved the revised policy statement "Adult Psychiatric Emergencies" in April 2023 which states:

> "Emergency departments (EDs) are a critical component of a comprehensive safety net for patients with psychiatric emergencies, and emergency physicians have an obligation to advocate for high-quality psychiatric emergency care. Psychiatric emergencies should be managed like any other medical emergency, with appropriate risk stratification, tailored laboratory work-up, timely treatment, and safe disposition."

The policy statement also recognizes that boarding of patients with psychiatric emergencies in the ED is inhumane, does not provide for a therapeutic alliance, impacts the care of all patients in the ED, and is a rapidly growing symptom of a systemic problem. These speak directly to ACEP's effort and commitment to improving transportation and transfer practices of this patient population,

Additionally, in the June 2024, the ACEP Board approved the revised policy statement "Patient Autonomy and Shared Decision-Making in Emergency Medical Services and Mobile Integrated Healthcare Community Paramedicine Programs." It states:

> "EMS systems programs must utilize a formal process for establishing a patient's medical decision-making capacity for dissent to medical assessment, treatment, and/or transportation."

This further speaks to the incorporation of the patients role in the decision-making process. Additionally, ACEP has multiple other relevant policy statements that advocate for and support evidence based best practices in the care of psychiatric patients and the transportation and transfer of patients, including but not limited to:

- Psychiatric Patient (Clinical Policy – approved December 2024)
- Access to Optimal Emergency Care for Children – (policy statement approved April 2021)
- The Management of Children and Youth with Pediatric Mental and Behavioral Health Emergencies – (policy statement approved January 2022)
- Transition of Care for Emergency Department Patients – (policy statement approved April 2021)
- Appropriate Interfacility Patient Transfer – (policy statement approved January 2022)
- Emergency Medical Services Interfaces with Health Care Systems – (policy statement approved June 2024)
- Emergency Department Planning and Resource Guidelines – (policy statement approved April 2021)

ACEP President Alison Haddock, MD, FACEP, appointed the Emergency Behavioral Health Workgroup in late 2024 in light of the development of the Focus Practice Designation (FPD) on Behavioral Health Emergencies It was determined to be critical and extremely beneficial for emergency physicians to have access to a clinical resource that guides emergency physicians in the care of behavioral health patients, developed by experts in behavioral health, that is evidence based, and supported by organizations from the entire health care team involved in the care of behavioral health patients. The workgroup is currently developing this resource and it will be shared with other relevant organizations such as the Emergency Nurses Association and the APA for review and feedback prior to publication and release.

ACEP is a member of the Coalition on Psychiatric Emergencies along with the American Association of Emergency Psychiatry, which may be able to provide some further resources.

ACEP Strategic Plan Reference

Career Fulfillment: Focus resources, education and networks to assist members in identifying career opportunities and having career fulfillment across different professional interests or life stages.

Practice Innovation: Using a systematic approach, identify and support the implementation of models for emergency physicians that expand the practice of acute, unscheduled care; Develop an organization framework to support the creation of innovative models by anticipating emerging trends in clinical and business practices

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted. Directed ACEP to create a policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient.

Amended Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted. Directed ACEP to advocate for federal support to decrease ED boarding of pediatric mental health patients and for increased, adequate reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted. Directed ACEP to create a psychiatric boarding toolkit to help address patient handoff and frequency of evaluation while boarding; activities of

daily living for the boarded patient; initiation of mental health treatment while boarding; and development of ED psychiatric observational medicine.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted. Directed ACEP to work with outside organizations to develop model practices focused on building bed capacity, reducing ED boarding, and improving quality of care for ED patients with acute mental health disorders; develop and disseminate best practices for acute mental health visits to reduce boarding and improve care; and work with AHRQ and other stakeholders to develop community and hospital based benchmark performance metrics for ED flow and link the licensure of inpatient psychiatric facilities to their willingness to accept patients.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted. Called for the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted. Directed ACEP to convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients and provide a report to the 2013 Council.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted. Directed ACEP to meet with the American Psychiatric Association and other stakeholders to create a standard for the medical stability of psychiatric patients that includes the conclusions from the 2006 ACEP "Clinical Policy: Clinical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 28(06) Psychiatric Bed Availability adopted. Directed ACEP to study the impact of psychiatric bed availability on emergency departments.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. Directed ACEP to provide guidance to states and chapters to respond to issues related to psychiatric and substance abuse patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. Directed ACEP to support legislative efforts that grant the emergency physician authority to involuntarily hold and/or transfer psychiatric patients to an appropriate facility when medically indicated.

