COUNCIL MEETING

October 27-28, 2017

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

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

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

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

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

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

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

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

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

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

- Speakers at committees, educational meetings, or other business meetings of the College shall be informed that they must comply with the College’s antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the College or its legal counsel.
Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

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

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

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

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

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

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

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

A. General

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

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

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

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

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

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

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

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

B. Disclosure Form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Additional Rules of Conduct

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

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

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

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

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

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

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

c. The names of the individuals who were present for discussion and votes relating to the action, policy, or arrangement in question, the content of the discussion including alternatives to the proposed action, policy, or arrangement, and a record of any votes taken in connection therewith.
Thursday, October 26

3:00 pm – 8:00 pm  Councillor Credentialing – Marquis Ballroom Foyer, Meeting Level 2
4:30 pm – 6:00 pm  Candidate Forum Subcommittee – Mount Vernon Square, Meeting Level 3
6:00 pm – 7:00 pm  Steering Committee Meeting – Capitol/Congress, Meeting Level 4
7:00 pm – 8:00 pm  Tellers, Credentials, & Elections Committee – LeDroit Park/Shaw, Meeting Level 3
7:00 pm – 8:00 pm  Reference Committee Briefing – Union Station, Meeting Level 3
8:00 pm – 9:00 pm  Councillor Orientation – University of DC/Catholic University, Meeting Level 1

Friday, October 27

7:30 am – 5:30 pm  Councillor Credentialing – Marquis Ballroom Foyer, Meeting Level 2
7:30 am – 8:00 am  Council Continental Breakfast – Marquis Ballroom Salons 5-6, Meeting Level 2
8:00 am – 9:15 am  Council Meeting – Marquis Ballroom Salons 5-6, Meeting Level 2
9:30 am – 12:30 pm  Reference Committee A – Independence Ballroom Salons A-C, Meeting Level 4
9:30 am – 12:30 pm  Reference Committee B – Independence Ballroom Salon D, Meeting Level 4
9:30 am – 12:30 pm  Reference Committee C – Independence Ballroom Salon E, Meeting Level 4
11:00 am – 12:30 pm  Reference Committee Boxed Luncheon – Independence Ballroom Foyer, Meeting Level 4
12:30 pm – 2:30 pm  Reference Committee Executive Sessions
                      A – Independence Ballroom Salons A-C, Meeting Level 4
                      B – Independence Ballroom Salon D, Meeting Level 4
                      C – Independence Ballroom Salon E, Meeting Level 4
12:45 pm – 2:15 pm  Town Hall Meeting – Marquis Ballroom, Meeting Level 2
2:30 pm – 4:30 pm  Candidate Forum – Independence Ballroom Salons A-E, Meeting Level 4
4:45 pm – 6:00 pm  Council Reconvenes – Marquis Ballroom, Meeting Level 2
6:15 pm – 7:15 pm  Candidate Reception – Marquis Ballroom, Meeting Level 2

Saturday, October 28

7:00 am – 8:30 am  Keypad Distribution – Marquis Ballroom Foyer, Meeting Level 2
7:00 am – 5:30 pm  Councillor Credentialing – Marquis Ballroom Foyer, Meeting Level 2
7:30 am – 8:00 am  Council Continental Breakfast – Marquis Ballroom, Meeting Level 2
8:00 am – 12:00 pm  Council Meeting – Marquis Ballroom, Meeting Level 2
12:00 pm – 1:30 pm  Council Awards Luncheon – Marquis Ballroom Salons 7-10, Meeting Level 2
1:45 pm – 5:45 pm  Council Reconvenes – Marquis Ballroom, Meeting Level 2
5:10 pm – 5:40 pm  Elections – Marquis Ballroom, Meeting Level 2
Friday, October 27, 2017

Continental Breakfast – Marquis Ballroom

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

2. Introductions

3. Welcome from DC Chapter President

4. Tellers, Credentials, & Election Committee
   A. Credentials Report
   B. Meeting Etiquette

5. Changes to the Agenda

6. Council Meeting Website

7. EMF Challenge

8. NEMPAC Challenge

9. Review and Acceptance of Minutes
   A. Council Meeting – October 14-15, 2016

10. Approval of Steering Committee Actions
    A. Steering Committee Meeting – January 18, 2017
    B. Steering Committee Meeting – June 26, 2017

11. Call for and Presentation of Emergency Resolutions

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

13. Nominating Committee Report
    A. Speaker
       1. Slate of Candidates
       2. Call for Floor Nominations
    B. Vice Speaker
       1. Slate of Candidates
       2. Call for Floor Nominations
    C. President-Elect
       1. Slate of Candidates
       2. Call for Floor Nominations
    D. Board of Directors
       1. Slate of Candidates
       2. Call for Floor Nominations
Friday, October 27, 2017 (Continued)

14. Candidate Opening Statements
   Dr. Cusick
   A. Speaker Candidates (2 minutes each) 8:35 am
   B. Vice Speaker Candidates (2 minutes each) 8:38 am
   C. President-Elect Candidates (5 minutes each) 8:45 am
   D. Board of Directors Candidates (2 minutes each) 9:05 am

15. Reference Committee Assignments
   Dr. Cusick 9:20 am

BREAK 9:20 am – 9:30 am

16. Reference Committee Hearings
   A – Governance & Membership – Independence Ballroom Salons A-C, Meeting Level 4
   B – Advocacy & Public Policy – Independence Ballroom Salon D, Meeting Level 4
   C – Emergency Medicine Practice – Independence Ballroom Salon E, Meeting Level 4

Lunch Available – Independence Ballroom Foyer 11:00 am – 12:30 pm

17. Reference Committee Executive Sessions
   A – Independence Ballroom Salons A-C, Meeting Level 4
   B – Independence Ballroom Salon D, Meeting Level 4
   C – Independence Ballroom Salon E, Meeting Level 4

BREAK – Return to main Council meeting room. 12:30 pm – 12:45 pm

18. Town Hall Meeting – Marquis Ballroom, Meeting Level 2  Dr. McManus 12:45 pm – 2:15 pm
   A. The Out-of-Network and Balance Billing Conundrum: What Can We Do About It?

19. Candidate Forum – Independence Ballroom Salons A-E, Meeting Level 4 2:30 pm – 4:30 pm
   Candidates rotate through Reference Committee meeting rooms.

BREAK – Return to main Council meeting room. 4:30 pm – 4:45 pm

20. Speaker’s Report – Marquis Ballroom, Meeting Level 2  Dr. Cusick 4:45 pm
   A. Leadership Development Advisory Group
   B. Board Actions on 2016 Resolutions
   C. Introduction of Honored Guests
   D. Introduction of Council Steering Committee
   E. Introduction of Board of Directors

21. In Memoriam  Dr. Cusick 5:00 pm
   A. Reading and Presentation of Memorial Resolutions  Dr. McManus 5:00 pm

   Adopt by observing a moment of silence.

22. ABEM Report  Dr. Kowalenko 5:10 pm

23. Secretary-Treasurer’s Report  Dr. Friedman 5:15 pm

24. EMRA Report  Dr. Kurtz 5:20 pm

25. EMF Report  Dr. House 5:25 pm

26. NEMPAC Report  Dr. Jacoby 5:30 pm

27. President’s Address  Dr. Parker 5:35 pm

Candidate Reception ● 6:15 pm – 7:15 pm ● Marquis Ballroom Salons 8-10
Saturday, October 28, 2017

Keypad Distribution – Marquis Ballroom Foyer
Continental Breakfast – Marquis Ballroom

7:00 am

1. Call to Order           Dr. Cusick
2. Tellers, Credentials, & Elections Committee Report   Dr. Costello
3. Electronic Voting
   A. Keypad Testing/Demographic Data Collection   Dr. Costello
4. Executive Directors Report   Mr. Wilkerson
5. Video – How to Submit Amendments Electronically
6. Reference Committee Reports
   A. Reference Committee ______
   B. Reference Committee ______
7. Awards Luncheon – Marquis Ballroom Salons 7-10
   A. Welcome    Dr. Cusick
   1. Recognition of Past Speakers and Past Presidents
   2. Recognition of Chapter Executives
   B. Award Announcements    Dr. Parker
   1. Wiegenstein Leadership Award – Brian Keaton, MD, FACEP
   2. Mills Outstanding Contribution to Emergency Medicine Award – Wesley Curry, MD, FACEP
   3. Outstanding Contribution in Education Award – Francis Counselman, MD, FACEP
   4. Outstanding Contribution in Research Award – Edward Jauch, MD, FACEP
   5. Outstanding Contribution in EMS Award – Salvatore Silvestri, MD, FACEP (awarded posthumously)
   6. Worrrie Excellence in Health Policy Award – Nathaniel Schlicher, MD, JD, MBA, FACEP
   7. Rupke Legacy Award – Compton Broders, MD, FACEP
   8. Honorary Membership Award – Patty Stowe, CAE; Laura Tiberi, CAE; and Gordon Wheeler
   9. Disaster Medical Sciences Award – Kristi Koenig, MD, FACPEP
   C. Reading and Presentation of Commendation Resolutions    Dr. Cusick/Dr. McManus
   D. Council Award Presentations    Dr. Cusick
   1. Council Service Milestone Awards – 5, 10, 15, 20, 25, 30, 35+ Year Councillors
   2. Council Teamwork Award – Government Services Chapter
   3. Council Horizon Award – Laura Medford-Davis, MD
   4. Council Curmudgeon Award – Pamela Bensen, MD, FACEP
   5. Council Meritorious Service Award – Kelly Gray-Eurom, MD, MMM, FACEP
8. Luncheon Adjourns – Return to main Council meeting room.   1:30 pm
9. Reference Committee Reports Continue
   C. Reference Committee ______
10. President-Elect’s Address    Dr. Kivela
11. Installation of President    Dr. Parker/Dr. Kivela
12. Elections
   A. Speaker
   B. Vice Speaker
   C. Board of Directors
   D. President-Elect
13. Announcements    Dr. Cusick
14. Adjourn    Dr. Cusick

Next Annual Council Meeting ● September 29-30, 2018 ● San Diego, CA
# 2017 Council Meeting Materials

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<td>• Vidor E. Friedman, MD, FACEP</td>
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<td>• Hans R. House, MD, FACEP</td>
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<td>• William P. Jaquis, MD, FACEP</td>
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<td>• John J. Rogers, MD, CPE, FACEP</td>
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   • John G. McManus, Jr., MD, MBA, FACEP

Council Vice Speaker Candidates
   • Sabina A. Braithwaite, MD, FACEP
   • Andrea L. Green, MD, FACEP
   • Gary R. Katz, MD, MBA, FACEP

20 Board of Directors Candidates
   • Stephen H. Anderson, MD FACEP
   • Kathleen J. Clem, MD, FACEP
   • Carrie de Moor, MD, FACEP (declared floor candidate)
   • J. T. Finnell, MD, FACEP
   • Alison Haddock, MD, FACEP
   • Jon Mark, Hirshon, MD, PhD, MPH, FACEP
   • Aisha T. Liferidge, MD, FACEP
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<td>James M. Cusick, MD, FACEP</td>
<td>Speaker</td>
<td>Denver, CO</td>
<td>CO</td>
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<td>John G. McManus, Jr., MD, MBA, FACEP</td>
<td>Vice Speaker</td>
<td>Evans, GA</td>
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<td>J. David Barry, MD, FACEP</td>
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<td>Long Beach, CA</td>
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<td>Douglas Char, MD, FACEP</td>
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<td>Saint Louis, MO</td>
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<td>Kathleen Clem, MD, FACEP</td>
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<td>Orlando, FL</td>
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<td>Alison Haddock, MD, FACEP</td>
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<td>Houston, TX</td>
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<td>Jonathan Heidt, MD, MHA, FACEP</td>
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<td>Sarah Hoper, MD, JD, FACEP</td>
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<td>Chadd Kraus, DO, DrPH, FACEP</td>
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<td>Lewisburg, PA</td>
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<td>Aisha Liferidge, MD, FACEP</td>
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<td>Donald L. Lum, MD, FACEP</td>
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<td>Northfield, MN</td>
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<td>Michael McCrea, MD, FACEP</td>
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<td>Annalise Sorrentino, MD, FACEP</td>
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<td>Jennifer L. Stankus, MD, JD, FACEP</td>
<td>Gig Harbor, WA</td>
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<td>Anne Zink, MD, FACEP</td>
<td>Palmer, AK</td>
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</table>
Procedures for Councillor and Alternate Seating

Councillor Credentialing

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

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

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

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

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

   c. If no certified councillor or alternate of a component body is present at the meeting, a member of that sponsoring body may be seated as a councillor pro tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council.

As stated in the Bylaws, Article VIII – Council, Section 5 – Voting Rights:

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

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

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

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

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

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

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

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

Voting Cards and Electronic Keypads

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

2. Voting will be by voting card, electronic keypad, or voice votes at the discretion of the Speaker.

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

Seating Exchange Between Credentialed Councillors and Alternates

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

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

3. If a councillor is leaving the floor of the Council, and there will not be an alternate replacement, the councillor must return the voting card and keypad to councillor credentialing. Once the councillor returns, the voting card and keypad will be returned to the councillor. If debate is occurring on the Council floor, the councillor should wait until final action has been taken on a particular issue before returning to his/her seat on the Council floor.
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
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</thead>
<tbody>
<tr>
<td>Alternate Councillors</td>
<td>Reserved Staff</td>
<td>Reserved Chapter Staff</td>
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<tr>
<td>Alternate Councillors</td>
<td>Alternate Councillors</td>
<td>Alternate Councillors</td>
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2017 Councillor Seating Chart

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<thead>
<tr>
<th>PROJECTION STAFF</th>
<th>PARLIAMENTARIAN</th>
<th>SPEAKER</th>
<th>VICE SPEAKER</th>
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<tbody>
<tr>
<td>TX=10 Telemedicine=1  Toxicology=1  WY=1  YPS=1</td>
<td>WA=9  WV=4  Undersea=1  Ultrasound=1</td>
<td>VA=11  VT=1  Wellness=1  Wilderness=1  Workforce=1</td>
<td>Quality=1  Research=1  Rural=1  Tactical=1  Trauma=1  UT=4  WI=6</td>
</tr>
<tr>
<td>TX=15</td>
<td>OR=5  PR=2  SC=5  Sports Med=1  SD=1</td>
<td>NY=14  Palliative=1</td>
<td>OH=9  Observation=1  OK=3  Pain Mgmt=1  Peds=1</td>
</tr>
<tr>
<td>PA=9  SAEM=1  TN=5</td>
<td>NY=15</td>
<td></td>
<td>OH=10  MD=5</td>
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<tr>
<td>ND=1  PA=10  RI=3</td>
<td>NC=11  NM=4</td>
<td></td>
<td>MI=10  MS=3  MD=2</td>
</tr>
<tr>
<td>MO=6  MN=7  NH=2</td>
<td>LA=5  NJ=10</td>
<td></td>
<td>MI=12  NV=3</td>
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<tr>
<td>MA=10  ME=3</td>
<td>IL=13  NE=2</td>
<td></td>
<td>GS=8  IN=6  Med Humanities=1</td>
</tr>
<tr>
<td>CA=4  EMS=1  EMRA=8</td>
<td>FL=8  Informatics=1  ID=2  KY=4</td>
<td></td>
<td>GS=8  HI=2  KS=3  MT=1</td>
</tr>
<tr>
<td>CA=15</td>
<td>FL=10  EMPM=1  Forensic=1  Freestanding=1  Geriatric=1</td>
<td></td>
<td>GA=9  International=1  IA=4</td>
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<tr>
<td>CA=12  Disaster=1  Dual Training=1</td>
<td>AR=2  Careers=1  CO=9  DC=3</td>
<td></td>
<td>CORD=1  CT=8  Cruise=1  Critical Care=1  Democratic=1  DE=2  Event Medicine=1</td>
</tr>
<tr>
<td>AZ=8  AAWEP=1  Air Med=1  AACEM=1  AK=1  AL=3</td>
<td>Board of Directors = 8</td>
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<td>Board of Directors = 7</td>
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410 Councillors + 29 past leaders = 439 seats
Past Presidents and Past Council Speakers Seating

Past presidents and past Council speakers are invited to sit with their delegation on the Council floor (see seating chart). The 2017 councillor seating chart includes the following:

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<th>Councillors</th>
<th>Past Leaders</th>
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<td>Connecticut</td>
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<tr>
<td>Government Svcs</td>
<td>14</td>
<td>2</td>
<td>16</td>
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<td>Michigan</td>
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<td>Ohio</td>
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<td>Texas</td>
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<tr>
<td>Virginia</td>
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<td>Washington</td>
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<td>ALABAMA CHAPTER</td>
<td>Councillor</td>
<td>Lisa M Bundy, MD, FACEP</td>
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<td>Muhammad N Husainy, DO, FACEP</td>
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<td>David J Garvey, MD, FACEP</td>
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<td>J Shane Hardin, MD, PhD</td>
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<td></td>
<td>Councillor</td>
<td>Lawrence M Stock, MD, FACEP</td>
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### 2017 COUNCILLORS & ALTERNATE COUNCILLORS

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<tr>
<th>Council</th>
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<tr>
<td>Councillor</td>
<td>Thomas Jerome Sugarman, MD, FACEP</td>
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<td>Gary William Tamkin, MD, FACEP</td>
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<td>Andrea M Wagner, MD, FACEP</td>
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<td>Lori D Winston, MD, FACEP</td>
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<tr>
<td>Alternate</td>
<td>Anna L Webster, MD, FACEP</td>
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<tr>
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<td>Bradley Alan Zlotnick, MD, FACEP</td>
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**COLORADO CHAPTER**

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<td>Councillor</td>
<td>Andrew J French, MD, FACEP</td>
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<td>Nathaniel T Hibbs, DO, FACEP</td>
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<td>Douglas M Hill, DO, FACEP</td>
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<td>Councillor</td>
<td>Christopher David Johnston, MD</td>
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<td>Carla Elizabeth Murphy, DO, FACEP</td>
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<td>Mark Notash, MD, FACEP</td>
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<td>Eric B Olsen, MD, FACEP</td>
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<td>Councillor</td>
<td>Donald E Stader, MD, FACEP</td>
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<tr>
<td>Alternate</td>
<td>James D Thompson, MD, FACEP</td>
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<tr>
<td>Alternate</td>
<td>Erik Janis Verzemnieks, MD</td>
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**CONNECTICUT CHAPTER**

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<td>Councillor</td>
<td>Thomas A Brunell, MD, FACEP</td>
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<td>Councillor</td>
<td>Daniel Freess, MD, FACEP</td>
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<td>David Peter John, MD, FACEP</td>
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<td>Councillor</td>
<td>Elizabeth Schiller, MD, FACEP</td>
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<td>Gregory L Shangold, MD, FACEP</td>
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<td>Councillor</td>
<td>David E Wilcox, MD, FACEP</td>
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<td>Hynes M Birmingham, MD, FACEP</td>
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<td>Karen J Jubanyik-Barber, MD</td>
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<tr>
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<td>Morton Elliot Salomon, MD, FACEP</td>
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**COUNCIL OF EMERGENCY MEDICINE RESIDENCY DIRECTORS (CORD)**

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<td>Councillor</td>
<td>Saadia Akhtar, MD</td>
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**DELAWARE CHAPTER**

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<td>Kathryn Groner, MD</td>
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<td>Councillor</td>
<td>John T Powell, MD, MHCDS, FACEP</td>
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<td>Andrew Luke Aswegan, MD, FACEP</td>
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<td>Vitaly Belyshev, MD</td>
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<tr>
<td>Alternate</td>
<td>Tracy A Brader, MD</td>
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<tr>
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<td>Melissa Cummings, MD</td>
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<td>Heather Lynn Farley, MD, FACEP</td>
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<tr>
<td>Alternate</td>
<td>Genna A Jerrard, MD</td>
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<tr>
<td>Alternate</td>
<td>Daniel O'Sullivan, MD</td>
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<tr>
<td>Alternate</td>
<td>Erin E Watson, MD, FACEP</td>
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**DISTRICT OF COLUMBIA CHAPTER**

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<td>Jessica Galarraga, MD, MPH</td>
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<td>Aisha T Liferidge, MD, FACEP</td>
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<td>Alternate</td>
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## 2017 COUNCILLORS & ALTERNATE COUNCILLORS