Amended Resolution 24(00) Inpatient Restraint or Seclusion Orders adopted. Directed ACEP to oppose any requirement by hospital representatives that emergency physicians provide inpatient restraint.

Prior Board Action

April 2025, approved the policy statement "Treating Physician Determines Patient Stability."

April 2025, approved the policy statement "Protection of Emergency Physicians from Coercion in Patient Transfers."

June 2024, approved the revised policy statement on "Patient Autonomy and Shared Decision-Making in Emergency Medical Services and Mobile Integrated Healthcare Community Paramedicine Programs;" originally approved June 2018 titled "Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs, replacing the following rescinded/sunsetted policy statements: Alternate Ambulance Transportation and Destination (2001-2018), Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018), Refusal of Medical Aid (2000-2018).

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted.

Amended Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted.

April 2023, approved the revised policy statement on "Adult Psychiatric Emergencies;" originally approved October 2020.

January 2022, approved the revised policy statement "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with the current title; revised and approved February 2009, February 2002, and June 1997; revised and approved September 1992 titled " Appropriate Inter-Hospital Patient Transfer;" originally approved September 1989 titled " Principles of Appropriate Patient Transfer."

February 2020, approved the revised policy statement "Use of Patient Restraints;" revised and approved April 2014; reaffirmed October 2007; revised and approved April 2001, June 2000, January 1996; originally approved with current title January 1991.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted.

June 2017, the Board approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in EDs. The Clinical Emergency Department Registry (CEDR) has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients.

January 2017, approved the clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," which replaced the September 2005 clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." The September 2005 clinical policy replaced the October 1998 "Clinical Policy for the Initial Approach to Patients Presenting with Altered Mental Status."

Amended Resolution 24(16) Mental Health Boarding Solutions adopted.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted.

October 2015, reviewed the information paper "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department."

October 2014, reviewed the information paper "Care of the Psychiatric Patient in the Emergency Department – a Review of the Literature."

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted.

January 2008 approved the survey on Psychiatric Bed Availability for distribution to the Emergency Department Directors Academy e-list.

Substitute Resolution 28(06) Psychiatric Bed Availability adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. The Board assigned the resolution to the State Legislative/Regulatory Committee to communicate ACEP' s position and assist chapters with legislative efforts in their states.

Amended Resolution 24(00) Inpatient Restraint or Seclusion Orders adopted

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, Emergency Medicine Clinical Practice and Innovation

Reviewed by: Melissa W. Costello, MD, FACEP, Speaker
Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 80(25)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding

PURPOSE: Collaborate with stakeholders to develop and disseminate a toolkit that includes evidence-based guidelines, best practices, case studies, and data-driven models that demonstrate successful implementation of elective surgical smoothing, tailored to different hospitals and resource levels. It further asks ACEP to advocate for the adoption of elective surgical smoothing principles as part of a broader hospital-wide patient flow improvement initiative, recognizing its role in reducing ED crowding, improved patient outcomes, and enhanced health care delivery.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as consulting with subject matter experts and collaborating with groups such as the American Hospital Association and the American College of Surgeons. The estimated cost for creation of the toolkit resource is approximately $15,000, with additional costs for dissemination.

WHEREAS, Emergency department (ED) crowding and boarding continue to pose significant risks to patient safety, quality of care, and hospital efficiency, leading to delayed treatment, increased mortality, and patient dissatisfaction; and

WHEREAS, A major contributing factor to ED crowding is inpatient bed availability, which is significantly impacted by scheduled elective surgeries that generate predictable, but often avoidable, surges in admissions; and

WHEREAS, Studies have demonstrated that hospital occupancy fluctuates significantly due to uneven scheduling of elective procedures, with midweek peaks in surgical admissions leading to periods of intense inpatient congestion that exacerbate ED boarding; and

WHEREAS, Research from leading institutions has shown that smoothing elective surgery schedules—by distributing procedures more evenly throughout the week—reduces inpatient census variability, improves hospital throughput, and decreases ED boarding without reducing surgical case volume or revenue; and

WHEREAS, The Institute for Healthcare Optimization (IHO) has demonstrated that elective surgery smoothing can improve hospital-wide flow, lower wait times, and reduce staff burnout by balancing workloads across the week; and

WHEREAS, A 2023 report from the Agency for Healthcare Research and Quality (AHRQ), developed in part from prior ACEP advocacy, identified elective surgery smoothing as an effective and evidence-supported strategy to reduce emergency department boarding and improve hospital flow; and

WHEREAS, Hospitals that have implemented elective surgery smoothing strategies have observed measurable improvements in ED throughput, including lower left-without-being-seen (LWBS) rates, reduced ED length-of-stay, and shorter ambulance diversion times; and

WHEREAS, Elective surgery smoothing has been successfully piloted in health systems such as Cincinnati Children's Hospital, showing that a data-driven approach to scheduling can optimize hospital capacity and improve patient outcomes; and

WHEREAS, Hospitals that fail to address surgical scheduling inefficiencies may inadvertently contribute to healthcare inequities, as ED crowding disproportionately affects vulnerable populations, including those reliant on emergency care due to barriers in primary and specialty care access; and

WHEREAS, The American College of Surgeons (ACS), the Institute for Healthcare Improvement (IHI), and other professional organizations have recognized the importance of system-wide strategies to improve patient flow and reduce crowding; and

WHEREAS, Implementing elective surgery smoothing is a cost-effective intervention that does not require additional hospital resources but instead optimizes existing capacity through improved scheduling strategies; and

WHEREAS, The benefits of elective surgery smoothing extend beyond the ED, improving post-anesthesia care unit (PACU) capacity, reducing ICU bottlenecks, and enhancing staff workflow efficiency across multiple hospital departments; and

WHEREAS, ACEP has previously advocated for policy changes addressing ED crowding, including financial incentives, health equity considerations, and operational improvements, but has not yet developed a comprehensive strategy to mitigate the impact of elective surgical scheduling on ED capacity; and

WHEREAS, A coordinated approach between emergency physicians, hospital administrators, and surgical departments is necessary to ensure that elective surgical scheduling aligns with hospital-wide capacity constraints and patient flow optimization; therefore be it

RESOLVED, That ACEP collaborates with relevant stakeholders, including the American College of Surgeons and the American Hospital Association, to develop and disseminate a comprehensive elective surgery scheduling toolkit aimed at guiding hospitals in implementing effective scheduling practices to mitigate ED crowding; and be it further

RESOLVED, That a comprehensive elective surgery scheduling toolkit developed by ACEP include evidence-based guidelines, best practices, case studies, and data-driven models demonstrating successful implementation of elective surgery smoothing, with specific recommendations tailored to different hospital settings and resource levels; and be it further

RESOLVED, That ACEP advocate for the adoption of elective surgery smoothing principles as part of broader hospital-wide patient flow improvement initiatives, recognizing its role in reducing ED crowding, improving patient outcomes, and enhancing health care efficiency.