**EMERGENCY MEDICINE RESIDENTS' ASSOCIATION**

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<tr>
<th>Role</th>
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<tr>
<td>Councillor</td>
<td>Nida F Degesys, MD</td>
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<tr>
<td>Councillor</td>
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<tr>
<td>Councillor</td>
<td>Tiffany Jackson, MD</td>
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<td>Councillor</td>
<td>Zachary Joseph Jarou, MD</td>
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<td>Councillor</td>
<td>Alicia Mikolaycik Kurtz, MD</td>
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<tr>
<td>Councillor</td>
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**FLORIDA CHAPTER**

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<td>Councillor</td>
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**GEORGIA CHAPTER**

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Councillor  Ernest Enjen Wang, MD, FACEP
Alternate  Jason A Kegg, MD, FACEP
## 2017 COUNCILLORS & ALTERNATE COUNCILLORS

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<td>Councillor</td>
<td>Michael D Bishop</td>
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<td>David T Coffin</td>
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2017 COUNCILLORS & ALTERNATE COUNCILLORS

Alternate Owen Grossman, MD
Alternate Richard Young McConnell, MD, FACEP
Alternate Randy L Pilgrim, MD, FACEP
Alternate James Scribner, MD
Alternate Michael D Smith, MD, MBA, CPE, FACEP

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Councillor Luke Christopher Sasaki, MD, FACEP
Councillor Larisa May Traill, MD, FACEP
Councillor Bradley J Uren, MD, FACEP
# 2017 Councillors & Alternate Councillors

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<td>Councillor</td>
<td>Gregory Link Walker, MD, FACEP</td>
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## 2017 COUNCILLORS & ALTERNATE COUNCILLORS

### NEBRASKA CHAPTER
- **Councillor**: Renee Engler, MD, FACEP
- **Councillor**: Laura R Millemont, MD, FACEP

### NEVADA CHAPTER
- **Councillor**: Eric John Anderson, MD, FACEP
- **Councillor**: Gregory Alan Juhl, MD, FACEP
- **Councillor**: John McCourt, MD, FACEP

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- **Councillor**: Sarah Garlan Johansen, MD, FACEP
- **Alternate**: Matthew Alexander Roginski, MD

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- **Councillor**: Victor M Almeida, DO, FACEP
- **Councillor**: Thomas A Brabson, DO, FACEP
- **Councillor**: Robert M Eisenstein, MD, FACEP
- **Councillor**: William Basil Felegi, DO, FACEP
- **Councillor**: Jenice Forde-Baker, MD, FACEP
- **Councillor**: Rachelle Ann Greenman, MD, FACEP
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### NEW MEXICO CHAPTER
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- **Alternate**: Alexander Feuchter, MD, FACEP
- **Alternate**: A Robb McLean, MD, FACEP

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- **Councillor**: Adam Ash, DO, FACEP
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- **Councillor**: Nestor B Nestor, MD, FACEP
- **Councillor**: William F Paolo, MD, FACEP
- **Councillor**: Salvatore R Pardo, MD, FACEP
## 2017 COUNCILLORS & ALTERNATE COUNCILLORS

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<th>Councillor</th>
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<td>Mikhail Podlog, DO</td>
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## NORTH CAROLINA CHAPTER

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## NORTH DAKOTA CHAPTER

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<tr>
<td>Councillor</td>
<td>Nicole Ann Veitinger, DO, FACEP</td>
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<td>Shaza M Aouthmany, MD</td>
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<td>Alternate</td>
<td>Christina Campana, DO, FACEP</td>
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<td>Alternate</td>
<td>B Bryan Graham, DO</td>
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<td>Alternate</td>
<td>Mary E Hancock, MD, FACEP</td>
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<td>Alternate</td>
<td>Onyeka Otugo, MD</td>
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<td>Alternate</td>
<td>John R Queen, MD, FACEP</td>
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<td>Bradley D Raetzke, MD, FACEP</td>
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<td>Alternate</td>
<td>Amy B Raubenolt, MD</td>
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<td>Alternate</td>
<td>Tonatiuh Rios-Alba, MD</td>
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<td>Jeffrey T Ruwe, MD</td>
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<td>Alternate</td>
<td>Peter B Toth, MD</td>
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<td>Matthew D Vrobel, MD</td>
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**OKLAHOMA CHAPTER**

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<tr>
<td>Councillor</td>
<td>Cecilia Guthrie, MD, FACEP</td>
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<td>Jeffrey Johnson, MD</td>
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<td>Councillor</td>
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<td>Jeffrey Michael Goodloe, MD, FACEP</td>
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<td>W Craig Sanford, Jr, MD, FACEP</td>
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<td>Carolyn Kay Synovitz, MD, MPH, FACEP</td>
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**OREGON CHAPTER**

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<td>Councillor</td>
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<td>Councillor</td>
<td>Michelle R Shaw, MD, FACEP</td>
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<td>Councillor</td>
<td>Evangeline Sokol, MD, FACEP, MD, FACEP</td>
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**PENNSYLVANIA CHAPTER**

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<td>Councillor</td>
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<td>Todd Pijewski, MD, FACEP</td>
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<td>Maria Koenig Guyette, MD, FACEP</td>
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<td>Ronald V Hall, MD</td>
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<td>Councillor</td>
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<td>Camilla Sulak, MD</td>
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2017 COUNCILLORS & ALTERNATE COUNCILLORS

PUERTO RICO CHAPTER
Councillor Miguel F Agrait Gonzalez, MD
Councillor Fernando L Soto Torres, MD
Alternate Jesus M Perez, MD

RHODE ISLAND CHAPTER
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Councillor Achyut B Kamat, MD, FACEP
Councillor Jessica Smith, MD, FACEP
Alternate L Anthony Cirillo, MD, FACEP
Alternate Michael Stephen Siclari, MD, FACEP
Alternate Christopher P Zabbo, DO, FACEP

SOCIETY OF ACADEMIC EMERGENCY MEDICINE
Councillor Kathleen J Clem, MD, FACEP

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Councillor Stephen A D Grant, MD, FACEP
Councillor Allison Leigh Harvey, MD, FACEP
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Councillor Frank C Smeeks, MD, FACEP
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Alternate John H Proctor, MD, MBA, FACEP

TEXAS CHAPTER
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Councillor R Lynn Rea, MD, FACEP
Councillor Richard Dean Robinson, MD, FACEP
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<td>Nicholas A Aunchman</td>
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<td>Stephen J Wolf</td>
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**UTAH CHAPTER**

**VERMONT CHAPTER**

**VIRGINIA CHAPTER**
# 2017 Councillors & Alternate Councillors

## Washington Chapter
- **Councillor**: Cameron Ross Buck, MD, FACEP
- **Councillor**: Carlton E Heine, MD, PhD, FACEP
- **Councillor**: Catharine R Keay, MD, FACEP
- **Councillor**: John Matheson, MD, FACEP
- **Councillor**: Nathaniel R Schlicher, MD, JD, FACEP
- **Councillor**: Patrick Solari, MD, FACEP
- **Councillor**: Jennifer L'Hommedieu Stankus, MD, JD, FACEP
- **Councillor**: Liam Yore, MD, FACEP
- **Alternate**: Jonathan W Alke, MD
- **Alternate**: Justin A Bacon, DO
- **Alternate**: Sabiha Barot, MD
- **Alternate**: David Cheever, MD
- **Alternate**: Enrique R Enguidanos, MD, FACEP
- **Alternate**: Raul J Garcia-Rodriguez, DO
- **Alternate**: Gregg A Miller, MD, FACEP
- **Alternate**: John S Milne, MD, MBA, FACEP

## West Virginia Chapter
- **Councillor**: Adam Thomas Crawford, DO
- **Councillor**: Christopher S Goode, MD, FACEP
- **Councillor**: Thomas Marshall, MD, FACEP
- **Alternate**: Frederick C Blum, MD, FACEP
- **Alternate**: David Benjamin Deuell, DO
- **Alternate**: Erica B Shaver, MD, FACEP

## Wisconsin Chapter
- **Councillor**: Howard Jeffery Croft, MD, FACEP
- **Councillor**: William D Falco, MD, MS, FACEP
- **Councillor**: William C Haselow, MD, FACEP
- **Councillor**: Jeffrey J Pothof, MD, FACEP
- **Councillor**: Robert Sands Redwood, MD
- **Councillor**: Michael Dean Repplinger, MD, PhD, FACEP
- **Alternate**: Lisa J Maurer, MD, FACEP

## Wyoming Chapter
- **Councillor**: Jessica Kisicki, MD, FACEP
- **Alternate**: Carol Lea Wright Becker, MD

## Air Medical Transport Section
- **Councillor**: Gaston Ariel Costa, MD
- **Alternate**: Leonard Scott Weiss, MD

## American Association of Women Emergency Physicians Section
- **Councillor**: E Lea Walters, MD, FACEP
- **Alternate**: Elizabeth Dubey, MD

## Careers in Emergency Medicine Section
- **Councillor**: Sullivan K Smith, MD, FACEP
- **Alternate**: Constance J Doyle, MD, FACEP

## Critical Care Medicine Section
- **Councillor**: Evie G Marcolini, MD, FACEP
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<th>Section</th>
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<tr>
<td>CRUISE SHIP MEDICINE SECTION</td>
<td>Theodore E Harrison, MD, FACEP</td>
<td>Sydeny W Schneidman, MD, FACEP</td>
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<td>DEMOCRATIC GROUP PRACTICE SECTION</td>
<td>David F Tulsiak, MD, FACEP</td>
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<td>Roy L Alson, MD, PhD, FACEP</td>
<td>David Wayne Callaway, MD, FACEP</td>
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<td>DUAL TRAINING SECTION</td>
<td>Carissa J Tyo, MD</td>
<td>De Benjamin Winter, III, MD</td>
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<td>R Carter Clements, MD, FACEP</td>
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<td>Gina Piazza, DO, FACEP</td>
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<td>EMERGENCY MEDICINE PRACTICE MANAGEMENT AND HEALTH POLICY SECTION</td>
<td>Liudvikas Jagminas, MD, FACEP</td>
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<td>Aaron Brody, MD</td>
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<td>Donald L Lum, MD, FACEP</td>
<td>Guy Nuki, MD</td>
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<td>Robert M Bramante, MD, FACEP</td>
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<td>John Carlton Maino, II, MD, FACEP</td>
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<td>Lawrence J R Goldhahn, MD, FACEP</td>
<td>Ralph James Riviello, MD, FACEP</td>
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<td>FREESTANDING EMERGENCY CENTERS</td>
<td>David C Ernst, MD, FACEP</td>
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<td>Christopher R Carpenter, MD, FACEP</td>
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<td>Teresita M Hogan, MD, FACEP</td>
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<td>INTERNATIONAL EMERGENCY MEDICINE SECTION</td>
<td>Gabrielle A Jacquet, MD, MPH, FACEP</td>
<td>Elizabeth L DeVos, MD, FACEP</td>
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<td>MEDICAL HUMANITIES SECTION</td>
<td>Seth Collings Hawkins, MD, FACEP</td>
<td>David P Sklar, MD, FACEP</td>
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<td>OBSERVATION SERVICES SECTION</td>
<td>Sharon E Mace, MD, FACEP</td>
<td>Kristy Ziontz, DO, FACEP</td>
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<td>PAIN MANAGEMENT SECTION</td>
<td>Alexis M LaPietra, DO</td>
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<td>PALLIATIVE MEDICINE SECTION</td>
<td>Sangeeta Lamba, MD, FACEP</td>
<td>Rebecca R Goett, MD</td>
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<td>PEDIATRIC EMERGENCY MEDICINE SECTION</td>
<td>Madeline Matar Joseph, MD, FACEP</td>
<td>Audrey Zelicof Paul, MD, PhD</td>
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<td>QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION</td>
<td>Brian Sharp, MD, FACEP</td>
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<td>Darrell L Carter, MD, FACEP</td>
<td>William Ken Milne, MD</td>
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<td>SPORTS MEDICINE SECTION</td>
<td>Jolie C Holschen, MD, FACEP</td>
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<td>TELEMEDICINE SECTION</td>
<td>Hartmut Gross, MD, FACEP</td>
<td>Alexander Chiu, MD</td>
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<td>Jennifer Hannum, MD, FACEP</td>
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<td>TRAUMA &amp; INJURY PREVENTION SECTION</td>
<td>Gregory Luke Larkin, MD, MPH, FACEP</td>
<td>Mark Robert Sochor, MD, FACEP</td>
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<td>UNDERSEA &amp; HYPERBARIC MEDICINE SECTION</td>
<td>Richard Walker, III, MD, FACEP</td>
<td>Robert W Sanders, MD, FACEP</td>
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<td>WELLNESS SECTION</td>
<td>Laura H McPeake, MD, FACEP</td>
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<td>Susan Theresa Haney, MD, FACEP</td>
<td>Pamela Andrea Ross, MD, FACEP</td>
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<td>Julie Marie Sanicola-Johnson, DO</td>
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## 2017 COUNCILLORS & ALTERNATE COUNCILLORS

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<th>Section</th>
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<td>WILDERNESS MEDICINE SECTION</td>
<td>Councillor</td>
<td>Henderson D McGinnis, MD, FACEP</td>
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<td>Susanne J Spano, MD, FACEP</td>
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<td>YOUNG PHYSICIANS SECTION</td>
<td>Councillor</td>
<td>Chadd K Kraus, DO, DrPH, MPH</td>
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<td>Hilary E Fairbrother, MD, FACEP</td>
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Councillor Handbook

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I. COMPOSITION OF THE COUNCIL

Introduction

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

What is the Council?

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

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

What Does the Council Do?

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

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

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

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

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

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

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

Business attire is appropriate for the Council meeting.

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

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

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

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

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

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

What is a Resolution?

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

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

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

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

Late Resolutions

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

Emergency Resolutions

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

What if I Have Questions About the Council?

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

How are Nominations and Elections Conducted?

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

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

With the exception of the president-elect, the Board of Directors elects its own officers (chair, vice president, and secretary-treasurer) each year during the first Board meeting after the Council meeting.
Each year a Candidate Forum is held. This year the Candidate Forum will be held from 2:30 – 4:00 pm in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee will moderate each session with the candidates. Candidates will answer questions and declare their views on issues facing emergency medicine. An informal reception will be held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and reception.

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

**What is the Steering Committee?**

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

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

**2017 Council Steering Committee**

| James Cusick, MD, FACEP, Chair | Aisha Liferidge, MD, FACEP (DC) |
| John McManus, Jr., MD, FACEP, Vice Chair | Donald M. Lum, MD, FACEP (Workforce) |
| James David Barry, MD, FACEP (GS) | Michael McCrea, MD, FACEP (OH) |
| Douglas Char, MD, FACEP (MO) | Orlee I. Panitch, MD, FACEP (MD) |
| Kathleen Clem, MD, FACEP (FL) | Jennifer L. Stankus, MD, JD, FACEP (WA) |
| Allison Haddock, MD, FACEP (TX) | Tony Salazar, MD, FACEP (NM) |
| Jonathan Heidt, MD, MHA, FACEP (MO) | Annalise Sorrentino, MD, FACEP (AL Alt) |
| Sarah Hoper, MD, JD, FACEP (TN) | Anne Zink, MD, FACEP (AK) |
| Chadd Kraus, DO, DrPH, FACEP (YPS Alt) | |

**III. COUNCIL REFERENCE COMMITTEE PROCEEDINGS AND REPORTS**

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

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

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

**Procedures**

Reference Committee hearings are open to all members of the College, its committees, and invited guests of the Reference Committee. Members of the College, its committees, and/or invited guests are privileged to present written testimony or to speak to the committee on the resolution under consideration. Upon recognition by the chair, non-members may be permitted to speak. The chair is privileged to call upon anyone attending the hearing if, in his/her opinion, the individual called upon may have information that would be helpful to the committee.
The Reference Committee hearings are scheduled from 9:30 am until 12:30 pm Friday, October 27. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

**Proceedings**

Equitable hearings are the responsibility of the Reference Committee chair. The committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, etc. The Reference Committee hearing is the proper forum for discussion of controversial items of business. Councillors who have not taken advantage of the hearings to present their viewpoints or introduce evidence should be reluctant to do so on the floor of the Council. While it is recognized that the concurrence of Reference Committee hearings creates difficulties in this respect, as does service by councillors on other Reference Committees, the submission of written testimony can alleviate these problems. But there is never compulsion for mute acceptance of Reference Committee recommendations when the report is presented. Written testimony is encouraged. In the event of extensive written testimony, the Reference Committee chair will report to the Reference Committee the number of written testimony received in favor and in opposition to the resolution. The Reference Committee chair has the discretion to read any written testimony, especially testimony that provides information not previously presented in other written or in-person testimony. All written testimony will be made available electronically to the Council unless determined by the Speaker to contain inaccurate information or inappropriate comments. The reading of any written testimony shall not exceed the time limits set by the chair for providing testimony on any particular resolution.

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a “pressing need” for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue. **Determination of a “pressing need” will be left to the discretion of the chair.** The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee.

If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

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

**Reports**

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

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

Each item referred to a Reference Committee is reported to the Council as follows:

1. identify the resolution by number and title
2. state concisely the committee’s recommendation
3. motions to refer or postpone should be listed at the beginning of the report, after the consent calendar
4. comment, as appropriate, on the testimony presented at the hearing
5. incorporate evidence supporting the recommendation of the committee

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

Examples of our common variants employing the procedure are:

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

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

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

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

Summary of Council Actions on Reference Committee Reports

<table>
<thead>
<tr>
<th>Matter Before the Council for Discussion from the Reference Committee’s Report</th>
<th>Reference Committee’s Recommendation</th>
<th>Speaker Action (Failing Council Action)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Resolution</td>
<td>1. To adopt or to not adopt</td>
<td>Puts question on adoption, clearly stating the reference committee’s recommendation</td>
</tr>
<tr>
<td>Original Resolution</td>
<td>2. To refer</td>
<td>Puts question on referral</td>
</tr>
<tr>
<td>Committee Substitute (amending original by adding, striking out, inserting, or substituting)</td>
<td>3. To adopt</td>
<td>Puts question on adoption of the committee’s substitute resolution</td>
</tr>
<tr>
<td>Committee Substitute Resolution (combining several like resolutions)</td>
<td>4. To adopt</td>
<td>Puts question on adoption of the committee’s substitute resolution</td>
</tr>
</tbody>
</table>

**Definition of Council Action**

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

**ADOPT**
Approve resolution as recommendation implemented through the Board of Directors

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

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

**NOT ADOPT**
Defeat (or reject) resolution in original or amended form.
### V. PRINCIPLE RULES GOVERNING MOTIONS

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt</th>
<th>Requires second?</th>
<th>Debatable</th>
<th>Amendable</th>
<th>Vote Required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied (in addition to withdraw)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>None</td>
<td>Amend(^3)</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Postpone temporarily(table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority(^2)</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
</tr>
<tr>
<td>6. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>Amend(^3)</td>
</tr>
<tr>
<td>7. Postpone definitely (to a certain time)</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend(^3), close debate, limit debate</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes(^3)</td>
<td>Yes(^3)</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend(^3), close debate, limit debate</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Rewordable motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Restorative, subsidiary</td>
</tr>
<tr>
<td>b. Restorative main motions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion, Subsidiary, restorative</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

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

2 Requires two-thirds vote when it would suppress a motion without debate.

3 Restricted.

4 Withdraw may be applied to all motions.
VI. INCIDENTAL MOTIONS

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

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

Definition

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

Submission and Deadline

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

All resolutions should be submitted to:

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

Bylaws and regular resolutions are due 90 days before the annual Council meeting. The 2017 Council meeting will be held on Friday, October 27 and Saturday, October 28 in Washington, DC. Therefore, the deadline for resolutions for the 2017 Council meeting is July 30, 2017.

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

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

Questions

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

Format

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

Whereas Statements

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

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

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

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

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

Bylaws Amendments

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

General Resolutions

The president, and not the Council, is responsible for determining the appropriate level of committee involvement for resolutions passed by the Council. In addition, the Council cannot "direct" another organization although the College can recommend a course of action to other organizations. For example, Resolution 49(84) directed the ACEP representatives to ABEM to seek ways in which to reduce the fees and associated examinee expenses for the certification examination. Since ACEP does not have representatives to ABEM and since ACEP does not have the authority to direct another organization, it would have been better to state that ACEP ask ABEM to seek ways to reduce examinee expenses.