Resolution References

1. Agency for Healthcare Research and Quality (AHRQ). *Emergency Department Boarding: Consensus Statement and Research Agenda from the Emergency Department Boarding Summit.* March 2023. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf
2. Institute for Healthcare Optimization (IHO). *Smoothing the Flow of Patients Through the Hospital.* Institute for Healthcare Optimization. Accessed May 2025. Available at: http://www.ihoptimize.org/what-we-do/patient-flow.htm

Background

This resolution asks ACEP to collaborate with stakeholders to develop and disseminate a toolkit that includes evidence-based guidelines, best practices, case studies, and data-driven models that demonstrate successful implementation of elective surgical smoothing, tailored to different hospitals and resource levels. It further asks ACEP to advocate for the adoption of elective surgical smoothing principles as part of a broader hospital-wide patient flow improvement initiative, recognizing its role in reducing ED crowding, improved patient outcomes, and enhanced health care delivery.

It has been well established that boarding in the ED is primarily due to hospital overflow. It is equally well known that boarding in the ED is greatest on Monday, Tuesday, Wednesday, and Thursday. While there is some variation by weekday in admissions through the emergency department and medical elective admissions, nearly all of the variation

seen is because of elective surgical cases. Surgical cases are rarely scheduled over the weekend based on resource limitations and staffing patterns. Studies have shown increased mortality with elective surgeries performed on the weekend.[1,2] This variation can be significant and one report indicated 42% of elective surgeries were performed on Mondays and Tuesdays.[2] Multiple large-scale studies and meta-analyses demonstrate that patients admitted on weekends have a higher risk of in-hospital mortality, even after adjusting for illness severity and demographic factors, though the absolute increase is modest (adjusted odds ratios typically in the range of 1.04–1.19). This effect is partly attributable to a higher acuity of illness among weekend admissions, as well as potential delays in care processes and reduced access to specialized services.[3,4]

Therefore, efforts to smooth the surgical schedule to reduce this variation would be one way to reduce the variation in hospital overload and reduce boarding in the ED. The process involves an analysis of historical surgical volume and case mix and then using data-driven or mathematical models to reallocate OR block time. Such modeling and alteration of the surgical schedule led to greater efficiency and lower peak census.[5]

However, on the horizon there are more effective tools for smoothing the OR schedule. The use of artificial intelligence (AI) has been shown to accurately predict the duration of surgical cases, optimize resource allocation, and reduce surgical cancellations. Multiple companies and algorithms exist today, and given the cost effectiveness of their results, it is likely to revolutionize surgical scheduling in the next year.[6]

Saudi Arabia is one country that is actively embracing the use of AI in health care. Their algorithms analyze factors like surgeon availability, patient data (including complexity and risk factors), and resource requirements (like operating rooms, instruments, and staff) to generate optimal surgical schedules. One anecdotal report suggests that the use of this and related techniques has increased surgical procedures in one hospital by 50%.

AI is moving rapidly into this space and multiple companies have created AI platforms for smoothing the OR schedule with a large return on investment. While a toolkit would be beneficial at this point in time, it is highly likely that technology and economic pressures to improve OR efficiency will happen faster than any toolkit can be compiled, launched, and distributed and could make an ACEP toolkit obsolete before it is completed.

Boarding is top priority for the College and a major focus of advocacy efforts. In November 2022, ACEP sent a letter to the President of the United States on the ED boarding crisis. It was cosigned by 34 other societies including AAEM, AFP, ACOEP, ACR, AMA, ASA, EMRA, ENA. Through ACEPs advocacy efforts, AHRQ held a summit on boarding where causes and solutions were discussed.

ACEP's advocacy efforts also led to the adoption of the Age-Friendly Hospital Measure, which incorporates efforts to address boarding in the geriatric population.

ACEP's toolkit on Emergency Department Crowding: High Impact Solutions discusses smoothing of surgical schedules as a potential solution but does not go into the detail of the toolkit proposed by this resolution.

ACEP has a dedicated area of the website dedicated to boarding resources for members.