Council Actions on Resolutions

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

- **Adopt**: Approve resolution exactly as submitted as recommendation implemented through the Board of Directors.
- **Adopt as Amended**: Approve resolution with additions, deletions, and/or substitutions, as recommendation to be implemented through the Board of Directors.
- **Refer**: Send resolution to the Board of Directors for consideration, perhaps by a committee, the Council Steering Committee, or the Bylaws Interpretation Committee. A resolution cannot be referred to other College committees.
- **Not Adopt**: Defeat (or reject) the resolution in original or amended form.

Board Actions on Resolutions

According to the Bylaws, Article VIII – Council, Section 2 – Powers of the Council: “The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions, including amendments to the College Manual, and other actions or appropriations enacted by the Council. The Board of Directors shall act on all resolutions adopted by the Council no later than the second Board meeting following the annual meeting and
shall address all other matters referred to the Board within such time and manner as the Council may determine.

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

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

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.”

Sample Resolutions

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

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

RESOLUTION 9(06)

WHEREAS, The College Bylaws provides for an Executive Committee of the Board of Directors; and
WHEREAS, The speaker has informally served on the Executive Committee; and
WHEREAS, The Executive Committee would benefit from having more formal and standard composition, including the membership of the speaker and the chair of the Board of Directors; and
WHEREAS, The College would benefit from having an Executive Committee appointed every year; therefore be it
RESOLVED, That the ACEP Bylaws, Article XI – Committees, Section 2 – Executive Committee, be amended to read:

ARTICLE XI – COMMITTEES
Section 2 – Executive Committee

The Board of Directors may appoint an Executive Committee. The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president, secretary-treasurer, and the immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board, subject to ratification by the Board at its next meeting. Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.
Resolution 23(06) shows how communication between the College and another organization can be stated.

RESOLUTION 23(06)

WHEREAS, Emergency medicine is recognized by the American Board of Medical Specialties as an independent specialty with a recognized, unique knowledge base and procedural skill set that is certifiable by board examination; and

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

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

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

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

WHEREAS, The expectation of patients who utilize emergency departments for their emergency medical care is that there is seamless, high quality medical and nursing care provided; therefore be it RESOLVED, That the American College of Emergency Physicians works with the Emergency Nurses Association (ENA) to facilitate the development by ENA of a position paper defining a standard of emergency nursing care that includes obtaining CEN certification and outlines a timetable for an emergency nurse to attain such certification; and be it further

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

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

RESOLUTION 16(99)

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

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

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

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

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

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

WHEREAS, Educational and enforcement measures have predominantly targeted boat operators and not boat passengers about the dangers of alcohol consumption and boating; therefore be it RESOLVED, That the American College of Emergency Physicians promote and endorse safe boating practices; and be it further

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

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

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

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

1 As modified by the ACEP Council Standing Rules
**ACEP Parliamentary Motions Guide**
Based on *Sturgis Standard Code of Parliamentary Procedure (4th Ed.)*

**Incidental Motions** - no order of precedence. Arise incidentally and decided immediately.

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

**Restorative Main Motions** - no order of precedence. Introduce only when nothing else pending.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(36) Amend a previous action</td>
<td>I move to amend the motion that was ...</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Varies</td>
</tr>
<tr>
<td>(38) Reconsider motion</td>
<td>I move to reconsider ...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>(42) Cancel previous action</td>
<td>I move to rescind...</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>(44) Take from table</td>
<td>I move to resume consideration of ...</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
</tbody>
</table>

Jim Slaughter, Certified Professional Parliamentarian – Teacher & Professional Registered Parliamentarian  
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web site: [www.jimslaughter.com](http://www.jimslaughter.com)
Council Standing Rules

Revised October 2015
Council Standing Rules

Revised October 2015

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed. A councillor or an alternate councillor may not serve simultaneously as an alternate councillor for more than one component body.

If the number of alternate councillors is insufficient to fill all councillor positions for a component body, then a member of that component body may be seated as a councillor pro-tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, and component bodies are responsible for abiding by the campaign rules.
Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by component body and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate councillor. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials, and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials, and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, and past speakers wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, etc.), and whether they are speaking “for” or “against” the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted by the presiding officer. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the presiding officer, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual’s name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.
Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.

When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, & Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor’s individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate’s total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, & Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, & Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Electronic Devices

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

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. See also Debate and Voting Immediately.
Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, or past speaker, after which nominations will be closed and shall not be reopened.

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

Parliamentary Procedure

The current edition of Sturgis, Standard Code of Parliamentary Procedure will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. See also Limiting Debate and Voting Immediately.

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

Past Presidents and Past Speakers Seating

Past presidents and past speakers of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

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

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

**Reports**

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

**Resolutions**

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

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body.

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

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

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

  Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as “Late Resolutions.”

- **Bylaws Resolutions**
  Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

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

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

• *Emergency Resolutions*

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

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

**Smoking Policy**

Smoking is not permitted in any College venue.

**Unanimous Consent Agenda**

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

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

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

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

**Voting Immediately**

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

**Voting on Resolutions and Motions**

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

Revised October 2016
# Bylaws

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ARTICLE I — NAME

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

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

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

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

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

ARTICLE III — COLLEGE MEETINGS

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

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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

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

Section 2.1 — Regular Members

Regular members of the College are physicians who devote a significant portion of their medical endeavors to emergency medicine. All regular members must meet one of the following criteria: 1) satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); 2) satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country; 3) satisfactory completion of a subspecialty training program in pediatric emergency medicine accredited by the ACGME; 4) primary board certification by an emergency medicine certifying body recognized by ACEP; or 5) eligibility for active membership in the College (as defined by the College Bylaws then in force) at any time prior to close of business December 31, 1999. Regular members shall be assigned by the Board of Directors to one of the following statuses: (1) active, (2) inactive, or (3) retired. Members who qualify will additionally be assigned to life status. All applicants for regular membership shall hold a current, active, full, valid, unrestricted, and unqualified license to practice medicine in the state, province, territory, or foreign country in which they practice, or be serving in a governmental medical assignment. All regular members must either continue to maintain a valid license to practice medicine or have voluntarily relinquished the license upon leaving medical practice. A license to practice medicine shall not be considered voluntarily relinquished if it was surrendered, made inactive, or allowed to expire under threat of probation or suspension or other condition or limitation upon said license to practice medicine by a licensing body in any jurisdiction.

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

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

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

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

Section 2.2 — Honorary Members

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

Section 2.3 — Candidate Members

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

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

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

Section 2.4 — International Members

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

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

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

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

Section 3 — Agreement

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

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

Section 4 — Disciplinary Action

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

Section 5 — Dues, Fees, and Assessments

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

Any member whose membership has been canceled for failure to pay dues or assessments shall lose all privileges of membership. The Board of Directors may establish procedures and policies with regard to the nonpayment of dues and assessments.
Section 6 — Official Publications

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

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

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

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

Section 2 — Fellow Status

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

ARTICLE VI — CHAPTERS

Section 1 — Charters

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

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

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

Section 3 — Qualifications

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

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

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

Section 4 — Component Branches

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

Section 5 — Charter Suspension – Revocation

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

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

Section 6 — Ultimate Authority by College

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

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

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

ARTICLE VIII — COUNCIL

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

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

Each component body shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body's councillor at Council meetings at which such councillor is not available to participate. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.
Section 2 — Powers of the Council

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

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

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

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

Section 3 — Meetings

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

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

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

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

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

Section 4 — Quorum

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

Section 5 — Voting Rights

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

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

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

Section 6 — Resolutions

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

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

Section 7 — Nominating Committee

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

Section 8 — Board of Directors Action on Resolutions

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

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

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

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

The management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws.
Section 2 — Composition and Election

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

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

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

Section 3 — Meetings

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

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

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

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

Section 4 — Removal

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

Section 5 — Vacancy

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

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

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 3 — Removal

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

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

Section 4 — Vacancy

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

Section 4.1 — President

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

Section 4.2 — President-Elect

In the event of a vacancy in the office of the president-elect, the Board of Directors, speaker, and vice speaker may fill the vacancy by majority vote for the remainder of the unexpired term from among the members of the Board. If the vacancy in the office of president-elect is filled in such a manner, at the next annual Council meeting, the Council shall, by majority vote of the credentialed councillors, either ratify the elected replacement, or failing such ratification, the Council shall elect a new replacement from among the members of the Board. The Council shall, in the normal course of Council elections, elect a new president-elect to succeed the just-ratified or just-elected president-elect only when the latter is succeeding to the office of president at the same annual meeting.
Section 4.3 — Chair, Vice President, & Secretary-Treasurer

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

Section 4.4 — Council Officers

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

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

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

Section 4.5 — Vacancy by Removal of a Board Officer

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

Section 4.6 — Vacancy by Removal of a Council Officer

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

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president’s term of office shall begin at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

Section 6 — Chair

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

Section 7 — Vice President

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

Section 8 — President-Elect

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

Section 9 — Secretary-Treasurer

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

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

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

Section 10 — Immediate Past President

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

Section 11 — Speaker

The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the Council, except that the vice speaker may preside at the discretion of the speaker. The speaker shall prepare, or cause to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and shall inform the councillors of the activities of the College. The speaker’s term of office shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to the Board of Directors of the College. No speaker may serve consecutive terms.
Section 12 — Vice Speaker

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

Section 13 — Executive Director

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

Section 14 — Assistant Secretary-Treasurer

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

ARTICLE XI — COMMITTEES

Section 1 — General Committees

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

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

Section 2 — Executive Committee

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

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

Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall be required to meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.
The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

Section 4 — Bylaws Interpretation Committee

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

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

Section 5 — Finance Committee

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

Section 6 — Bylaws Committee

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

Section 7 — Compensation Committee

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.
The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board’s proposed compensation, the Compensation Committee’s recommendation will then take effect.

ARTICLE XII — ETHICS

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

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

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

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

Section 2 — Notice

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

Section 3 — Amendment Under Initial Consideration

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

Section 4 — Contested Amendment

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

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

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

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

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

Section 2 — Annual Report

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

Section 3 — Parliamentary Authority

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

Section 4 — College Manual

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

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

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

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

Section 2 — Definitions

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

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

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

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

   Section 3 — Non-Exclusive; Continuation

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

   Section 4 — Insurance or Other Arrangement

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

   Section 5 — Exclusion of Certain Acts from Indemnification

   Notwithstanding any other provision of this Article XV, no Director, Officer, or Employee of the College shall be indemnified for any dishonest or fraudulent acts, willful violation of applicable law, or actions taken by such person when acting outside of the scope of such person’s office, position, or authority with or granted by the College or the Board of Directors.
I. Applications for Membership
II. Procedures for Addressing Charges of Ethical Violations and Other Misconduct
   A. Complaint Received
   B. Executive Director
   C. Bylaws Committee
   D. Ethics Committee
   E. Board of Directors
   F. Ad Hoc Committee
   G. Right of Respondent to Request a Hearing
   H. Hearing Procedures
   I. Disciplinary Action: Censure, Suspension, or Expulsion
   J. Disclosure
   K. Ground Rules
III. Chartering Chapters
IV. Charter Suspension-Revocation
V. Filling Board Vacancies Created by Other Than Removal
VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council
VII. Amendments
I. Applications for Membership

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

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

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

A. Complaint Received

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

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

B. Executive Director

1. Sends a written acknowledgement to the complainant confirming the complainant’s intent to file a complaint and identifying the elements that must be addressed in an ethics complaint.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct (“Procedures”.”)
3. Notifies the ACEP President and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the chair of the Ethics and/or Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics for Emergency Physicians or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
b. Determines, in consultation with the Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics for Emergency Physicians, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or

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

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

e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

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

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

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

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

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

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

F. Ad Hoc Committee
1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.
2. This Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.
3. The Ad Hoc Committee:
   a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and the complaint and response.
   b. May request further information in writing from the complainant and/or respondent.
   c. Decides to:
      i. Dismiss the complaint; or
      ii. Render a decision to impose disciplinary action based on written record.
   d. If the Ad Hoc Committee determines to impose disciplinary pursuant to Section F.3.c.ii., the respondent will be provided with notification of the Ad Hoc Committee’s determination and the option of:
      i. A hearing conducted by the Ad Hoc Committee; or
      ii. The imposition of the Ad Hoc Committee decision based solely on the written record.
   e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.

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

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

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

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

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

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

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

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

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

I. Disciplinary Action: Censure, Suspension, or Expulsion

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Chartering Chapters

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

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

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

IV. Charter Suspension-Revocation

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

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

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

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

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

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

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

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

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

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

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

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

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

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

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

VII. Amendments

The method of amending the College Manual shall be specified in the College Bylaws.
The 45th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am, Friday, October 14, 2016, by Speaker James M. Cusick, MD, FACEP.

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

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

Victoria Coan sang the National Anthem.

Scot Shepherd, MD, FACEP, president of the Las Vegas Chapter, welcomed councillors and other meeting attendees.

Melissa Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 325 councillors of the 394 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Mr. Eric Joy provided an overview of the Council meeting Web site and other technology enhancements.

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

Peter Jacoby, MD, FACEP, addressed the Council regarding the National Emergency Medicine Political Action Committee (NEMPAC) Challenge.

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2016 Council meeting:

**Alabama**
- Lisa M Bundy, MD, FACEP
- Muhammad N Husainy, DO, FACEP
- Annalise Sorrentino, MD, FACEP

**Alaska**
- Anne Zink, MD, FACEP

**Arizona**
- Patricia A Bayless, MD, FACEP
- Paul Andrew Kozak, MD, FACEP
- Donald J Lauer, MD, MPH, FACEP
- J Scott Lowry, MD, FACEP
- Wendy Ann Lucid, MD, FACEP
- Craig Norquist, MD, FACEP
- Dale P Woolridge, MD, PhD, FACEP

**Arkansas**
- Darren E Flamik, MD, FACEP
- Paul A Veach, MD, FACEP
Assoc of Academic Chairs of EM

Gabor David Kelen, MD, FACEP

California

John D Bibb, MD, FACEP
Rodney W Borger, MD, FACEP
John Dirk Coburn, MD
Fred Dennis, MD, MBA, FACEP
Carrieanne E Drenten, MD
Irv E Edwards, MD, FACEP
Andrew N Fenton, MD, FACEP
Marc Allan Futernick, MD, FACEP
Vikant Gulati, MD, FACEP
Ramon W Johnson, MD, FACEP
Kevin M Jones, DO
Roneet Lev, MD, FACEP
Stephen J Liu, MD, FACEP
John Thomas Ludlow, MD
William K Mallon, MD
Cameron J McClure, MD, FACEP
Aimee K Moulin, MD, FACEP
Leslie Mukau, MD, FACEP
Chi Lee Perlroth, MD, FACEP
Maria Raven, MD, MPH, FACEP
Vivian Reyes, MD, FACEP
Nicolas Sawyer, MD
Eric W Snyder, MD, FACEP
Peter Erik Sokolove, MD, FACEP
Lawrence M Stock, MD, FACEP
Thomas Jerome Sugarman, MD, FACEP
Gary William Tamkin, MD, FACEP
Lori D Winston, MD, FACEP

Colorado

Nathaniel T Hibbs, DO, FACEP
Douglas M Hill, DO, FACEP
Kevin W McGarvey, MD
Carla Elizabeth Murphy, DO, FACEP
Eric B Olsen, MD, FACEP
Lee Wilton Shockley, MD, FACEP
Donald E Stader, MD, FACEP

Connecticut

Hynes M Birmingham, MD, FACEP
Mark R Dziedzic, MD, FACEP
Daniel Freess, MD, FACEP
Elizabeth Schiller, MD, FACEP
Gregory L Shangold, MD, FACEP
David E Wilcox, MD, FACEP

Council of EM Residency Directors

Saadia Akhtar, MD

Delaware

Kathryn Groner, MD
John T Powell, MD, MHCDS, FACEP

District of Columbia

Ethan A Booker, MD, FACEP
Natalie L Kirilichin, MD
Aisha T Liferidge, MD, FACEP

Emergency Medicine Residents’ Association

Christian J Dameff, MD
Nida F Degesys, MD
Florida

Andrew I Bern, MD, FACEP
Jordan GR Celeste, MD
Amy Ruben Conley, MD, FACEP
Jay L Falk, MD, FACEP
Kelly Gray-Eurom, MD, MMM, FACEP
Larry Allen Hobbs, MD, FACEP
Saundra A Jackson, MD, FACEP
Steven B Kailes, MD, FACEP
Michael Lozano, MD, FACEP
Kristin McCabe-Kline, MD, FACEP
Raymond Merritt, DO
Ernest Page, II, MD, FACEP
Sanjay Pattani, MD, FACEP
Danyelle Redden, MD, FACEP
Todd L Slesinger, MD, FACEP
Kristine Staff, MD
Joel B Stern, MD, FACEP

Georgia

Matthew R Astin, MD, FACEP
James Joseph Dugal, MD, FACEP(E)
Matthew Taylor Keadey, MD, FACEP
Jeffrey F Linzer, Sr, MD, FACEP
Matthew Lyon, MD, FACEP
DW “Chip” Pettigrew, III, MD, FACEP
Johnny L Sy, DO, FACEP
Matthew J Watson, MD, FACEP

Government Services

James David Barry, MD, FACEP
Marco Coppola, DO, FACEP
Melissa L Givens, MD, FACEP
Joshua Jacobson, DO
Chad Kessler, MD, MHPE, FACEP
Julio Rafael Lairret, DO, FACEP
Linda L Lawrence, MD, FACEP
Brett A Matzek, MD, FACEP
David S McClellan, MD, FACEP
Torree M McGowan, MD, FACEP
Nadia M Pearson, DO, FACEP
Christopher G Scharenbrock, MD, FACEP
Gillian Schmitz, MD, FACEP

Hawaii

Jason K Fleming, MD, FACEP
Richard M McDowell, MD, FACEP

Idaho

Nathan R Andrew, MD, FACEP
Ken John Gramyk, MD, FACEP

Illinois

Christine Babcock, MD, FACEP
E Bradshaw Bunney, MD, FACEP
Shu Boung Chan, MD, FACEP
Cai Glushak, MD, FACEP
David L Griffen, MD, PhD, FACEP
John W Hafner, MD, FACEP
George Z Hevesy, MD, FACEP
Janet Lin, MD, FACEP
Valerie Jean Phillips, MD, FACEP
Henry Pitzele, MD, FACEP
Yanina Purim-Shem-Tov, MD, FACEP
William P Sullivan, DO, FACEP
Nathan Seth Trueger, MD, MPH

Indiana
Sara Ann Brown, MD, FACEP
John T Finnell, II, MD, FACEP
John Thomas Rice, MD, FACEP
James L Shoemaker, Jr, MD, FACEP
Christopher S Weaver, MD, FACEP
Lindsay M Weaver, MD, FACEP

Iowa
Ryan M Dowden, MD, FACEP
Andrew Sean Nugent, MD, FACEP
Rachael Sokol, DO, FACEP
Michael E Takacs, MD, FACEP

Kansas
Chad Michael Cannon, MD, FACEP
John M Gallagher, MD, FACEP
Jeffrey G Norvell, MD, FACEP

Kentucky
David Wesley Brewer, MD, FACEP
Royce Duane Coleman, MD, FACEP
Melissa Platt, MD, FACEP
Ryan Stanton, MD, FACEP

Louisiana
James B Aiken, MD, MHA, FACEP
Jon Michael Cuba, MD, FACEP
Phillip Luke LeBas, MD, FACEP
Mark Rice, MD, FACEP
Michael D Smith, MD, MBA, CPE, FACEP

Maine
Garreth C Debiegun, MD, FACEP
James B Mullen, III, MD, FACEP
Charles F Pattavina, MD, FACEP

Maryland
Jason D Adler, MD, FACEP
Richard J Ferraro, MD, FACEP
Kerry Forrestal, MD, FACEP
Hugh F Hill, III, MD, JD, FACEP
Kathleen D Keeffe, MD, FACEP
Orlee Israeli Panitch, MD, FACEP
Esteban Schabelman, MD, FACEP