Background References

1. Aylin P, Alexandrescu R, Jen MH, Mayer EK, Bottle A. Day of Week of Procedure and 30 Day Mortality for Elective Surgery: Retrospective Analysis of Hospital Episode Statistics. *BMJ (Clinical Research Ed.).* 2013;346:f2424. doi:10.1136/bmj.f2424.
2. Ranganathan S, Riveros C, Tsugawa Y, et al. Postoperative Outcomes Following Preweekend Surgery. *JAMA Network Open*. 2025;8(3):e2458794. doi:10.1001/jamanetworkopen.2024.58794..
3. Bressman E, Rowland JC, Nguyen VT, Raucher BG. Severity of Illness and the Weekend Mortality Effect: A Retrospective Cohort Study. *BMC Health Services Research*. 2020;20(1):169. doi:10.1186/s12913-020-5029-6.
4. Ko SQ, Strom JB, Shen C, Yeh RW. Mortality, Length of Stay, and Cost of Weekend Admissions. *J Hosp Med*. 2018;13(7):476-481. doi:10.12788/jhm.2906.
5. Zenteno AC, Carnes T, Levi R, Daily BJ, Dunn PF. Systematic OR Block Allocation in a Large Academic Medical Center: Comprehensive Review on a Data-Driven Surgical Scheduling Strategy. *Ann Surg*. 2016;264(6):973-981. doi:10.1097/SLA.0000000000001560.
6. Bellini V, Russo M, Domenichetti T, et al. Artificial Intelligence in Operating Room Management. *J Med Syst.* 2024;48(1):19. doi:10.1007/s10916-024-02038-2.
7. Caresyntax. https://caresyntax.com. Accessed July 13, 2025

8. Bartek MA, Saxena RC, Solomon S, et al. Improving Operating Room Efficiency: Machine Learning Approach to Predict Case-Time Duration. *J Am Coll Surg*. 2019;229(4):346-354.e3. doi:10.1016/j.jamcollsurg.2019.05.029.
9. The Impact of AI on Surgery Scheduling and Operating Room Efficiency. April 14, 2025. https://www.medigy.com/news/blogs/the-impact-of-ai-on-surgery-scheduling-and-operating-room-efficiency/. Accessed July 13, 2025.

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.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other work to support this effort as well as consulting with subject matter experts and collaborating with groups such as the American Hospital Association and the American College of Surgeons. The estimated cost for creation of the toolkit resource is approximately $15,000, with additional costs for dissemination.

Prior Council Action

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.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Called for ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate overcrowding and treatment delays affecting ED and other hospital patients and for it to include 7 specific elements, including smoothing of elective surgery scheduling and diagnostic/therapeutic procedures.

Prior Board Action

June 2024, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department." Previously revised September 2018; originally approved January 2012.

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved February 2023, June 2017, April 2011, April 2008, and January 2007; originally approved October 2000.

November 2022, reviewed ACEP's letter to the President of the United States regarding the "Emergency Department Boarding Crisis."

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

September 2018, approved the revised policy statement "Definition of Boarded Patient;" reaffirmed October 2017; originally approved January 2011.

May 2016, reviewed the report, "Emergency Department Crowding: High Impact Solutions."

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

January 2008, reviewed the information paper, "Optimizing Emergency Department Front-End Operations."

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
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Michael J. McCrea, MD, FACEP, Vice Speaker
Sandra M. Schneider, MD, FACEP, Interim Council Secretary and Interim Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 81(25)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: In Memory of Joshua Alinger, MD

WHEREAS, The American College of Emergency Physicians mourns the loss of Joshua Alinger, MD, who passed away on April 6, 2025, at the age of 34; and

WHEREAS, Dr. Alinger was a valued resident physician in the Department of Emergency Medicine at Northwestern University Feinberg School of Medicine; and

WHEREAS, He received his undergraduate degree from Oregon State University, later earning both a doctoral degree and his medical degree from Washington University School of Medicine; and

WHEREAS, Dr. Alinger was known for his curiosity and extensive knowledge base and was admired by colleagues, mentors, and patients alike; and

WHEREAS, During his residency, he contributed meaningfully to research on the topics of hepatic steatosis, vertigo management, as well as HIV, and was selected into the inaugural NIH NINDS Neuro-EM Scholars Pathway; and