Massachusetts
Brien Alfred Barnewolt, MD, FACEP
Kate Burke, MD, FACEP
Stephen K Epstein, MD, MPP, FACEP
Jeffrey Hopkins, MD, FACEP
Kathleen Kerrigan, MD, FACEP
Matthew B Mostofi, DO, FACEP
Mark D Pearlmutter, MD, FACEP
Jesse Michael Schafer, MD  
Peter B Smulowitz, MD, FACEP  
Brian Sutton, MD, FACEP

Michigan  
Michael J Baker, MD, FACEP  
Keenan M Bora, MD, FACEP  
Kathleen Cowling, DO, FACEP  
Nicholas Dyc, MD, FACEP  
Gregory Gafni-Pappas, DO, FACEP  
Rami R Khoury, MD, FACEP  
Robert T Malinowski, MD, FACEP  
Jacob Manteuffel, MD, FACEP  
James C Mitchiner, MD, MPH, FACEP  
Kevin Monfette, MD, FACEP  
David T Overton, MD, FACEP  
Paul R Pomeroy, Jr, MD, FACEP  
Luke Chris Sasaki, MD, FACEP  
Larisa May Traill, MD, FACEP  
Bradley J Uren, MD, FACEP  
Bradford L Walters, MD, FACEP  
Mildred J Willy, MD, FACEP  
James Michael Ziadeh, MD, FACEP

Minnesota  
William G Heegaard, MD, FACEP  
David M Larson, MD, FACEP  
David A Milbrandt, MD, FACEP  
David Nestler, MD, MS, FACEP  
Gary C Starr, MD, FACEP  
Thomas E Wyatt, MD, FACEP  
Andrew R Zinkel, MD, FACEP

Mississippi  
Melissa Wysong Costello, MD, FACEP  
Lawrence Albert Leake, MD, FACEP

Missouri  
Douglas Mark Char, MD, FACEP  
Jonathan Heidt, MD, MHA, FACEP  
Thomas B Pinson, MD, FACEP  
Robert Francis Poirier, Jr., MD, MBA, FACEP  
Sebastian A Rueckert, MD, MBA, FACEP  
Christine Sullivan, MD, FACEP

Montana  
Harry Eugene Sibold, MD, FACEP

Nebraska  
Renee Engler, MD, FACEP  
Laura R Millemion, MD, FACEP

Nevada  
Eric John Anderson, MD, FACEP  
Gregory Alan Juhl, MD, FACEP  
Scott Franklin Shepherd, MD, FACEP

New Hampshire  
Reed Brozen, MD, FACEP  
Matthew Alexander Roginski, MD

New Jersey  
Victor M Almeida, DO, FACEP  
Robert M Eisenstein, MD, FACEP  
William Basil Felegi, DO, FACEP  
Jenice Forde-Baker, MD, FACEP
Anthony William Hartmann, MD, FACEP
Steven M Hochman, MD, FACEP
Marjory E Langer, MD, FACEP
Alexis M LaPietra, DO
J Mark Meredith, MD, FACEP

New Mexico
Eric Michael Ketcham, MD, FACEP
Tony B Salazar, MD, FACEP

New York
Brahim Ardolic, MD, FACEP
Samuel Francis Bosco, MD, FACEP
Jay Miller Brenner, MD, FACEP
Jeremy T Cushman, MD, FACEP
Jason Zemmel D’Amore, MD, FACEP
Mathew Foley, MD, FACEP
Theodore J Gaeta, DO, FACEP
Sanjey Gupta, MD, FACEP
Michael Gary Guttenberg, DO, FACEP
Abbas Husain, MD, FACEP
Stuart Gary Kessler, MD, FACEP
Penelope Chun Lema, MD, FACEP
Joshua B Moskovitz, MD, MPH, FACEP
Nestor B Nestor, MD, FACEP
Salvatore R Pardo, MD, FACEP
Jennifer Pugh, MD, FACEP
Jeffrey S Rabrich, DO, FACEP
Christopher C Raio, MD, FACEP
Gary S Rudolph, MD, FACEP
James Gerard Ryan, MD, FACEP
Frederick M Schiavone, MD, FACEP
Trent T She, MD
Virgil W Smaltz, MD, MPA, FACEP
Jeffrey J Thompson, MD, FACEP
Asa “Peter” Viccellio, MD, FACEP

North Carolina
Gregory J Cannon, MD, FACEP
Jennifer Casaletto, MD, FACEP
Charles W Henrichs, III, MD, FACEP
Jeffrey Allen Klein, MD, FACEP
Thomas Lee Mason, MD, FACEP
Abhishek Mehrotra, MD, FACEP
Bret Nicks, MD, FACEP
Jennifer L Raley, MD, FACEP
Stephen A Small, MD, FACEP
Michael J Utecht, MD, FACEP

North Dakota
K J Temple, MD, FACEP

Ohio
Eileen F Baker, MD, FACEP
Saurin P Bhatt, MD
Dan Charles Breece, DO, FACEP
Laura Michelle Espy-Bell, MD
Purva Grover, MD, FACEP
Gary R Katz, MD, MBA, FACEP
Erika Charlotte Kube, MD, FACEP
Thomas W Lukens, MD, PhD, FACEP
John L Lyman, MD, FACEP
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<td>Achyut B Kamat, MD</td>
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<td>Society of Academic Emergency Medicine</td>
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Texas
Sara Andrabi, MD
Carrie de Moor, MD, FACEP
Justin W Fairless, DO, FACEP
Angela Siler Fisher, MD, FACEP
Diana L Fite, MD, FACEP
Andrea L Green, MD, FACEP
Robert D Greenberg, MD, FACEP
Alison Haddock, MD, FACEP
Justin P Hensley, MD, FACEP
Heidi C Knowles, MD, FACEP
John Bruce Moskow, MD, FACEP
Heather S Owen, MD, FACEP
Daniel Eugene Peckenpaugh, MD, FACEP
R Lynn Rea, MD, FACEP
Richard Dean Robinson, MD, FACEP
Chet D Schrader, MD, FACEP
Nicholas P Steinour, MD, FACEP
Gerad A Troutman, MD, FACEP
Hemant H Vankawala, MD, FACEP
James M Williams, DO, FACEP
Sandra Williams, DO, FACEP

Utah
James V Antinori, MD, FACEP
Bennion D Buchanan, MD, FACEP
John R Dayton, MD, FACEP
Stephen Carl Hartsell, MD, FACEP

Vermont
Joshua Harris, MD

Virginia
Brian C Dawson, MD, FACEP
Bruce M Lo, MD, MBA, RDMS, FACEP
Cameron K Olderog, MD, FACEP
Jeremiah O'Shea, MD, FACEP
Joran Sequeira, MD
Mark Robert Sochor, MD, FACEP
Sara F Sutherland, MD, MBA, FACEP
Stephen J Wolf, MD, FACEP

Washington
Cameron Ross Buck, MD, FACEP
Enrique R Enguidanos, MD, FACEP
John Matheson, MD, FACEP
Nathaniel R Schlicher, MD, JD, FACEP
Patrick Solari, MD, FACEP
Jennifer L’Hommedieu Stankus, MD, JD, FACEP
Liam Yore, MD, FACEP

West Virginia
Frederick C Blum, MD, FACEP
Thomas Marshall, MD, FACEP

Wisconsin
Howard Jeffery Croft, MD, FACEP
William D Falco, MD, MS, FACEP
William C Haselow, MD, FACEP
Michael Dean Repplinger, MD, PhD, FACEP

Wyoming
Waseem A Khawaja, MD, FACEP
Sections of Membership
Air Medical Transport  Gaston Ariel Costa, MD
Amer Assoc of Women Emergency Physicians  E Lea Walters, MD, FACEP
Careers in Emergency Medicine  Sullivan K Smith, MD, FACEP
Critical Care Medicine  Ayan Sen, MD, FACEP
Cruise Ship Medicine  Sydney W Schneidman, MD, FACEP
Democratic Group Practice  David F Tulsiak, MD, FACEP
Disaster Medicine  Roy L Alson, MD, PhD, FACEP
Dual Training  Michael C Bond, MD, FACEP
Emergency Medical Informatics  Jeffrey A Nielson, MD, FACEP
Emergency Medical Services-Prehospital Care  Gina Piazza, DO, FACEP
EM Practice Management & Health Policy  Jonathan F Thomas, MD
Emergency Medicine Research  Nidhi Garg, MD, FACEP
Emergency Medicine Workforce  Guy Nuki, MD
Emergency Ultrasound  Robert M Bramante, MD, FACEP
Forensic Medicine  Lawrence J R Goldhahn, MD, FACEP
Freestanding Emergency Centers  Michael Joseph Sarabia, MD, FACEP
Geriatric Emergency Medicine  Marianna Karounos, DO, FACEP
International Emergency Medicine  Elizabeth L DeVos, MD, FACEP
Medical Humanities  David P Sklar, MD, FACEP
Observation Services  Carol L Clark, MD, MBA, FACEP
Palliative Medicine  Kate Aberger, MD, FACEP
Pediatric Emergency Medicine  Madeline Matar Joseph, MD, FACEP
Quality Improvement & Patient Safety  Jeffrey J Pothof, MD, FACEP
Rural Emergency Medicine  Darrell L Carter, MD, FACEP
Sports Medicine  Christopher Aaron Gee, MD, MPH, FACEP
Tactical Emergency Medicine  Howard K Mell, MD, MPH, CPE, FACEP
Telemedicine  Hartmut Gross, MD, FACEP
Toxicology  Jennifer Hannum, MD, FACEP
In addition to the credentialed councillors, the following past leaders attended all or part of the Council meeting and were not serving as councillors:

**Past Presidents**
- Nancy J. Auer, MD, FACEP (WA)
- Larry A. Bedard, MD, FACEP (CA)
- Brooks F. Bock, MD, FACEP (CO)
- Michael L. Carius, MD, FACEP (CT)
- Angela F. Gardner, MD, FACEP (TX)
- Gregory L. Henry, MD, FACEP (MI)
- J. Brian Hancock, MD, FACEP (MI)
- John C. Johnson, MD, FACEP (IN)
- Nicholas J. Jouriles, MD, FACEP (OH)
- Brian F. Keaton, MD, FACEP (OH)
- Linda L. Lawrence, MD, FACEP (GS)
- Alex M. Rosenau, DO, FACEP (PA)
- Robert W. Schafermeyer, MD, FACEP (NC)
- Sandra M. Schneider, MD, FACEP (TX)
- David C. Seaberg, MD, CPE, FACEP (TN)
- Richard L. Stennes, MD, MBA, FACEP (CA)
- Robert E. Suter, DO, MPH, FACEP (TX)
- Michael J. Bresler, MD, FACEP (CA)
- Kevin M. Klauer, DO, FACEP (OH)
- Todd B. Taylor, MD, FACEP (TN)
- Arlo F. Weltge, MD, MPH, FACEP (TX)
- Dennis C. Whitehead, MD, FACEP (MI)

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

**Council Standing Rules**

**Preamble**
These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

**Alternate Councillors**
A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

If the number of alternate councillors is insufficient to fill all councillor positions for a particular chapter, section, or EMRA, then a member of that sponsoring body may be seated as a councillor pro-tem by either the concurrence of an officer of the sponsoring body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

**Amendments to Council Standing Rules**
These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

**Announcements**
Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the
speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

**Appeals of Decisions from the Chair**
A two-thirds vote is required to override a ruling by the chair.

**Board of Directors Seating**
Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

**Campaign Rules**
Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, chapters, and sections, etc. are responsible for abiding by the campaign rules.

**Cellular Phones, Pagers, and Computers**
Cellular phones, pagers, and computers must be kept in “quiet” mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of computers for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

**Councillor Allocation for Sections of Membership**
To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

**Councillor Seating**
Councillor seating will be grouped by chapter and the location rotated year to year in an equitable manner.

**Credentialing and Proper Identification**
To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate status. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

**Debate**
Councillors, members of the Board of Directors, past presidents, and past speakers wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, etc.), and whether they are speaking “for” or “against” the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the chair, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual’s name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.
Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting. When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, and Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor’s individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a runoff will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate’s total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, and Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, and Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. See also Debate and Voting Immediately.

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committees shall consider activity and involvement in the College, the Council, and chapter or sections when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, or past speaker, after which nominations will be closed and shall not be reopened.

A prospective floor candidate or an individual who intends to nominate a candidate from the floor may make this intent known in advance by notifying the Council secretary in writing. Upon receipt of this notification, the
candidate becomes a “declared floor candidate” and has all the rights and responsibilities of committee nominated candidates. See also Election Procedures.

Parliamentary Procedure
The current edition of Sturgis, Standard Code of Parliamentary Procedure will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. See also Personal Privilege and Voting Immediately.

Past Presidents and Past Speakers Seating
Past presidents and past speakers of the College are invited to sit with their respective chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

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

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

Reference Committees
Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council. Reference Committee meetings are open to all members of the College, its committees, and invited guests.
Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.
A Reference Committee may recommend that a resolution:
A) Be Adopted or Not Be Adopted: In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.
B) Be Amended or Substituted: In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.
C) Be Referred: In this case, the speaker shall state the motion to refer. Debate on a Reference Committee’s motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.
Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

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

Resolutions
“Resolutions” are considered formal motions that if adopted by a majority vote of the Council and ratified by the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.
Resolutions must be submitted in writing by at least two members or by chapters, sections, committees, or the Board of Directors. A letter of endorsement from the sponsoring body is required if submitted by a chapter, section, or committee.
All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When
appropriate, amendments will be distributed or projected for viewing.

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

• **Regular Non-Bylaws Resolutions**

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

  Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as “Late Resolutions.”

• **Bylaws Resolutions**

  Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

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

• **Late Resolutions**

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

• **Emergency Resolutions**

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

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

**Smoking Policy**

Smoking is not permitted in any College venue.
Unanimous Consent Agenda

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

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

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

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

Voting Immediately

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

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

Voting on Resolutions and Motions

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

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The councillors reviewed and accepted the minutes of the October 24-25, 2015, Council meeting and approved the actions of the Steering Committee taken at their January 26, 2016, and May 15, 2016, meetings.

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

Dr. Cusick reported that two late resolutions were received and reviewed by the Steering Committee. One late resolution was withdrawn and the other late resolution was accepted and assigned to Reference Committee C.

Dr. Cusick presented the Nominating Committee report. Four members were nominated for President-Elect: Hans R. House MD, MACM, FACEP; Paul D. Kivela, MD, MBA, FACEP; Robert E. O'Connor, MD, MPH, FACEP; and John J. Rogers, MD, CPE, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Seven members were nominated for four positions on the Board of Directors: James J. Augustine, MD, FACEP; John T. Finnell, MD, FACEP; Kevin M. Klauer, DO, EJD, FACEP; Debra G. Perina, MD, FACEP; Gillian R. Schmitz, MD, FACEP; Matthew J. Watson, MD, FACEP; and James M. Williams, DO, MS, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

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

2016 Council Resolutions

The Council recessed at 9:15 am for the Reference Committee hearings. The resolutions considered by the 2016 Council appear below as submitted.

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Michael J. Gerardi, MD,
FACEP, for his exemplary service, leadership, and commitment to the College, the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 2
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, MD, FACEP, as one of the leaders in Emergency Medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Kenneth L. DeHart, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

RESOLUTION 3
RESOLVED, That the “Unanimous Consent” section of the Council Standing Rules be amended to read:

Unanimous Consent Agenda

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

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

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

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee’s recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. The requester, when recognized by the chair, may give a one-minute summary of the reason for extraction to enable the Council to determine the “merits of extraction.” The Reference Committee chair will then read the summary of the testimony from the Reference Committee Report. Without debate, a one-third affirmative vote of the councillors present and voting is required to remove the item from the Unanimous Consent Agenda. This process will be repeated for each item requested to be removed from the Unanimous Consent Agenda. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

RESOLUTION 4
RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be amended to read:

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

RESOLUTION 5
RESOLVED, That the 2016 ACEP Council supports the establishment of a full voting designated young physician position on the ACEP Board of Directors.

RESOLUTION 6
RESOLVED, That the ACEP Board of Directors pursue an appropriate avenue to study and determine if any specific issues posed to Senior/Late Career Emergency Physicians exist, and that if there is a need to address issues related to Senior/Late Career Emergency Physicians, to address those issues in an appropriate manner to be determined by the ACEP Board and that a report on this matter shall be delivered to the 2017 ACEP Council.
RESOLUTION 7
RESOLVED, That the ACEP Board of Directors develop strategies to increase diversity within the ACEP Council and its leadership and report back to the Council on effective means of implementation.

RESOLUTION 8
RESOLVED, That ACEP oppose mandatory, required, high stakes secured examination for Maintenance of Certification (MOC) in Emergency Medicine; and be it further
RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

RESOLUTION 9
RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further
RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

RESOLUTION 10
RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further
RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

RESOLUTION 11
RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further
RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

RESOLUTION 12
RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medical care, clinical and non-clinical, reach out and build coalitions with non-medical organizations involved in developing quality standards to achieve objective and meaningful advances in quality in the eyes of our patients, institutions, and payers; and be it further
RESOLVED, That the American College of Emergency Physicians, in conjunction with non-medical organizations involved in developing quality standards, define the costs of providing the highest levels of quality care, to quality/safety reflects reimbursement and reimbursement reflects quality/safety.

RESOLUTION 13
RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further
RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council’s next scheduled meeting; and be it further
RESOLVED, That ACEP reaffirms its support of:
1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge (before 11 am) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital
RESOLUTION 14
RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs; and be it further

RESOLVED, That ACEP endorse integration of a dashboard for reporting and tracking of behavioral health patients boarding in EDs in electronic health record systems as a means for linking to broader priority systems, for communicating the impact of boarded behavioral health patients, and to further collaborate with all appropriate health care and government stakeholders.

RESOLUTION 15
RESOLVED, That ACEP shall create a study of the impact of narrow networks laws and potential solutions that address balance billing issues without increasing the burden on the patient; and be it further

RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks does not affect a physician’s ability to receive fair reimbursement for providing medical care.

RESOLUTION 16
RESOLVED, That ACEP develop a report or information paper supporting the use of Freestanding Emergency Centers as an alternative care model for the replacement of Emergency Departments in Critical Access and Rural Hospitals that have closed, or are in imminent risk of closure, to maintain access to emergency care in the underserved and rural regions of the United States.

RESOLUTION 17
RESOLVED, That ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patient’s deductibles after the insurance company pays the physician the full negotiated rate; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates that advocates for a national law requiring health care insurance companies to collect patient’s deductibles after the insurance company pays the physician the full negotiated rate.

RESOLUTION 18
RESOLVED, That ACEP oppose the overstep of CMS mandated reporting standards that require potential harm to patients without the recognition of appropriate physician assessment and evidence based goal directed care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and the public the dangers of CMS overstep of physician responsibility to patients for quality indicators and actively work to communicate to hospitals the need and options to recognize appropriate physician treatment while avoiding unnecessary harm to patients.

RESOLUTION 19
RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

RESOLUTION 20
RESOLVED, That the American College of Emergency Physicians work with the Undersea & Hyperbaric Medical Society (UHMS) and the Divers Alert Network (DAN) to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide timely and appropriate treatment to patients in need.

RESOLUTION 21
RESOLVED, That ACEP develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and be it further

RESOLVED, That ACEP provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

RESOLUTION 22
RESOLVED, That ACEP study the moral and ethical responsibilities of emergency physicians within the context of court ordered forensic collection of evidence in the context of patient refusal of consent, and if appropriate,
develop policy to support emergency physician’s professional responsibilities when in conflict with court ordered forensic collection of evidence or medical treatment.

**RESOLUTION 23**
RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further
RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction and maintenance programs (including methadone, buprenorphine) from the Emergency Department.

**RESOLUTION 24**
RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further
RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further
RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and the National Academy of Medicine to develop community and hospital based benchmark performance metrics for ED mental health flow and linking inpatient psychiatric facilities acceptance of patients to licensure.

**RESOLUTION 25**
RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training and assessment for national registry testing and certification in recognition of the current level of training and experience of military medical specialist providers in our nation’s service.

**RESOLUTION 26**
RESOLVED, That ACEP supports users of clinical ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of clinical ultrasound by non-radiology specialists and the billing for such services; and be it further
RESOLVED, That ACEP continue to support emergency physicians working to develop and implement clinical ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

**RESOLUTION 27**
RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further
RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

**RESOLUTION 28**
RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further
RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

**RESOLUTION 29**
RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further
RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further
RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including such innovative treatments as allowing school nurses and other trained school personnel to administer Naloxone, “safe injection sites,” and needle exchange programs.
**RESOLUTION 30**

RESOLVED, That ACEP investigate the scope of treatment of marijuana intoxication in the ED that has legal implications; and be it further

RESOLVED, That ACEP determines if there are state or federal laws that provide guidance to emergency physicians in the treatment of marijuana intoxication in the ED; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee or task force to answer clinically relevant questions that address the need to care for ED patients with possible marijuana (or other drug) intoxication; and be it further

RESOLVED, That ACEP investigate how other medical specialties address the treatment of marijuana intoxication in other clinical settings; and be it further

RESOLVED, That ACEP provide the resources necessary to coordinate the treatment of marijuana intoxication in the ED.

**RESOLUTION 31 (This late resolution was accepted by the Council for submission.)**

RESOLVED, That ACEP actively oppose the FDA approval of sublingual formulations of synthetic fentanyl analogs, including sufentanil, via direct testimony or other means that the Board may find suitable; and be it further

RESOLVED, That ACEP create a report detailing the risks, benefits, and alternatives to the use of narcotic analgesics that, by their specific route of administration or formulation, carry a higher risk of misuse or abuse than other similarly classified drugs, in EMS and Emergency Medicine.

Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 3-8 were referred to Reference Committee A. Chad Kessler, MD, FACEP, chaired Reference Committee A and other members were: James R. Kennedye, MD, MPH, FACEP; Heidi C. Knowles, MD, FACEP; Paul R. Pomeroy, Jr., MD, FACEP; Anne Zink, MD, FACEP; Leslie Moore, JD; and Dan Sullivan.

Resolutions 9-20 were assigned to Reference Committee B. Nathaniel R. Schlicher, MD, JD, FACEP, chaired Reference Committee B and other members were: Jordan GR Celeste, MD, FACEP; William B. Felegi, DO, FACEP; Heather A. Heaton, MD; Donald L. Lum, MD, FACEP; Tony B. Salazar, MD, FACEP; Harry Monroe; and Barbara Tomar, MHA.

Resolutions 21-31 were referred to Reference Committee C. Kelly Gray-Eurom, MD, MMM, FACEP, chaired Reference Committee C and other members were: Sabina A. Braithwaite, MD, FACEP; Gregory Cannon, MD, FACEP; Nathaniel T. Hibbs, DO, FACEP; Ramon W. Johnson, MD, FACEP; Harry E. Sibold, MD, FACEP; Margaret Montgomery, RN, MSN; and Sandy Schneider, MD, FACEP.

At 1:00 pm a Town Hall Meeting was held. The topic was “Alternate Delivery Models and Their Impact on Emergency Medicine.” Marco Coppola, DO, FACEP, served as the moderator and the discussants were Paolo Coppola, MD, FACEP; Hartmut Gross, MD, FACEP; Howard Mell, MD, FACEP; and Gerard Troutman, MD, FACEP.

The Candidate Forum began at 2:30 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:15 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. Cusick introduced the Board of Directors and honored guests and then addressed the Council.

Dr. Cusick reviewed the procedure for the adoption of the 2016 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then presented the memorial resolution to the colleagues of Kenneth L. DeHart, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting 2016 and adopted the memorial resolution by observing a moment of silence.

Dr. Cusick announced that the commendation resolution would be presented during the Council luncheon on
Saturday, October 15, 2016.

Michael L Carius, MD, FACEP, reported on activities of the American Board of Emergency Medicine.

William P. Jaquis, MD, FACEP, presented the secretary-treasurer’s report.

Ramnik Dhaliwal, MD, JD, addressed the Council regarding the activities of the Emergency Medicine Residents’ Association.

Brooks Bock, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

Peter Jacoby, MD, FACEP, addressed the Council regarding the activities of NEMPAC and the 911 Network.

Jay A. Kaplan, MD, FACEP, president, addressed the Council. He reflected on his past year as ACEP president and highlighted the successes of the College.

The Council recessed at 5:30 pm for the candidate reception and reconvened at 8:00 am on Saturday, October 15, 2016.

Dr. Costello reported that 386 councillors of the 394 eligible for seating had been credentialed. She then introduced the members of the Tellers, Credentials, & Elections Committee, reviewed the electronic voting procedures, and conducted a test of the keypads using demographic and survey questions.

Mr. Wilkerson addressed the Council and then showed a video of the new ACEP headquarters building.

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Amended Resolution 6 and Amended Resolution 7

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

**AMENDED RESOLUTION 6**

*RESOLVED, THAT THE ACEP BOARD OF DIRECTORS PURSUE AN APPROPRIATE AVENUE CREATE A TASK FORCE TO STUDY AND DETERMINE IF ANY ISSUES SPECIFIC ISSUES POSED TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS, EXIST, AND THAT IF THERE IS A NEED TO ADDRESS ISSUES RELATED TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS, TO ADDRESS THOSE ISSUES IN AN APPROPRIATE MANNER TO BE DETERMINED BY THE ACEP BOARD AND THAT A REPORT ON THIS MATTER SHALL BE DELIVERED THE TASK FORCE SHALL MAKE RECOMMENDATIONS REGARDING IDENTIFIED ISSUES TO THE BOARD, WHICH SHALL DELIVER AN UPDATE ON THIS MATTER TO THE 2017 ACEP COUNCIL.*

**AMENDED RESOLUTION 7**

*RESOLVED, THAT THE ACEP BOARD OF DIRECTORS WORK IN A COORDINATED EFFORT WITH THE COMPONENT BODIES OF THE COUNCIL TO DEVELOP STRATEGIES TO INCREASE DIVERSITY WITHIN THE ACEP COUNCIL AND ITS LEADERSHIP AND REPORT BACK TO THE COUNCIL ON EFFECTIVE MEANS OF IMPLEMENTATION.*

The committee recommended that Resolution 3 not be adopted.

It was moved THAT RESOLUTION 3 BE ADOPTED. The motion was not adopted.
The committee recommended that Resolution 4 be adopted.

It was moved THAT RESOLUTION 4 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 5 not be adopted.

It was moved THAT RESOLUTION 5 BE ADOPTED.

It was moved THAT THE WORDS “FULL VOTING” BE DELETED. The motion was not adopted.

The main motion was then voted on and was not adopted

The committee recommended that Resolution 8 not be adopted.

It was moved THAT RESOLUTION 8 BE ADOPTED.

It was moved THAT RESOLUTION 8 BE DIVIDED. The motion was adopted.

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

RESOLVED, THAT ACEP OPPOSE MANDATORY, REQUIRED, HIGH STAKES SECURED EXAMINATION WORK WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE (ABEM) TO FURTHER DEVELOP ALTERNATIVE WAYS TO ASSESS MEDICAL KNOWLEDGE OTHER THAN BY A HIGH-STAKES STANDARDIZED TEST FOR MAINTENANCE OF CERTIFICATION (MOC) IN EMERGENCY MEDICINE. The motion was adopted.

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

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 8 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

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

The committee recommended the following resolutions by unanimous consent:

**For adoption:** Resolution 21, Resolution 22, Amended Resolution 25, Amended Resolution 26, Resolution 27, and Resolution 28.

Resolution 21 was extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

**AMENDED RESOLUTION 25**

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICINE CARE, SUPPORT CURRENT STATE AND FEDERAL INITIATIVES FOR ACCELERATED TRAINING AND ASSESSMENT FOR NATIONAL REGISTRY TESTING AND CERTIFICATION IN RECOGNITION OF THE TO ALLOW TRANSITION OF CURRENT MILITARY PRE-HOSPITAL PERSONNEL TO THE CIVILIAN SECTOR AND WHICH RECOGNIZE THE CURRENT LEVEL OF TRAINING AND EXPERIENCE OF MILITARY MEDICAL SPECIALIST PROVIDERS IN OUR NATION’S SERVICE.

**AMENDED RESOLUTION 26**

RESOLVED, THAT ACEP SUPPORTS USERS OF CLINICAL EMERGENCY ULTRASOUND WITH A STATEMENT DECLARING OPPOSITION TO THE USE OF EXCLUSIVE IMAGING CONTRACTS TO LIMIT THE USE OF CLINICAL EMERGENCY ULTRASOUND BY NON-RADIOLOGY SPECIALISTS AND THE BILLING FOR SUCH SERVICES; AND BE IT FURTHER
RESOLVED, THAT ACEP CONTINUE TO SUPPORT EMERGENCY PHYSICIANS WORKING TO DEVELOP AND IMPLEMENT CLINICAL EMERGENCY ULTRASOUND PROGRAMS WHO FACE OPPOSITION IN HOSPITALS WHERE RADIOLOGISTS OR OTHERS HOLD EXCLUSIVE IMAGING CONTRACTS.

The committee recommended that RESOLUTION 21 BE ADOPTED.

It was moved THAT 21 BE ADOPTED.

Without objection, the title of the resolution was amended by deleting the words “including warm handoffs.”

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 23 be adopted.

It was moved THAT AMENDED RESOLUTION 23 BE ADOPTED:

RESOLVED, THAT ACEP REVIEW THE EVIDENCE ON ED-INITIATED TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS TO PROVIDE EMERGENCY PHYSICIAN EDUCATION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION AND MAINTENANCE PROGRAMS SUCH AS (INCLUDING METHADONE, BUPRENORPHINE), FROM THE EMERGENCY DEPARTMENT.

Without objection, the title was amended by replacing the word “medical” with the word “medication.”

It was moved THAT THE WORDS “SUCH AS” AND THE WORD “BUPRENORPHINE” BE DELETED. The motion was adopted.

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

RESOLVED, THAT ACEP REVIEW THE EVIDENCE ON ED-INITIATED TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS TO PROVIDE EMERGENCY PHYSICIAN EDUCATION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION AND MAINTENANCE PROGRAMS AND THE DEVELOPMENT OF CLINICAL POLICY GUIDELINES REGARDING OPIOID WITHDRAWAL MANAGEMENT IN THE EMERGENCY DEPARTMENT. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 24 be adopted.

It was moved THAT AMENDED RESOLUTION 24 BE ADOPTED:

RESOLVED, THAT ACEP PARTNER WITH STAKEHOLDERS INCLUDING THE AMERICAN PSYCHIATRIC ASSOCIATION, THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, THE NATIONAL ALLIANCE OF MENTAL ILLNESS, AND OTHER INTERESTED PARTIES, TO DEVELOP MODEL PRACTICES FOCUSED ON BUILDING BED CAPACITY, ENHANCING ALTERNATIVES, AND REDUCING THE LENGTH OF STAY FOR MENTAL HEALTH PATIENTS IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP AND SHARE THESE ED MENTAL HEALTH BEST PRACTICES DESIGNED TO REDUCE ED MENTAL HEALTH VISITS, REDUCE ED MENTAL HEALTH BOARDING, AND IMPROVE THE OVERALL CARE OF PATIENTS WHO BOARD IN OUR EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND THE NATIONAL ACADEMY OF MEDICINE APPROPRIATE STAKEHOLDERS TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND LINKING INPATIENT
PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS TO LICENSURE.

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

RESOLVED, THAT ACEP WORK WITH THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND OTHER APPROPRIATE STAKEHOLDERS TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND LINKING INPATIENT PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS TO LICENSURE. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 35 be adopted.

It was moved THAT AMENDED RESOLUTION 29 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THE TRAINING AND EQUIPPING OF ALL FIRST RESPONDERS, INCLUDING POLICE, FIRE, AND EMS PERSONNEL TO USE INJECTABLE AND NASAL SPRAY NALOXONE; AND BE IT FURTHER RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THAT APPROPRIATELY TRAINED PHARMACISTS BE ABLE TO DISPENSE NALOXONE WITHOUT PRESCRIPTION; AND BE IT FURTHER RESOLVED, THAT ACEP DEVELOP A COMPREHENSIVE POLICY ON THE PREVENTION AND TREATMENT OF THE OPIOID USE DISORDER EPIDEMIC INCLUDING SUCH INNOVATIVE TREATMENTS, AS ALLOWING SCHOOL NURSES AND OTHER TRAINED SCHOOL PERSONNEL TO ADMINISTER NALOXONE, “SAFE INJECTION SITES,” AND NEEDLE EXCHANGE PROGRAMS. The motion was adopted.

The committee recommended that Resolution 30 not be adopted.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP INVESTIGATE THE SCOPE OF TREATMENT OF MARIJUANA INTOXICATION POSSIBLE COMPLICATIONS OF CANNABINOID USE IN THE ED THAT HAS HAVE LEGAL IMPLICATIONS; AND BE IT FURTHER RESOLVED, THAT ACEP DETERMINES IF THERE ARE STATE OR FEDERAL LAWS THAT PROVIDE GUIDANCE TO EMERGENCY PHYSICIANS IN THE TREATMENT OF MARIJUANA INTOXICATION IN THE ED; AND BE IT FURTHER RESOLVED, THAT THE BOARD OF DIRECTORS ASSIGN AN APPROPRIATE COMMITTEE OR TASK FORCE TO ANSWER CLINICALLY RELEVANT QUESTIONS THAT ADDRESS THE NEED TO CARE FOR ED PATIENTS WITH POSSIBLE MARIJUANA (OR OTHER DRUG) INTOXICATION COMPLICATIONS OF CANNABINOID USE; AND BE IT FURTHER RESOLVED, THAT ACEP INVESTIGATE HOW OTHER MEDICAL SPECIALTIES ADDRESS THE TREATMENT OF MARIJUANA INTOXICATION COMPLICATIONS OF CANNABINOID USE IN OTHER CLINICAL SETTINGS; AND BE IT FURTHER RESOLVED, THAT ACEP PROVIDE THE RESOURCES NECESSARY TO COORDINATE THE TREATMENT OF MARIJUANA INTOXICATION COMPLICATIONS OF CANNABINOID USE IN THE ED.

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

The committee recommended that Amended Resolution 31 be adopted.

It was moved THAT AMENDED RESOLUTION 31 BE ADOPTED:
RESOLVED, THAT ACEP ACTIVELY OPPOSE THE FDA APPROVAL OF SUBLINGUAL FORMULATIONS OF SYNTHETIC FENTANYL ANALOGS, INCLUDING SUFENTANIL, VIA DIRECT TESTIMONY OR OTHER MEANS THAT THE BOARD MAY FIND SUITABLE.

RESOLVED, THAT ACEP CREATE A REPORT DETAILING THE RISKS, BENEFITS, AND ALTERNATIVES TO THE USE OF NARCOTIC ANALGESICS THAT, BY THEIR SPECIFIC ROUTE OF ADMINISTRATION OR FORMULATION, CARRY A HIGHER RISK OF MISUSE OR ABUSE THAN OTHER SIMILARLY CLASSIFIED DRUGS, IN EMS AND EMERGENCY MEDICINE. The motion was adopted.

The Council recessed at 11:30 am for the awards luncheon and reconvened at 1:00 pm on Saturday, October 15, 2016.

REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 9, Resolution 11, Amended Resolution 12, Amended Resolution 13, Amended Resolution 14, Amended Resolution 15, Amended Resolution 16, Amended Resolution 17, Resolution 19 and Resolution 20.

For referral: Resolution 10.

Amended Resolution 12, Resolution 13, and Amended Resolution 17 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 14

RESOLVED, THAT THE ACEP PROMOTE THE DEVELOPMENT AND APPLICATION OF THROUGHPUT QUALITY DATA MEASURES AND DASHBOARD REPORTING FOR BEHAVIORAL HEALTH PATIENTS BOARDED IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENDORSE INTEGRATION OF A DASHBOARD FOR REPORTING AND TRACKING OF BEHAVIORAL HEALTH PATIENTS BOARDING IN EDS IN ELECTRONIC HEALTH RECORD SYSTEMS AS A MEANS FOR LINKING TO BROADER PRIORITY SYSTEMS, FOR COMMUNICATING THE IMPACT OF BOARDED BEHAVIORAL HEALTH PATIENTS, AND TO FURTHER COLLABORATE WITH ALL APPROPRIATE HEALTH CARE AND GOVERNMENT STAKEHOLDERS.

AMENDED RESOLUTION 15

RESOLVED, THAT ACEP SHALL CREATE A STUDY OF THE IMPACT OF NARROW NETWORKS LAWS AND POTENTIAL SOLUTIONS THAT ADDRESS BALANCE BILLING ISSUES WITHOUT INCREASING THE BURDEN ON THE PATIENT; AND BE IT FURTHER

RESOLVED, THAT ACEP DEDICATE RESOURCES AND SUPPORT TO ENSURE ANY PROPOSED LEGISLATION REGARDING NARROW NETWORKS DOES NOT AFFECT PROTECTS A PHYSICIAN’S ABILITY TO RECEIVE FAIR PAYMENT FOR PROVIDING EMERGENCY MEDICAL CARE.

AMENDED RESOLUTION 16

RESOLVED, THAT ACEP DEVELOP A REPORT OR INFORMATION PAPER SUPPORTING ANALYZING THE USE OF FREESTANDING EMERGENCY CENTERS AS AN ALTERNATIVE CARE MODEL FOR THE REPLACEMENT OR TO MAINTAIN ACCESS TO EMERGENCY CARE IN AREAS WHERE EMERGENCY DEPARTMENTS IN CRITICAL ACCESS AND RURAL HOSPITALS THAT HAVE CLOSED, OR ARE IN IMMINENT RISK OF CLOSURE, TO MAINTAIN ACCESS TO EMERGENCY CARE IN THE UNDERSERVED AND RURAL REGIONS OF THE UNITED STATES THE PROCESS OF CLOSING.
The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 12 BE ADOPTED:

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICAL CARE, CLINICAL AND NON-CLINICAL, REACH OUT AND BUILD COALITIONS WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING NON-CLINICAL QUALITY STANDARDS TO ACHIEVE OBJECTIVE AND MEANINGFUL ADVANCES IN QUALITY IN THE EYES OF OUR PATIENTS, INSTITUTIONS, AND PAYERS; AND BE IT FURTHER THAT INCLUDE AN EVALUATION OF THE COST OF PROVIDING THE HIGHEST LEVEL QUALITY OF CARE.

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN CONJUNCTION WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING QUALITY STANDARDS, DEFINE THE COSTS OF PROVIDING THE HIGHEST LEVELS OF QUALITY CARE, TO QUALITY/SAFETY REFLECTS REIMBURSEMENT AND REIMBURSEMENT REFLECTS QUALITY/SAFETY.

It was moved THAT RESOLUTION 12 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED.

RESOLVED, THAT ACEP REQUEST THAT THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) UNDER SECTION 319 OF THE PUBLIC HEALTH SERVICE (PHS) ACT DETERMINES THAT EMERGENCY DEPARTMENT BOARDING AND HALLWAY CARE IS AN IMMEDIATE THREAT TO THE PUBLIC HEALTH AND PUBLIC SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE UNITED STATES PUBLIC HEALTH SERVICE, THE JOINT COMMISSION, AND OTHER APPROPRIATE STAKEHOLDERS TO DETERMINE THE NEXT ACTION STEPS TO BE TAKEN TO REDUCE EMERGENCY DEPARTMENT CROWDING AND BOARDING WITH A REPORT BACK TO THE ACEP COUNCIL AT THE COUNCIL’S NEXT SCHEDULED MEETING; AND BE IT FURTHER

RESOLVED, THAT ACEP REAFFIRMS ITS SUPPORT OF PUBLICLY PROMOTE THE FOLLOWING AS SUSTAINABLE SOLUTIONS TO HOSPITAL CROWDING WHICH HAVE THE HIGHEST IMPACT ON PATIENT SAFETY, HOSPITAL CAPACITY, ICU AVAILABILITY, AND COSTS:

1. SMOOTHING OF ELECTIVE ADMISSIONS AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
2. EARLY DISCHARGE (BEFORE 11 AM) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
3. ENHANCED WEEKEND DISCHARGES AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
4. THE REQUIREMENT FOR A GENUINE INSTITUTIONAL SOLUTION TO BOARDING WHEN THERE IS NO HOSPITAL CAPACITY, WHICH MUST INCLUDE BOTH PROVIDING ADDITIONAL STAFF AS NEEDED AND REDISTRIBUTING THE MAJORITY OF ED BOARDERS TO OTHER AREAS OF THE HOSPITAL.
5. THE CONCEPT OF A TRUE 24/7 HOSPITAL.