WHEREAS, His untimely passing is a profound loss to the field of emergency medicine and to all who had the privilege of knowing him; therefore be it

RESOLVED, That the American College of Emergency Physicians mourns the loss and expresses its deep sorrow at the passing of Joshua Alinger, MD, and extends heartfelt condolences to his family, friends, colleagues, and the Northwestern University Emergency Medicine community.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 82(25)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired)

WHEREAS, Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), a distinguished scholar, physician, educator, and veteran, departed this life on January 15, 2025, at the age of 82, surrounded by his loving family in San Antonio, TX; and

WHEREAS, Dr. Gordon was born on May 4, 1942, in Washington, DC, to Frank and Frances Gordon, and was raised in Silver Spring, MD, alongside his brothers Edward, Michael, and Carl; and

WHEREAS, Dr. Gordon demonstrated an unwavering commitment to education, earning a B.S. in Physical Chemistry from Howard University where he graduated Summa Cum Laude, followed by a PhD in the same field from Oregon State University as a NASA fellow; and

WHEREAS, Dr. Gordon answered the call to serve his country, serving with distinction in the Vietnam War as a member of the First Cavalry and receiving numerous commendations, including the Bronze Star and the Air Medal with Oak Leaf Clusters; and

WHEREAS, Following his military service, Dr. Gordon pursued a career in medicine, earning his MD from the University of Maryland School of Medicine, completing his residency at Brooke Army Medical Center, and retiring as a Lieutenant Colonel after 20 years of dedicated service in the United States Army; and

WHEREAS, Dr. Gordon's passion for education and leadership was evident in his tenure as a professor at the U.S. Military Academy at West Point and later at the UT Health Science Center, where he retired as a full professor, shaping the next generation of medical professionals; and

WHEREAS, His commitment to public health extended beyond the classroom, as he served for 22 years as the Medical Director for San Antonio and Bexar County's EMS, ensuring the highest standards of emergency medical care; and

WHEREAS, He was active for many years with the Texas College of Emergency Physicians, particularly with the EMS Committee meetings and activities; and

WHEREAS, Dr. Gordon devoted his time and leadership to numerous organizations, serving as president of the American Red Cross in San Antonio, the Bexar County Medical Society, the Northwest Rotary Club, and the West San Antonio Chamber of Commerce; and

WHEREAS, In addition to his professional accomplishments, Dr. Gordon was a talented musician, skilled craftsman, and dedicated community volunteer, sharing his artistry through performances with the National Symphony and crafting intricate stained-glass lamps, exotic pens, and chess sets; and

WHEREAS, His legacy of service extended to the American Heart Association, the Multiple Sclerosis Society, and countless other charitable causes, reflecting his lifelong dedication to improving lives and advancing medical care; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), and his extraordinary contributions to emergency medicine, education, and community service; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), acknowledging that though he may be gone, his remarkable achievements and enduring impact will be remembered with gratitude and admiration.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 83(25)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Elizabeth B. Jones, MD, FACEP

WHEREAS, Elizabeth B. Jones, MD, FACEP, a devoted physician, researcher, and mentor, passed away on December 7, 2024, at the age of 64, following a courageous battle with gastric cancer; and

WHEREAS, Dr. Jones earned her medical degree from Louisiana State University School of Medicine, and completed residencies in internal medicine at the Medical College of Virginia, and in emergency medicine at Carolinas Medical Center in Charlotte, NC; and

WHEREAS, She served for a decade in the Department of Emergency Medicine in the Medical College of Virginia before joining the faculty of McGovern Medical School in Houston in 1999, where she would become a respected senior faculty member in the Department of Emergency Medicine; and

WHEREAS, Dr. Jones made pioneering contributions to emergency medicine research, serving as principal investigator for the UTHealth Houston hub of the Neurological Emergency Treatment Trials Network since 2006 and as a site PI for the CORE-EM hub, leading investigations in time-critical conditions such as sepsis, status epilepticus, and stroke; and