Without objection, the title of the resolution was amended to read: “Emergency Department Boarding and Crowding is a Public Health Emergency.”

Without objection, item 2. was amended to read: “EARLY DISCHARGE STRATEGIES (BEFORE E.G., 11 AM DISCHARGES, SCHEDULED DISCHARGES, STAGGERED DISCHARGES) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.”

The amended main motion was then voted on and was adopted.
The committee recommended that Amended Resolution 17 be adopted.

It was moved THAT AMENDED RESOLUTION 17 BE ADOPTED:

RESOLVED, THAT ACEP ADD TO ITS LEGISLATIVE AGENDA AS A PRIORITY TO ADVOCATE FOR HEALTH CARE INSURANCE COMPANIES TO BE REQUIRED TO COLLECT PATIENTS’ DEDUCTIBLES FOR EMTALA-RELATED CARE AFTER THE INSURANCE COMPANY PAYS THE PHYSICIAN THE FULL NEGOTIATED RATE, AND BE IT FURTHER RESOLVED, THAT ACEP SUBMIT A RESOLUTION TO THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES THAT ADVOCATES FOR A NATIONAL LAW REQUIRING HEALTH CARE INSURANCE COMPANIES TO COLLECT PATIENTS’ DEDUCTIBLES AFTER THE INSURANCE COMPANY PAYS THE PHYSICIAN FOR THE FULL NEGOTIATED RATE EMTALA RELATED CARE.

It was moved THAT AMENDED RESOLUTION 17 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 18 be adopted.

It was moved THAT AMENDED RESOLUTION 18 BE ADOPTED.

RESOLVED, THAT ACEP OPPOSE THE OVERSTEP OF WORK WITH CMS REGARDING MANDATED REPORTING STANDARDS THAT REQUIRE MAY RESULT IN POTENTIAL HARM TO PATIENTS WITHOUT THE RECOGNITION OF APPROPRIATE PHYSICIAN ASSESSMENT AND EVIDENCE BASED, GOAL DIRECTED CARE OF INDIVIDUAL PATIENTS; AND BE IT FURTHER RESOLVED, THAT ACEP ACTIVELY COMMUNICATE TO MEMBERS AND THE PUBLIC HOSPITALS THE DANGERS OF CMS OVERSTEP OF PHYSICIAN RESPONSIBILITY TO PATIENTS FOR THAT QUALITY INDICATORS COULD PRESENT HARM TO POTENTIAL PATIENTS, AND ACTIVELY WORK TO COMMUNICATE TO HOSPITALS THE NEED AND OPTIONS TO RECOGNIZE APPROPRIATE PHYSICIAN TREATMENT WHILE AVOIDING UNNECESSARY HARM TO PATIENTS, THE IMPORTANCE OF PHYSICIAN AUTONOMY IN TREATMENT. The motion was adopted.

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

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

Dr. Costello reported that 392 of the 394 councillors eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Klauer and Dr. Schmitz were elected to a three-year term. Dr. Augustine and Dr. Perina were re-elected to a three-year term.

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

There being no further business, Dr. Cusick adjourned the 2016 Council meeting at 3:00 pm on Saturday, October 15, 2016. The next meeting of the ACEP Council is scheduled for October 27-28, 2017, at the Marriott Marquis Hotel in Washington, DC.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary

Approved by,

James M. Cusick, MD FACEP
Council Speaker
Steering Committee Meeting  
January 18, 2017  
ACEP Headquarters  
Irving, TX  

Minutes

Speaker James Cusick, MD, FACEP, called to order a regular meeting of the Steering Committee of the Council of the American College of Emergency Physicians at 8:02 am Central time on Wednesday, January 18, 2017, at the ACEP headquarters in Irving, TX.

Steering Committee members present for all or portions of the meeting were: David Barry, MD, FACEP; Douglas Char, MD, FACEP; James Cusick, MD, FACEP, speaker; Kathleen Clem, MD, FACEP; Alison Haddock, MD, FACEP; Jonathan Heidt, MD, FACEP; Sarah Hopper, MD, FACEP; Chadd Kraus, DO, FACEP; Aisha Liferidge, MD, FACEP; Donald Lum, MD, FACEP; Michael McCrea, MD, FACEP; John McManus, MD, FACEP, vice speaker; Orlee Panitch, MD, FACEP; Tony Salazar, MD, FACEP; Annalise Sorrentino, MD, FACEP; Jennifer Stankus, MD, JD, FACEP; and Anne Zink, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Sabina Braithwaite, MD, FACEP; Marco Coppola, DO, FACEP; Jon Mark Hirshon, MD, FACEP; Hans House, MD, FACEP; Tiffany Jackson, MD; William Jaquis, MD, FACEP, vice president; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, president-elect; Kevin Klauer, DO, FACEP; Rebecca Parker, MD, FACEP, president; Debra Perina, MD, FACEP; John Rogers, MD, FACEP, chair of the Board; Mark Rosenberg, DO, FACEP; and Gillian Schmitz, MD, FACEP.

Staff present for all or portions of the meeting were: Rachel Donihoo; Mary Ellen Fletcher, CPC, CEDC; Laura Gore; Pawan Goyal, MD; Margaret Montgomery, RN; Sonja Montgomery, CAE; Craig Price, CAE; Sandra Schneider, MD, FACEP; Gene Scruggs; Julie Wassom; Gordon Wheeler; Dean Wilkerson, JD, MBA, CAE; and Carole Wollard.

Officer and Staff Reports

Speaker

Dr. Cusick welcomed the committee and discussed preparations for the meeting.

Vice Speaker

Dr. McManus thanked everyone for their participation.

President

Dr. Parker reported on her media interviews, the AMA Interim Meeting, assignments she has made to implement the 2016 Council resolutions, and the status of ACEP’s lawsuit against the Center for Consumer Information and Insurance Oversight (CCIIO). She also encouraged everyone to attend the upcoming Leadership & Advocacy Conference.

President-Elect

Dr. Kivela reported on the plans for revamping the ACEP website, the importance of the Clinical Emergency Data Registry (CEDR), out-of-network and balance billing challenges, and the wine tasting event that will be held at the Leadership & Advocacy Conference.
Mr. Wilkerson welcomed everyone to the new ACEP headquarters building. He reported on the 50th anniversary activities being planned, the upcoming Wellness Summit, and the current fiscal year budget challenges with the additional expenses for CEDR, the CCIIO litigation, and other increased expenses.

**Steering Committee Expectations**

Dr. Cusick reminded the Steering Committee of their expectation to attend the March 12, 2017, Steering Committee subcommittee meetings in Washington, DC and the entire Leadership & Advocacy Conference March 12-15. The Steering Committee will also meet at 6:00 pm on October 26, 2017, in Washington, DC, the evening prior to the Council meeting. Steering Committee members were also reminded that supporting NEMPAC and EMF is strongly encouraged as part of their leadership role.

**Councillor Allocation**

Dr. Cusick reported that councillor allocation for 2017 is 410, which is an increase of 16 councillors than were allocated for the 2016 meeting. Twelve chapters gained one councillor and one chapter gained two councillors. Two new sections, Event Medicine and Pain Management, were approved and met the minimum membership requirements of 100 members by December 31, 2016, adding two new councillors for 2017. The Medical Director’s Section had 74 members and did not meet the minimum membership requirement of 100 members. The other 33 sections met the minimum membership requirement of 100 members and will have a councillor for the 2017 Council meeting.

**2016 Council Meeting Minutes**

The Steering Committee reviewed the draft 2016 Council meeting minutes. The minutes will be provided to the 2017 Council for approval at the annual meeting.

**Tellers, Credentials, & Elections Committee Report**

The Steering Committee reviewed a report from the Tellers, Credentials, & Elections Committee from the 2016 Council meeting, including the results of the demographic data questions. It was suggested that the Council be reminded of the importance, purpose, and need for accurate responses to the demographic questions and that the questions not be referred to as “practice” questions for testing the keypads.

The Annual Meeting Subcommittee will review the demographic data questions and provide suggestions for this year’s questions.

**Distribution of Council Meeting Materials**

Ms. Montgomery provided a list of Council meeting items that are currently printed and distributed by first class mail. The mailing is sent to more than 800 individuals and all of the materials are available electronically. It was noted that some of the items are valuable to receive in print as well as electronically. The committee supported removing the printed campaign flyers, the NEMPAC Council Challenge flyer, and the EMF Council Challenge flyer from the first class mailing. Printed mailing of the candidate campaign flyers is referenced in the Candidate Campaign Rules, therefore, the committee will need to revise the Campaign Rules. Electronic distribution of the campaign flyers can still occur.

**2017 Council Meeting**

Dr. Cusick discussed various aspects of the 2016 Council meeting and requested suggestions for potential changes for the 2017 meeting. The committee discussed the Unanimous Consent Agenda and decided not to resubmit a Council Standing Rules resolution on unanimous consent for the 2017 Council meeting. The committee also discussed whether to issue printed badges to guests and other members attending the Council meeting. There was
consensus to provide adhesive name tags at Councillor Credentialing for guests to use rather than issue printed name badges.

The Annual Meeting Subcommittee will review the Town Hall meeting format and provide suggestions for potential topics for the 2017 meeting. The subcommittee will also review the demographic questions and provide suggestions for the 2017 questions.

**Council Meeting Technology**

Dr. Cusick led a discussion of the technology needs and requested suggestions for potential enhancements for the Council meeting. There was consensus that the current technology works well and additional enhancements were not identified. The committee also discussed the increased use and success of social media during the meeting.

**Elections Process**

Dr. McManus led a discussion of the campaign and election process for candidates. Dr. Coppola provided suggestions for changing the Candidate Forum. The committee supported continuing the current format of the Candidate Forum and suggested extending the time by 30 minutes.

The committee discussed an inquiry from a member about the ability to post their comments about a particular candidate or candidates on non-ACEP sites. The Campaign Rules only reference personal social media sites, however, the member was advised against promoting candidates on non-ACEP sites. There was consensus that ACEP cannot monitor and enforce social media postings by non-candidates.

The committee reviewed the Candidate Campaign Rules.

It was moved THAT THE CANDIDATE CAMPAIGN RULES, #13.K., BE AMENDED TO READ: COMMUNICATIONS AND/OR INTERVIEWS REGARDING CANDIDACY IN EMERGENCY MEDICINE NEWSLETTERS OR PUBLICATIONS OTHER THAN THOSE PUBLISHED BY ACEP ARE PROHIBITED. PUBLICATION IN PEER REVIEWED AND RESEARCH JOURNALS ON ISSUES OTHER THAN CANDIDACY ARE ALLOWED. The motion was adopted.

The committee discussed the advisability of continuing the videos of each candidate.

It was moved THAT THE CAMPAIGN VIDEOS BE DISCONTINUED. The motion was not adopted.

There were mixed reactions about the usefulness of the videos, but there was consensus to develop additional guidelines for the videos.

The committee discussed travel to chapters by the candidates and concurred that it is a barrier for some individuals to seek nomination because of the time and expense. The committee agreed that limitations on the candidate travel to chapters should be explored and potentially included in the Campaign Rules, however, there is not time to revise the rules for 2017 before this year’s chapter meetings begin.

The Candidate Forum Subcommittee will discuss these issues in further detail and provide their recommendations to the Steering Committee.

**Action on Resolutions**

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2016, 2015, and 2014 Council meetings were provided for review. The reports will be assigned to the Annual Meeting Subcommittee for further review.
Subcommittee Appointments

Dr. Cusick asked for volunteers to serve on three subcommittees. The following subcommittees were appointed:

Annual Meeting Subcommittee: Dr. Clem (Chair), Dr. Haddock, Dr. Hoper, Dr. Kraus, Dr. Lum, Dr. Salazar, and Dr. Zink.

Bylaws & Council Standing Rules Subcommittee: Dr. Heidt (Chair), Dr. Barry, Dr. Liferidge, Dr. McCrea, and Dr. Sorrentino.

Candidate Forum Subcommittee: Dr. Cusick (Chair), Dr. Barry, Dr. Char, Dr. Heidt, Dr. Lum, Dr. McCrea, Dr. Panitch, Dr. Sorrentino, Dr. Stankus, and Dr. Zink.

The subcommittee objectives and deadlines will be provided by e-mail. The subcommittee reports will be discussed at the June 26, 2017, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Monday, June 26, 2017, at the ACEP headquarters in Irving, TX.

With no further business, the meeting was adjourned at 2:45 pm Central time on Wednesday, January 18, 2017.

Respectfully submitted,

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

Approved by,

James M. Cusick, MD, FACEP
Council Speaker and Chair
Steering Committee Meeting
June 26, 2017
ACEP Headquarters
Irving, TX

Minutes

Speaker James Cusick, MD, FACEP, called to order a regular meeting of the Steering Committee of the Council of the American College of Emergency Physicians at 8:00 am Central time on Monday, June 26, 2017, at the ACEP headquarters in Irving, TX.

Steering Committee members present for all or portions of the meeting were: David Barry, MD, FACEP; Douglas Char, MD, FACEP; James Cusick, MD, FACEP, speaker; Kathleen Clem, MD, FACEP; Alison Haddock, MD, FACEP; Jonathan Heidt, MD, FACEP; Chadd Kraus, DO, FACEP; Aisha Liferidge, MD, FACEP; Michael McCrea, MD, FACEP; John McManus, MD, FACEP, vice speaker; Tony Salazar, MD, FACEP; Annalise Sorrentino, MD, FACEP; Jennifer Stankus, MD, JD, FACEP; and Anne Zink, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Marco Coppola, DO, FACEP; Vidor Friedman, MD, FACEP, secretary-treasurer; Andrea Green, MD, FACEP; Tiffany Jackson, MD; Christopher Kang, MD, FACEP; Jay Kaplan, MD, FACEP, immediate past president; Kevin Klauer, DO, FACEP; Rebecca Parker, MD, FACEP, president; and John Rogers, MD, FACEP, chair of the Board.

Staff present for all or portions of the meeting were: Tom Bedford; Mary Ellen Fletcher, CPC, CEDC; Pawan Goyal, MD; Bill Malcolm; Margaret Montgomery, RN; Sonja Montgomery, CAE; Loren Rives, MNA; Sandra Schneider, MD, FACEP; Gene Scruggs; Julie Wassom; Dean Wilkerson, JD, MBA, CAE; and Carole Wollard.

Minutes

The minutes of the January 18, 2017, Steering Committee meeting were approved as written.

Officer and Staff Reports

Speaker

Dr. Cusick submitted a written activity report. He thanked the Steering Committee subcommittees for their work and announced the 2017 Council awards recipients:

Council Meritorious Service Award – Kelly Gray-Eurom, MD, MMM, FACEP
Council Teamwork Award – Government Services Chapter
Council Horizon Award – Laura Medford-Davis, MD,
Council Curmudgeon Award – Pamela Bensen, MD, FACEP

Dr. Cusick announced the 2017 candidates.

President-Elect: Vidor Friedman, MD, FACEP (FL)
Hans House, MD, FACEP (IA)
William Jaquis, MD, FACEP (MD)
John Rogers, MD, FACEP (GA)

Speaker John G. McManus, Jr., MD, FACEP (GS) – unopposed

Vice Speaker Sabina Braithwaite, MD, FACEP (MO)
Andrea Green, MD, FACEP (TX)
Gary Katz, MD, FACEP (OH)
Board of Directors: Stephen Anderson, MD, FACEP (incumbent – WA)
Kathleen Clem, MD, FACEP (FL)
Carrie de Moor, MD, FACEP (declared floor candidate, Freestanding Emergency Centers Section)
J.T. Finnell, MD, FACEP (IN)
Alison Haddock, MD, FACEP (TX)
Jon Mark Hirshon, MD, FACEP (incumbent – MD)
Aisha Liferidge, MD, FACEP (MD)
Virgil Smaltz, MD, FACEP (NY)

Vice Speaker

Dr. McManus submitted a written activity report. He reminded everyone that 2018 Council committee interest is open and encouraged everyone to submit their interests by the deadline.

President

Dr. Parker reported on her recent trip to Washington, DC, to meet with members of Congress to discuss protection of emergency medicine in the revised health care bill, the fundraiser she attended for House Speaker Paul Ryan, and the annual American Medical Association (AMA) House of Delegates meeting. The AMA adopted several resolutions that were favorable to emergency medicine and ACEP will have eight delegates to the AMA next year instead of six. She also reported on ACEP’s meetings with other medical specialty organizations and discussions with the American Board of Emergency Medicine about maintenance of certification.

Executive Director

Mr. Wilkerson reported on ACEP’s membership increasing above 37,000; record registration for ACEP16 and the Leadership & Advocacy Conference; growing participation in the Clinical Emergency Data Registry; readership ratings for ACEP Now; and recent ACEP staff retirements. He announced that the new Associate Executive Director for Public Affairs was hired and will attend the June Board of Directors meeting.

Immediate Past President

Dr. Kaplan reported on his attendance at the recent Action Collaborative on Physician Resilience meeting and the Hospital Flow Conference hosted by ACEP.

Annual Meeting Subcommittee

Dr. Clem presented the subcommittee’s report on their assigned objectives. The subcommittee reviewed the format and topics from previous Town Hall meetings and provided a list of proposed topics for the 2017 Town Hall meeting. The subcommittee did not recommend any changes to the format of the Town Hall meeting. There was consensus for the Town Hall meeting to focus on a single topic and presenting various aspects of the issue by high-level speakers/content experts and include time for Q & A. The Council officers will make the final determination about the format, topic, and speakers this summer.

The subcommittee reviewed the Board’s actions on 2014-2016 resolutions and concurred that the actions taken are consistent with the Council’s expectations. The Actions on Resolutions reports will be updated this summer to reflect additional activity that may have occurred since January 2017. The updated reports will be provided to the 2017 Council and posted in the Council section of the ACEP Website. The subcommittee recommended that the Council speaker highlight some of the actions on the prior year’s resolutions during his report to the Council. A new database for actions on past resolutions that members can access through the ACEP Website has been developed. Staff are working on uploading the resolutions, which will take considerable time to include all resolutions since 1972. It is expected to be available to members and staff by spring 2018.

The subcommittee concurred that certain demographic questions should be asked every year to analyze demographic changes within the Council and that the survey should be brief with a maximum of 10 questions. The
The steering committee will provide additional input for the 2017 questions over the summer for review and approval by the Council officers.

The Steering Committee also reviewed the draft 2017 Council Meeting agenda. There was consensus to extend the Candidate Forum, and the Council meeting, by 30 minutes to accommodate the additional number of candidates. Dr. Cusick reminded everyone that the President’s Awards Gala will occur on Saturday, October 28, following the Council meeting, starting at 8:00 pm.

New Council Award

Dr. Liferidge presented a recommendation to develop a new “Council Champion Award in Diversity and Inclusion.” The purpose of the award is to recognize “an active Council participant, a group of councillors, or a component body that has demonstrated a sustained commitment to diversity and inclusion through service, programmatic activities, professional development, and other contributions that support and enhance opportunities for individuals of diverse backgrounds.” Comments were provided to further refine the criteria to focus on service to the Council.

It was moved THAT THE STEERING COMMITTEE APPROVE ESTABLISHING THE NEW “COUNCIL CHAMPION AWARD IN DIVERSITY AND INCLUSION” WITH IMPLEMENTATION TO OCCUR IN 2018. The motion was adopted.

Bylaws & Council Standing Rules Subcommittee

Dr. Heidt presented the subcommittee’s report on their assigned objectives. The Steering Committee determined at their January 18 meeting to not resubmit a resolution on unanimous consent for the 2017 Council meeting. However, a councillor from PA submitted a draft resolution on unanimous consent for the Steering Committee to consider sponsoring or cosponsoring. There was consensus against sponsoring or cosponsoring the resolution. There were concerns expressed regarding the requirement that all resolutions (except Bylaws) would be placed on the unanimous consent agenda and requires a second for extraction.

The Steering Committee reviewed the Bylaws amendment submitted by the Bylaws Committee to the Board of Directors for cosponsorship, “Chapter Bylaws Conformance Standards – Housekeeping Change. The Steering Committee did not have any concerns about this amendment.

Candidate Forum Subcommittee

Dr. Cusick reported that the majority of the subcommittee’s objectives will be completed this summer and during the 2017 Council meeting. The subcommittee developed additional guidance regarding video development:

“Video submission by candidates is not mandatory. If the candidate chooses to submit a video, it must feature only the candidate without additional props. The filming should take place in a quiet, neutral setting (not walking through the ED or any other dramatic setting), a lapel or table mic should be used to provide for clear audio, and without any background music or graphics. A hospital or university audio visual department may be used to develop the video if the cost is nominal. The candidate must also provide a disclosure about the video production, including the cost, and how (personal cell phone or other video device, hospital or university audio visual services, etc.) and where the video was filmed.”

It was moved THAT THE STEERING COMMITTEE APPROVE THE ADDITIONAL GUIDANCE FOR VIDEO DEVELOPMENT FOR INCLUSION IN THE CANDIDATE CAMPAIGN RULES, ITEM #7. The motion was adopted.

At the January meeting, the Steering Committee supported discontinuing the printed mailing of the candidate campaign flyers with other selected Council meeting materials. It was noted that the printed mailing of the candidate campaign flyers is referenced in the Candidate Campaign Rules, #6.
Steering Committee Meeting Minutes – June 26, 2017

Page 4

It was moved THAT THE CANDIDATE CAMPAIGN RULES, ITEM #6, BE APPROVED AS REVISED AND THAT ITEM #13.I, BE AMENDED TO REPLACE THE WORD “PRINTING” WITH THE WORD “FINALIZED.” The motion was adopted.

June Board Meeting Discussion on Several 2016 Resolutions

The Steering Committee reviewed recommendations submitted to the Board of Directors regarding actions on several 2016 resolutions:

- Amended Resolution 14(16) Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs
- Amended Resolution 25(16) Military Medics Integration into Civilian EMS
- Amended Resolution 26(16) Opposition of Exclusive Imaging Contracts Limiting
- Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use
- Referred Amended Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards
- Referred Resolution 30(16) Treatment of Marijuana in the ED

The Steering Committee supported the recommendations proposed for each of these resolutions.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Thursday, October 26, 2017, at the Marriott Marquis Hotel in Washington, DC, 6:00 pm – 7:00 pm.

With no further business, the meeting was adjourned at 12:55 pm Central time on Monday, June 26, 2017.

Respectfully submitted, Approved by,

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

James M. Cusick, MD, FACEP
Council Speaker and Chair
DEFINITION OF COUNCIL ACTIONS

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

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

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

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

NOT ADOPT
Defeat (or reject) the resolution in original or amended form.
2017 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 10-26

Brahim Ardolic, MD, FACEP (NY), Chair
Patricia A. Bayless, MD, FACEP (AZ)
Justin Fuehrer, DO, (EMRA)
Mark Notash, MD, FACEP (CO)
Susanne J. Spano, MD, FACEP (Wilderness Section)
Arvind Venkat, MD, FACEP (PA)

Leslie Moore, JD
Cynthia Singh, MS

Reference Committee B
Advocacy & Public Policy
Resolutions 27-41

Michael Lozano, MD, FACEP (FL), Chair
Daniel Freess, MD, FACEP (CT)
Nathaniel T. Hibbs, DO, FACEP (CO)
Jeffrey F. Linzer, MD, FACEP (GA)
Heather A. Marshall, MD, FACEP (NM)
John Matheson, MD, FACEP (WA)

Harry Monroe
Ryan McBride

Reference Committee C
Emergency Medicine Practice
Resolutions 42-55

John H. Proctor, MD, MBA, FACEP (TN), Chair
Enrique R. Enguidanos, MD, FACEP (WA)
Heather A. Heaton, MD, FACEP (MN Alt)
Marianna Karounos, DO, FACEP (NJ Alt)
Michael D. Smith, MD, MBA, CPE, FACEP (LA Alt)
James M. Williams, DO, MS, FACEP (TX)

Margaret Montgomery, RN, MSN
Loren Rives, MNA
INTRODUCTION

2017 Annual Council Meeting
Thursday Evening, October 26 through Saturday, October 28, 2017
Marriott Marquis Hotel

For all of the Council information visit the Council Meeting Web site: http://acep.myeventpartner.com/. The resolutions and other resource documents for the meeting are located under the “Document Library” tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the President-Elect candidates, Board of Directors candidates, and the resolutions. To print only certain pages of any of the PDF compendiums, please note the page numbers on the left in the “Bookmark” panel and enter the specific range of page numbers you want to print. (From the menu bar, click on File, Print, Pages from, and enter the specific page numbers.)

The ACEP staff and your Council officers have diligently prepared background information for the resolutions submitted by the deadline. In addition to this compendium of resolutions in PDF format, you will also find on the Council Meeting Web site the individual resolutions in Word file formats. Again, you can download and print this entire compendium, or only specific resolutions. Please review the resolutions and background information in advance of the Council meeting. **We strongly encourage online discussion of the resolutions via e-mail (the Council’s e-list).** You may post a message to cmail@elist.acep.org.

Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council and are for information only. Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Additional documents may be added to the Council Meeting Web site over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Washington, DC!

Your Council officers,

James M. Cusick, MD, FACEP
Speaker

John G. McManus, Jr., MD, MBA, FACEP
Vice Speaker
## 2017 Council Resolutions

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<th>Resolution #</th>
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<th>Reference Committee</th>
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| 1            | Commendation for James M. Cusick, MD, FACEP  
               Colorado Chapter |                     |
| 2            | Commendation for Robert E. O’Connor, MD, MPH, FACEP  
               Delaware Chapter  
               Virginia College of Emergency Physicians |                     |
| 3            | Commendation for Gordon B. Wheeler  
               Washington Chapter |                     |
| 4            | In Memory of Charles R. Bauer, MD, FACEP  
               Texas College of Emergency Physicians |                     |
| 5            | In Memory of Diane Kay Bollman  
               Michigan College of Emergency Physicians |                     |
| 6            | In Memory of Aaron T. Daggy, MD, FACEP  
               New York Chapter |                     |
| 7            | In Memory of Geoffrey Edmund Renk, MD, PhD, FACEP  
               South Carolina College of Emergency Physicians |                     |
| 8            | In Memory of Salvatore Silvestri, MD  
               Florida College of Emergency Physicians |                     |
| 9            | In Memory of Robert Wears, MD, FACEP  
               Florida College of Emergency Physicians |                     |
| 10           | Chapter Bylaws Conformance Standards – Housekeeping Change – Bylaws Amendment  
               Bylaws Committee  
               Board of Directors | A                     |
| 11           | Diversity of ACEP Councillors – Bylaws Amendment  
               Emergency Medicine Residents’ Association  
               Young Physicians Section | A                     |
| 12           | Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment  
               Florida College of Emergency Physicians  
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               Virginia College of Emergency Physicians  
               Washington Chapter  
               Wisconsin Chapter | A                     |
| 13           | Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment  
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               Virginia College of Emergency Physicians  
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               Wisconsin Chapter | A                     |
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<td><em>Douglas Char, MD, FACEP</em></td>
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<td><em>Arlo Weltge, MD, FACEP</em></td>
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<td><em>Anne Zink, MD, FACEP</em></td>
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<td><em>Angela Mattke, MD, FACEP</em></td>
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| 29 | CPR Training  
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| 30 | Demonstrating the Value of Emergency Medicine to Policy Makers & the Public  
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   John Bibb, MD, FACEP  
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   Ramon Johnson, MD, FACEP  
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   California Chapter | B |
| 31 | Endorsement of Supervised Injection Facilities  
   Donald Stader, MD, FACEP  
   Erik Verzemnieks, MD | B |
| 32 | Essential Medicines  
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| 33 | Immigrant & Non-Citizen Access to Care  
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| 34 | Generic Injectable Drug Shortages  
   Rick Blum, MD, FACEP  
   Mark DeBard, MD, FACEP  
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| 35 | Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment  
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| 36 | Maternity & Paternity Leave  
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| 37 | Medically Supervised Injection Facilities  
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| 38 | Prescription Drug Pricing  
   Connecticut College of Emergency Physicians  
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   Geriatric Emergency Medicine Section | B |
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*Texas College of Emergency Physicians* | B                    |
| 40          | Reimbursement for Emergency Services<br>
*Indiana Chapter* | B                    |
| 41          | Reimbursement for Hepatitis C Virus Testing Performed in the ED<br>
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| 42          | ACEP Policy Related to Cannabis<br>
*Arizona College of Emergency Physicians* | C                    |
| 43          | Expanding ACEP Policy on Workforce Diversity in Health Care Settings<br>
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*Larry Bedard, MD, FACEP<br>*Nicole Berwald, MD, FACEP<br>*Leila Getto, MD, FACEP<br>*Susan Haney, MD, FACEP<br>*Bernard Lopez, MD, FACEP<br>*Tracy Sanson, MD, FACEP<br>*Vicken Totten, MD, FACEP<br>*Evangeline Sokol, MD, FACEP<br>*Mary Westergaard, MD, FACEP* | C                    |
| 44          | Guidelines for Opioid Prescribing in the Emergency Department<br>
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| 45          | Group Contract Negotiation to End-of-Term Timeframes<br>
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| 46          | Impact of Climate Change on Patient Health and Implications for Emergency Medicine<br>
*California Chapter<br>*Washington Chapter<br>*Wilderness Medicine Section* | C                    |
| 47          | Improving Patient Safety Through Transparency in Medical Malpractice Settlements<br>
*Jack Handley, MD, FACEP<br>*Charles Pilcher MD FACEP | C                    |
| 48          | Non-Fatal Strangulation<br>
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*William Green, MD, FACEP<br>*Michael L. Weaver, MD, FACEP<br>*Ralph Riviello, MD, FACEP<br>*Heather Rozzi, MD, FACEP<br>*William Smock, MD* | C                    |
| 49          | Participation in ED Information Exchange and Prescription Drug Monitoring Systems<br>
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*Hawaii Chapter* | C |
| 51           | Retirement or Interruption of Clinical Emergency Medicine Practice  
*Texas College of Emergency Physicians* | C |
| 52           | Support for Harm Reduction and Syringe Services Programs  
*Donald Stader, MD, FACEP*  
*Erik Verzemnieks, MD* | C |
| 53           | Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders  
*Georgia College of Emergency Physicians* | C |
| 54           | Use of Cannabis as an Exit Drug for Opioid Dependency  
*Larry Bedard, MD, FACEP*  
*Dan Morhaim, MD, FACEP* | C |
| 55           | Workplace Violence  
*Howard Mell, MD, FACEP*  
*Missouri College of Emergency Physicians* | C |

**Late Resolutions**
RESOLUTION: 1(17)

SUBMITTED BY: Colorado Chapter

SUBJECT: Commendation for James M. Cusick, MD, FACEP

WHEREAS, James M. Cusick, MD, FACEP, has served the American College of Emergency Physicians with distinction and dedication as Council Vice Speaker 2013-15 and Council Speaker 2015-17; and

WHEREAS, Dr. Cusick has represented the Council at Board of Directors meetings during his terms as Vice Speaker and Speaker, representing the Council with dedication, tireless efforts, and a voice of common sense; and

WHEREAS, Dr. Cusick has diligently devoted time, creativity, and enthusiasm to his duties as a Council officer, leading in the management and conduction of business of the Council and has been instrumental in streamlining and coordinating efforts to enhance productivity within the Council; and

WHEREAS, Dr. Cusick has demonstrated a long history of service to the College and the Council, serving many years as councillor, serving on the Steering Committee as a member and Chair, being instrumental in the further diversification of the Steering Committee, and utilizing his expertise on many other committees and task forces of the College; and

WHEREAS, Dr. Cusick has been recognized as a pioneer in the field of EMS, was a charter member and past Chair of the EMS-Prehospital Care Section, past Medical Director of a national ambulance company, and serves as the College’s liaison to the Commission on Accreditation of Ambulance Services (CAAS) Board of Directors; and

WHEREAS, Dr. Cusick is a leader in the field of international emergency medicine, is an active member of the International Emergency Medicine Section, and serves as the College’s International Ambassador to the emergency medicine community in Argentina where he continues to teach and train EMS personnel and physicians; and

WHEREAS, Dr. Cusick has served both the College and the specialty of emergency medicine in an exemplary fashion in his roles as member, donor, and board member of both the Emergency Medicine Foundation (EMF) and the National Emergency Medicine Political Action Committee (NEMPAC); and

WHEREAS, Dr. Cusick has maintained an active presence in the Colorado Chapter and has demonstrated leadership by his previous service on the Board of Directors and as President of the Colorado Chapter; and

WHEREAS, Dr. Cusick has continued to practice full-time clinical emergency medicine while serving his constituents in the College as Vice Speaker and Speaker; and

WHEREAS, Dr. Cusick maintains commitment to the cause and mission of emergency medicine and is a recognized leader and advocate for the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends James M. Cusick, MD, FACEP, as a practicing emergency physician rendering excellent care to the patients we serve, for his leadership in the College as Council Vice Speaker and Council Speaker over the past four years, and for his lifetime of service and dedication to the specialty of Emergency Medicine.
RESOLUTION: 2(17)

SUBMITTED BY: Delaware Chapter
Virginia College of Emergency Physicians

SUBJECT: Commendation for Robert E. O’Connor, MD, MPH, FACEP

WHEREAS, Robert E. O’Connor, MD, MPH, FACEP, has capably served the American College of Emergency Physicians in a variety of leadership positions since becoming a member in 1982; and

WHEREAS, Dr. O’Connor has enjoyed a distinguished career serving his patients by continually striving for excellence as a compassionate and capable emergency physician; and

WHEREAS, Dr. O’Connor has devoted his career to education and research in a quest to train future physicians and to find better ways to care for our patients; and

WHEREAS, Dr. O’Connor has participated in 310 scientific presentations, with 250 published abstracts and 162 peer-reviewed publications; and

WHEREAS, Dr. O’Connor has delivered more than 150 national and international invited lectures to a wide range of audiences; and

WHEREAS, Dr. O’Connor has extensive service in leadership roles with the Delaware and Virginia Chapters; and

WHEREAS, Dr. O’Connor has served the College with his service on the national Board of Directors from 2010 through 2016, including serving as Chair of the Board 2015-16, Vice-President 2013-14, and Secretary-Treasurer 2012-13; and

WHEREAS, Dr. O’Connor has shown exemplary leadership and outstanding service with his dedication, tireless efforts, and expertise on a variety of ACEP committees, task forces, sections, the Council, and Board of Directors; and

WHEREAS, Dr. O’Connor has served academic emergency medicine programs in the roles of EMS Director, Research Director, Residency Director, and Department Chair; and

WHEREAS, Dr. O’Connor has had a profound, positive, and enduring impact on emergency medicine at the Christiana Care Health System in Newark, Delaware and the University of Virginia School of Medicine in Charlottesville, Virginia; and

WHEREAS, Dr. O’Connor will no doubt continue to serve the College and the specialty of emergency medicine in the future; therefore, be it

RESOLVED, That the American College of Emergency Physicians commends Robert E. O’Connor, MD, MPH, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of Emergency Medicine.
RESOLUTION: 3(17)

SUBMITTED BY: Washington Chapter

SUBJECT: Commendation for Gordon B. Wheeler

WHEREAS, Gordon B. Wheeler served the American College of Emergency Physicians (ACEP) with distinction and dedication as Associate Executive Director of Public Affairs for 17 years; and

WHEREAS, Mr. Wheeler played a critical role in the evolution and current success of ACEP, influencing and guiding the College at every level; and

WHEREAS, Mr. Wheeler has been a mentor for hundreds, if not thousands, of emergency physicians, encouraging their interests, helping them find their voice, and guiding their careers within the College; and

WHEREAS, Mr. Wheeler provided unwavering support and sage counsel to chapter and national leaders, including dozens of College presidents; and

WHEREAS Mr. Wheeler managed the highly effective Washington, DC office, strengthened collaboration with government agencies and professional organizations, and cultivated relationships with numerous Members of Congress; and

WHEREAS, Mr. Wheeler was instrumental to the College’s leadership and advocacy efforts at state and national levels; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Gordon B. Wheeler for his service as Associate Executive Director of Public Affairs.
RESOLUTION: 4(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Charles R. Bauer, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a compassionate physician, dedicated educator, mentor, pioneer, military officer, and colleague in Charles R. Bauer, MD, FACEP, who passed away on June 4, 2017, at the age of 83; and

WHEREAS, Dr. Bauer joined the University of Texas Health Science Center as a general and trauma surgeon, served as the assistant dean for ambulatory and emergency services, was board certified in both surgery and emergency medicine, and laid the foundation for the Department of Emergency Medicine and the emergency medicine residency at UT Health San Antonio; and

WHEREAS, Dr. Bauer served as the first chief of emergency medicine at UT Health and medical director of the emergency department at University Health System; and

WHEREAS, Dr. Bauer developed the South Texas Poison Center located at the Health Science Center, was instrumental in the establishment of the Texas Poison Center Network, and served as the founding chair of the Southwest Texas Regional Advisory Council (STRAC); and

WHEREAS, Dr. Bauer served in the US Air Force and retired as a colonel in the Texas State Guard, served as the chief medical officer of the Texas State Guard Medical Brigade and was awarded the Superior Service Award, the highest non-combat award given to a Texas military forces member; and

WHEREAS, Dr. Bauer was recognized by the Bexar County Medical Society and honored with its highest accolade, the Golden Aesculapius Award, for a lifetime of distinguished service to his patients and the medical profession; and

WHEREAS, Dr. Bauer mentored hundreds of medical students, taught for 35 years, and was actively involved in the medical student clerkship in emergency medicine at age 83 until just weeks before his passing; and

WHEREAS, Dr. Bauer touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, pioneer, friend, and devoted husband and father; and

WHEREAS, Dr. Bauer shaped the future of emergency medicine in San Antonio with his leadership, vision, enthusiasm, and dedication; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Charles R. Bauer, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Charles R. Bauer MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of Texas and the United States.
RESOLUTION: 5(17)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Diane Kay Bollman

WHEREAS, Emergency medicine lost a staunch advocate for the specialty in Diane Kay Bollman, an organizational leader, dedicated mentor, and dear friend, who passed away on July 2, 2017, at the age of 67; and

WHEREAS, Diane served as Executive Director of the Michigan College of Emergency Physicians for 24 years; and

WHEREAS, Diane was recognized for her exemplary service to emergency medicine by election to honorary membership in the American College of Emergency Physicians (ACEP); and

WHEREAS, Diane served on ACEP’s National/Chapter Relations Committee, as well as its Membership Committee; and

WHEREAS, Diane’s outstanding organizational leadership was further recognized by her induction into the Michigan Society of Association Executives Hall of Fame; and

WHEREAS, Diane was known for her broad smile and warm hug, as well as her educated and informed opinion, was a respected professional in the field of association management, and was a dear friend to the ACEP chapters’ executive directors; and

WHEREAS, Diane understood the value of camaraderie by hosting the seemingly never ending, late night social events, making certain there were sufficient poker chips, popcorn, and a welcoming room always available; and

WHEREAS, Diane demonstrated a resilient and unwavering commitment to professionalism in executive director leadership, and throughout her career continued to be recognized by her peers, serving as Chair of the ACEP Chapter Executive’s Forum in 1999 and from 2011 – 2013; and

WHEREAS, Diane was an organizational “den mother” to a generation of emergency medicine leaders, “big docs and baby docs” alike, and this mentorship advanced the social mission of the College and indirectly benefitted the lives of millions of patients cared for by members of the Michigan College of Emergency Physicians; and

WHEREAS, Diane touched the lives of countless individuals as a role model, colleague, consultant, friend, and devoted wife, mother, and grandmother; therefore be it