WHEREAS, Dr. Jones was known by colleagues and students as a fierce patient advocate, a leader of high standards, and a professional whose integrity and dedication inspired all who worked with her; and

WHEREAS, She was active for many years with the Texas College of Emergency Physicians; and

WHEREAS, She was not only a brilliant physician and researcher, but also a beloved mentor, colleague, and friend – remembered for her intelligence, kindness, unwavering support, and example of excellence; and

WHEREAS, Outside of medicine, Dr. Jones lived life with joy and adventure, as an avid white-water kayaker, a dedicated marathon runner in cities across the world, and a passionate and talented cook who trained at both the Culinary Institute of America in New York and Le Cordon Bleu in Paris; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the memory of Elizabeth B. Jones, MD, FACEP, and her extraordinary contributions to emergency medicine, patient advocacy, academic excellence, and integrity in research and clinical care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Elizabeth B. Jones, MD, FACEP, acknowledging that though she may be gone, her remarkable achievements and enduring impact will be remembered with gratitude and admiration.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 84(25)

SUBMITTED BY: California Chapter

SUBJECT: In Memory of Brian Wai Lin, MD

WHEREAS, With the passing of Brian Wai Lin, MD, on June 15, 2025, emergency medicine lost a brilliant clinician, an innovative educator, a beloved colleague, and an extraordinary mentor to countless students and residents in California and beyond; and

WHEREAS, Dr. Lin earned his medical degree from the Icahn School of Medicine at Mount Sinai in 2005, and completed his residency in emergency medicine at Stanford Health Care, where he began a lifelong commitment to excellence in emergency care and medical education; and

WHEREAS, Dr. Lin was board certified in emergency medicine by the American Board of Emergency Medicine and practiced with distinction in Northern California, including at Stanford Health Care and Kaiser Permanente San Francisco Medical Center since 2009; and

WHEREAS, Dr. Lin served as Assistant Clinical Professor of Emergency Medicine at the University of California, San Francisco (UCSF) School of Medicine, where he developed a longitudinal clerkship for medical students and earned the 2024 TPMG Teaching Award for Excellence in Undergraduate and Graduate Medical Education in recognition of his outstanding contributions to medical education; and

WHEREAS, Dr. Lin was nationally recognized for his expertise in wound management and suturing, frequently teaching at leading conferences such as ACEP's Scientific Assembly and SEMPA 360, and sharing his knowledge widely through his educational platform, www.lacerationrepair.com; and

WHEREAS, Dr. Lin authored multiple peer-reviewed publications that advanced clinical practice and education, including work on telehealth integration, ECG interpretation, and dermal wound care; and

WHEREAS, Dr. Lin's unique combination of clinical excellence, humility, generosity, and warmth left an indelible mark on those who worked with him and he was described by colleagues as brilliant, compassionate, and profoundly kind; and

WHEREAS, Dr. Lin's passing has deeply saddened the emergency medicine community, where his legacy continues to inspire those who had the privilege to know and learn from him; and

WHEREAS, Beyond his professional accomplishments, Dr. Lin was a man of vibrant spirit and diverse talents; he was a talented capoeirista, ukelele player, and rock climber, bringing grace and energy to his pursuits; and

WHEREAS, His infectious laugh lit up every room, and he was cherished for the joy and authenticity he shared so freely; and

WHEREAS, He had a deep and unwavering love for his patients, for the art of medicine, and most profoundly, for his family and all those around him and his compassion and presence enriched the lives of many and will be remembered with gratitude and admiration; therefore be it

RESOLVED, That the American College of Emergency Physicians and the California Chapter recognizes the extraordinary contributions of Brian Wai Lin, MD, to the specialty of emergency medicine as a physician, educator, innovator, and mentor; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Brian Wai Lin, MD, especially his beloved children Isaiah, Elliot, and Daphne, along with his loved ones, friends, students, residents, and colleagues our heartfelt condolences and deepest appreciation for his lasting impact on the specialty of emergency medicine and the lives of those he touched with generosity and grace.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2025 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 85(25)

SUBMITTED BY: Virginia College of Emergency Physicians

SUBJECT: In Memory of Forrest Daniel McCoig, MD

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Forrest Daniel McCoig, MD, passed away surrounded by his family on June 1, 2025, at the age of 87; and

WHEREAS, Dr. McCoig completed his undergraduate studies at Asbury College in Kentucky before proceeding to the Medical College of Virginia and earning his medical degree in 1963; and

WHEREAS, He completed his internship at Riverside Hospital in Newport News and began his emergency medicine career at Hampton General Hospital; and

WHEREAS, Dr. McCoig joined the U.S. Navy as a medical officer aboard the nuclear submarine, the Ethan Allen, stationed out of New London, CT and Norfolk, VA, he finished those tours in 1969 as a Lt. Commander; and

WHEREAS, He then returned to the Hampton General Hospital Emergency Department as a staff physician, where he treated more than 175,000 patients over 28 years; and

WHEREAS, Dr. McCoig was also on staff at Mary Immaculate Hospital and the HOPE Center during that tenure; and

WHEREAS, Dr. McCoig was at the helm of numerous professional organizations and training programs over his career; and

WHEREAS, He became a charter member and first president of the Virginia College of Emergency Physicians, serving from 1971-1974; and

WHEREAS, He received a lifetime achievement award from Virginia College of Emergency Physicians and was honored with it becoming an award named in his honor; and

WHEREAS, Dr. McCoig served as Chairman of the Hampton General Hospital Emergency Department several times and chaired the Advanced Life Support subcommittee under five governors, becoming the first appointee to the Governor's Advisory Committee on Emergency Medicine Services; and

WHEREAS, In 1972, and again in 1982, he was cited by the Mayor of Hampton for his part in starting, and teaching, the first EMT and Cardiac Tech courses in Virginia; and

WHEREAS, Dr. McCoig retired in 1992 and received a White Coat award from the Virginia College of Emergency Physicians, recognizing his many years of service in the specialty of emergency medicine; and

WHEREAS, Forrest, or "Frosty" to many friends and colleagues, owing to his sun-bleached hair, was a big personality, who worked, played, and lived vivaciously; and

WHEREAS, He excelled, and delighted, in a variety of hobbies, activities, interests and adventures, began a life-long love of magic as a young teen and performed a legion of shows for family, friends, parties, and charity events throughout his lifetime; and

WHEREAS, He achieved the top rank of Excelsior in the Order of Merlin, from the International Brotherhood of Magicians, for over 50 years of membership and entertained others with his expert ventriloquy skills, where his witty banter with his dummy, Shaggy, always kept folks laughing; and

WHEREAS, As a Civil War historian, Forrest collected a vast array of prints and books and spoke fluently on the subject; and

WHEREAS, Behind the scenes, he was an exceptional artist, drew true-to-life portraits for every senior in his high school graduating class, which were displayed in the yearbook alongside their photos, and he illustrated numerous newsletters, cards, and even grandchildren's school projects over the years; and

WHEREAS, As a college student, Forrest went on a mission trip as a trumpeter with a music quartet to Central America, preaching the gospel and playing music in more than 300 services, in both English and Spanish; and

WHEREAS, Though he was an enthusiast of skiing, boating, and even flying, he was probably best known for his passion for cars and motorcycles and owned a vast array of both over his lifetime, but retirement found him mostly riding Harleys with his fellow "Rumbling Farts" motorcycle group; and

WHEREAS, "Doc" as his cycling brethren called him, led them all over Virginia, as well as road trips to South Dakota and Florida for Bike Weeks, always abiding by their motto, "Live to Ride, Ride to Eat"; and therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Forrest Daniel McCoig, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Virginia College of Emergency Physicians extends to his devoted wife Katharine (married in 1958) of 23 years, and mother to their children James, Amy, and Laura, and his wife Janet (married in 1991) of 34 years, and mother to Kelly, gratitude for his service as an emergency physician, as well as for his dedication and commitment to the specialty of emergency medicine.