RESOLVED, That ACEP and the Michigan College of Emergency Physicians hereby acknowledges the many contributions made by Diane Kay Bollman as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That ACEP and the Michigan College of Emergency Physicians extend to the family of Diane Kay Bollman, her friends, and her colleagues, our condolences along with our profound gratitude for her tremendous service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States and likely beyond.
RESOLUTION: 6(17)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Aaron T. Daggy, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a staunch advocate, compassionate physician, dedicated educator, mentor, and dear friend and colleague in Aaron T. Daggy, MD, FACEP, who passed away suddenly December 7, 2015, at the age of 39, leaving behind his beloved wife Bridgett, young son Eli, and newborn twins, Owen and Willow; and

WHEREAS, Dr. Daggy graduated from Case Western University and Indiana University School of Medicine, completing his emergency medicine residency at the University of Pittsburgh and served in emergency departments in the states of Pennsylvania and New York; and

WHEREAS, Dr. Daggy demonstrated a life-long passion for EMS and fire, serving as medical director, and indeed, an active firefighter in multiple agencies in Pennsylvania and New York in the spirit of his late maternal grandfather; and

WHEREAS, Dr. Daggy was an exemplary clinician who was looked up to by fellow physicians, nurses, physician assistants, EMS personnel, and hospital staff; and

WHEREAS, Dr. Daggy touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, consultant, friend, and devoted husband and father; and

WHEREAS, Dr. Daggy shaped the future of pre-hospital care and fire response in the areas he served with his leadership, vision, enthusiasm, and boundless energy; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Aaron T. Daggy, MD, FACEP, as one of the leaders in pre-hospital medicine, EMS and fire, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Aaron T. Daggy, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of New York and the United States.
RESOLUTION: 7(17)

SUBMITTED BY: South Carolina College of Emergency Physicians

SUBJECT: In Memory of Geoffrey Edmund Renk, MD, PhD, FACEP

WHEREAS, The specialty of emergency medicine and the South Carolina College of Emergency Physicians (SCCEP) lost a staunch advocate, compassionate physician, dedicated educator, and dear friend and colleague in Geoffrey E. Renk, MD, PhD, FACEP, who passed away April 30, 2017, at the age of 62; and

WHEREAS, Dr. Renk was educated at the Medical University of South Carolina in Charleston (MS 1979; MD, PhD 1986) and completed his residency in emergency medicine at Martin Luther King Hospital in Los Angeles, and practiced emergency medicine in the Los Angeles area before moving to Charleston where he practiced at St. Francis Hospital for almost 20 years; and

WHEREAS, Dr. Renk served as Medical Director of the emergency department at St. Francis Hospital in Charleston, SC, was on the Board of Directors for Bon Secours-St. Francis Hospital, was head of his emergency physician group, and helped design the new emergency department at St. Francis hospital; and

WHEREAS, Dr. Renk was an active and contributing member of the South Carolina College of Emergency Physicians, the American College of Emergency Physicians, and the American Medical Association since relocating to South Carolina; and

WHEREAS, Dr. Renk served as the President of the SCCEP, as well as representing SCCEP in the ACEP Council, and mentored many physicians and nurses into leadership positions from all areas of South Carolina; and

WHEREAS, Dr. Renk actively promoted life-long education and learning for himself and others, becoming certified in ultrasound during his practice, and developing and sharing his talents as a musician, sailor, surfer, kite-boarder, and hotelier; and

WHEREAS, Dr. Renk touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, consultant, friend, and devoted husband; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Geoffrey Edmund Renk, MD, PhD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Lisa Flaggman, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.
RESOLUTION: 8(17)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: In Memory of Salvatore Silvestri, MD

WHEREAS, Salvatore “Sal” Silvestri, MD, a leader in EMS for Florida and the United States, passed away February 26, 2017, at an early age and left behind family, friends, residents, medical students, and colleagues; and

WHEREAS, Dr. Silvestri served on the Florida College of Emergency Physicians (FCEP) Board of Directors, the Florida Emergency Medicine Foundation, FCEP EMS/Trauma Committee, Florida Association of EMS Medical Directors, national ACEP EMS Section, and the Orange County EMS Advisory Council; and

WHEREAS, Dr. Silvestri was the EMS Medical Director for Orange County EMS; and

WHEREAS, Dr. Silvestri was the Emergency Medicine Residency Program Director for Orlando Health; and

WHEREAS, Dr. Silvestri was an original investigator and author of numerous publications on prehospital care that advanced the science and practice of emergency medical services; and

WHEREAS, Dr. Silvestri mentored medical students to recognize emergency medicine as their life-long field for career development; and

WHEREAS, Dr. Silvestri was the mentor for many emergency medicine residents who looked up to him for knowledge, faith, and family support; and

WHEREAS, Dr. Silvestri also had hundreds of EMTs and paramedics who he educated, supported, and mentored; and

WHEREAS, Dr. Silvestri, to his family and his FCEP family, will always be remembered for his kind heart; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the contributions made by Sal Silvestri, MD, as a leader in emergency medicine and EMS; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Sal Silvestri, MD, our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to learn so much from a kind, gentle, caring leader in our emergency medicine world.
RESOLUTION: 9(17)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: In Memory of Robert Wears, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a premier researcher, staunch advocate, compassionate physician, dedicated educator, and dear friend and colleague in Robert Wears MD, FACEP, who passed away July 16, 2017, at the age of 70; and

WHEREAS, Dr. Wears was an active and contributing member of both national ACEP and the Florida College of Emergency Physicians since their beginnings and was recognized with life fellow status since 1980; and

WHEREAS, Dr. Wears was an associate editor for *Annals of Emergency Medicine*, as well as serving on the editorial boards of *Human Factors and Ergonomics*, the *Journal of Patient Safety*, and the *International Journal of Risk and Safety in Medicine*; and

WHEREAS, Dr. Wears graduated from the Johns Hopkins School of Medicine and was in the very first class of emergency medicine residents at the University of Florida College of Medicine Jacksonville; and

WHEREAS, Dr. Wears earned a master’s degree in computer sciences from the University of North Florida and a doctorate degree in industrial safety from the Crisis & Risk Research Centre at the Ecole des Mines de Paris - Paris Institute of Technology in France; and

WHEREAS, Dr. Wears served as a Professor at the University of Florida College of Medicine Jacksonville for over 40 years, as well as a visiting Professor in the Clinical Safety Research Unit at Imperial College London; and

WHEREAS, Dr. Wears was an international leader and expert in patient safety, and his internationally recognized research led to improvements in patient care by focusing on human factors engineering, including the study of team dynamics during emergency department shift changes and patient-care handoffs; and

WHEREAS, Dr. Wears published more than 150 articles in medical journals around the world, more than 20 book chapters, and co-edited five books; and

WHEREAS, Dr. Wears was a mentor to so many students, residents, and young faculty throughout his career being generous with his time, vast knowledge, and his wisdom; and

WHEREAS, Dr. Wears touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, friend, and devoted husband and father; and

WHEREAS, Dr. Wears was a pioneering force in academic emergency medicine and a masterful, yet humble, academic scholar who was always in “learner mode” and the pursuit of new knowledge; and

WHEREAS, Dr. Wears shaped the future of emergency medicine, not only in Florida, but throughout the nation, whose leadership and continuous innovations resulted in improved system efficiency, and ultimately, more effective patient care; therefore be it
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Wears, MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of the specialty; and be it further

RESOLVED, That national ACEP and the Florida College of Emergency Physicians extends to his wife, Dianne Wears, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine.
2017 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 10-26

Brahim Ardolic, MD, FACEP (NY), Chair
Patricia A. Bayless, MD, FACEP (AZ)
Justin Fuehrer, DO, (EMRA)
Mark Notash, MD, FACEP (CO)
Susanne J. Spano, MD, FACEP (Wilderness Section)
Arvind Venkat, MD, FACEP (PA)

Leslie Moore, JD
Cynthia Singh, MS
RESOLUTION: 10(17)
SUBMITTED BY: Bylaws Committee
Board of Directors
SUBJECT: Chapter Bylaws Conformance Standards – Housekeeping Change

PURPOSE: Amends the Bylaws by removing the titles to specific chapter bylaws guidance documents, which may change in the future and necessitate additional amendments to the national ACEP Bylaws, and simply refers to "current approved chapter bylaws guidance documents."

FISCAL IMPACT: Budgeted resources to update and distribute the Bylaws.

WHEREAS, Chapter bylaws are addressed in the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws; and

WHEREAS, The ACEP Board and Bylaws Committee have made concerted effort to provide chapters with clear and useful guidance in chapters' review and revision of their bylaws; and

WHEREAS, Conformity to the ACEP Bylaws and guidance documents is an ongoing requirement of chapters; and

WHEREAS, Chapter bylaws guidance documents are referenced in the ACEP Bylaws by specific titles which may change; and

WHEREAS, Amendment of the ACEP Bylaws may be necessary to update references that are no longer technically accurate; therefore be it

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1, be amended to read:

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

Background

This resolution amends the Bylaws by removing the titles to specific chapter bylaws guidance documents, which may change in the future and necessitate additional amendments to the national ACEP Bylaws, and simply refers to current approved chapter bylaws guidance documents.”
The Bylaws Committee has the ongoing responsibility to provide guidance to chapters in the review and revision of chapter bylaws and to ensure compliance with the national ACEP Bylaws. The Whereas statements in the resolution explain that this housekeeping change deletes references to specific titles of chapter bylaws guidance documents that may change in the future. The current chapter bylaws guidance documents include the Bylaws Guide to Chapters, the Bylaws Committee Chapter Review Process, the Guidelines for Bylaws, and the Model Chapter Bylaws. The Board of Directors must approve any changes to these chapter bylaws guidance documents.

**ACEP Strategic Plan Reference**

None

**Fiscal Impact**

Budgeted resources to update and distribute the Bylaws.

**Prior Council Action**

Resolution 5(10) Chapter Bylaws Amendments adopted. Clarified the procedures for chapter bylaws proposed amendments and the response to such proposals.

Amended Resolution 6(97) Chapter Bylaws Compliance adopted. Defined the period of time within which chapters must amend their bylaws to resolve conflicts that may be caused by Council action to amend national ACEP’s Bylaws.

Amended Resolution 11(96) Chapter Charter adopted. Instituted the requirement that chapter bylaws must conform to the “Model Chapter Bylaws.”

**Prior Board Action**

June 2017, approved cosponsoring the Chapter Bylaws Conformance Standards resolution with the Bylaws Committee for submission to the 2017 Council.

Resolution 5(10) Chapter Bylaws Amendments adopted.

Amended Resolution 6(97) Chapter Bylaws Compliance adopted

Amended Resolution 11(96) Chapter Charter adopted.

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

**Reviewed by:** James Cusick, MD, FACEP, Speaker  
John McManus, MD, FACEP, Vice Speaker  
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 11(17)

SUBMITTED BY: Emergency Medicine Residents’ Association
Young Physicians Section

SUBJECT: Diversity of ACEP Councillors

PURPOSE: Seeks to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent diversity of membership, including candidate physician and young physician members.

FISCAL IMPACT: Budgeted resources to update and distribute the Bylaws.

WHEREAS, As of May 2017, ACEP had 7,525 candidate physician members who comprised 20% of ACEP’s total membership; and

WHEREAS, At the 2016 ACEP Council meeting, only 4% of credentialed councillors were candidate physicians; and

WHEREAS, ACEP is committed to increasing diversity and inclusion, including multigenerational diversity within our organization; and

WHEREAS, The current composition of the ACEP Council does not adequately reflect the diversity of ACEP’s membership; and

WHEREAS, Early engagement of ACEP candidate and young physician members is more likely to keep them engaged in ACEP throughout their careers; and

WHEREAS, Investing in future leaders and giving them representation and a voice is critical for increasing retention, value, and participation; therefore be it

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

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

Background

This resolution calls for ACEP to strongly encourage, rather than require, chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young
physician members. It is important for residents, young physicians, and others who represent a minority of members of the College, to become active in their state chapters and sections and to seek appointment or election as a councillor or alternate councillor. Increasing diversity in leadership at the chapter and section levels will automatically increase the diversity in leadership within the Council.

A Diversity Summit was convened by ACEP in April 2016 to discuss diversity and inclusion and a task force was appointed in June 2016 with the following objectives:

1. Engage the specialty of emergency medicine on diversity and inclusion.
2. Identify obstacles to advancing within the profession of emergency medicine related to diversity and inclusion and ways to overcome the obstacles.
3. Highlight the effects of diversity and inclusion on patient outcomes and identify ways to improve these outcomes.

The Diversity & Inclusion Task Force has conducted a survey of the membership to better understand the diversity within ACEP’s membership and the degree to which members’ backgrounds influence their interactions with ACEP and their practice of emergency medicine. They are also performing a survey to look at the diversity within current leadership positions in the field. These will become baseline data and will be compared to data in the future as ACEP continues diversity and inclusion initiatives.

Additionally, in response to Amended Resolution 7(16) Diversity in Emergency Medicine Leadership, a Leadership Diversity Task Force was appointed with the following objectives:

1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices.
2. Survey current pipeline programs within the Council’s component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership.
3. Identify barriers to becoming a councillor, Council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type.

The task force plans to present their recommendations to the Board of Directors in April 2018.

**ACEP Strategic Plan Reference**

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Increase total membership and transitioning resident retention.

Objective E – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Objective F – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

**Fiscal Impact**

Budgeted resources to update and distribute the Bylaws.

**Prior Council Action**

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to develop strategies to increase diversity within the ACEP Council and its leadership and provide a report to the Council on effective means of implementation.

Substitute Resolution 33(04) Future Leaders of ACEP adopted. Directed ACEP to work with chapters, committees,
and sections to establish leadership development priorities and strategies and compile a list of innovative leadership development strategies and disseminate them through its publications and meetings.

Resolution 27(00) Future Policy Leaders in Emergency Medicine adopted. The resolution called for ACEP to develop a financial mechanism to support residents to attend the legislative and leadership meeting, and that ACEP explore partnerships in developing a specific leadership program for future leaders.

Resolution 26(00) Leadership Challenge adopted. The resolution called for ACEP to formally study and evaluate its leadership development process and leadership requirements in consideration of changing emergency physician practices and demographics, and that the Board report back to the Council in one year regarding recommendations for consideration based on that assessment.

Resolution 2(92) EMRA Councillor Allotment adopted. The resolution provided EMRA with two additional councillors.

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine adopted. The resolution directed ACEP to continue to work with UA/EM to develop policies to ensure that leaders in academic emergency medicine have access to leadership development materials including information on development of academic departments, staffing and residency funding, faculty development, and academic advancement.

Resolution 1(88) EMRA Councillor Allotment adopted. This resolution entitled EMRA to two councilors and two alternate councilors.

Resolution 2(76) adopted, which codified in the Bylaws the allocation of one councillor for EMRA.

Resolution 1(75) adopted, which allocated one councillor for EMRA at the 1975 Council meeting with full voting privileges and future representation to be determined.

Prior Board Action

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

Resolution 33(04) Future Leaders of ACEP adopted.

Resolution 27(00) Future Policy Leaders in Emergency Medicine adopted.

Resolution 26(00) Leadership Challenge adopted.

Resolution 2(92) EMRA Councillor Allotment adopted.

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine adopted.

Resolution 1(88) EMRA Councillor Allotment adopted.

Resolution 2(76) adopted.

Resolution 1(75) adopted.

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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 12(17)

SUBMITTED BY: Florida College of Emergency Physicians
Louisiana Chapter
Virginia College of Emergency Physicians
Washington Chapter
Wisconsin Chapter

SUBJECT: Seating of Past Chairs of the Board in the ACEP Council

PURPOSE: Seeks to amend the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

FISCAL IMPACT: Budgeted staff resources to update and distribute the Bylaws. Minimal additional costs for increasing the number of seats on the Council floor.

WHEREAS, The management and control of the College is vested in the Board of Directors; and
WHEREAS, The meetings of the Board of Directors are chaired by an elected officer of the Board; and
WHEREAS, The Board of Directors are required to meet at least three times annually; and
WHEREAS, The Chair of the Board is responsible for all matters of business that come before the Board of Directors during regularly scheduled and special meetings; and
WHEREAS, The Bylaws permit ACEP Past Presidents and ACEP Past Speakers, if not certified as councillors or alternate councillors by a sponsoring body, to be seated with their delegations and participate in the Council in a non-voting capacity; and
WHEREAS, The ACEP Council encourages and values the participation of past leaders during discussion of business on the Council floor; therefore be it
RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two, be amended to read:

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

Background

This is a companion resolution to Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment.

This resolution seeks to amend the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and
past speakers of the Council.

Since 1989, past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity.

Beginning in 2002, the Board implemented a trial process of the immediate past president serving as chair of the Board. In 2005, the Council and the Board adopted Resolution 13(05) Election of Board Chair by the Board of Directors. This resolution amended the Bylaws to codify the position of chair of the Board, elected by the Board from among the current Board members.

Since 2005, the Board has elected eight individuals as chair of the Board who had not previously served as ACEP president; however, one was elected president-elect after serving as chair and this year’s chair is a candidate for president-elect. Adoption of this resolution will result in an additional seat on the Council floor (if these individuals are not serving as councillors) beginning in 2018 for: California (2 seats), Indiana, New Mexico, Florida, and Virginia.

Past chairs of the Board (as well as past presidents and past speakers) have an opportunity to serve as councillors or alternate councillors within their component bodies. However, some may not pursue this opportunity so that others can serve. Two past chairs of the Board, who did not serve as president, served as councillors in 2016.

As mentioned in the resolution, the Council encourages and values the participation of past leaders during Council discussions. The Council Standing Rules allow for seating of the current members of the Board on the Council floor and they are granted full floor privileges except the right to vote. Additionally, the Council Standing Rules “Debate” section, paragraph 4, state: “…other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual’s name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.” Testimony in a Reference Committee is allowed by any person recognized at the microphone by the Reference Committee chair.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to update and distribute the Bylaws. Minimal additional costs for increasing the number of seats on the Council floor

Prior Council Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted. This Bylaws amendment formally created the position of chair of the Board, elected by the Board from among the current Board members.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for seating of Past Presidents and Past Speakers of ACEP with their delegations as non-voting participants in the Council.

Prior Board Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted.

June 2005, approved submitting the “Election of Board Chair by the Board of Directors” Bylaws resolution to the 2005 Council.
April 2005, directed the President-Elect Ramifications Task Force to prepare a Bylaws resolution to formalize the chair of the Board position.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.

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

- Leslie Patterson Moore, JD
- General Counsel

**Reviewed by:** James Cusick, MD, FACEP, Speaker
- John McManus, MD, FACEP, Vice Speaker
- Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
Council Standing Rules Amendment

RESOLUTION: 13(17)

SUBMITTED BY: Florida College of Emergency Physicians
Louisiana Chapter
Virginia College of Emergency Physicians
Washington Chapter
Wisconsin Chapter

SUBJECT: Seating of Past Chairs of the Board in the ACEP Council

PURPOSE: Seeks to amend the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

FISCAL IMPACT: Budgeted staff resources to update and distribute the Council Standing Rules. Minimal additional costs for increasing the number of seats on the Council floor.

WHEREAS, The management and control of the College is vested in the Board of Directors; and

WHEREAS, The meetings of the Board of Directors are chaired by an elected officer of the Board; and

WHEREAS, The Board of Directors are required to meet at least three times annually; and

WHEREAS, The Chair of the Board is responsible for all matters of business that come before the Board of Directors during regularly scheduled and special meetings; and

WHEREAS, The Council Standing Rules permit ACEP Past Presidents and ACEP Past Speakers, if not certified as councillors or alternate councillors by a sponsoring body, to be seated with their delegations and participate in the Council in a non-voting capacity; and

WHEREAS, The ACEP Council encourages and values the participation of past leaders during discussion of business on the council floor; therefore be it

RESOLVED, That the “Debate” section, paragraph one, of the Council Standing Rules be amended to read:

“Councillors, members of the Board of Directors, past presidents, and past speakers, and past chairs of the Board wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, past chair, etc.), and whether they are speaking “for” or “against” the motion;” and be it further

RESOLVED, That the “Nominations” section, paragraph one, of the Council Standing Rules be amended to read:

“A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, or past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened;” and be it further
RESOLVED, That the “Past Presidents and Past Speakers Seating” section of the Council Standing Rules be amended to read:

“Past Presidents, and Past Speakers, and Past Chairs of the Board Seating

Past presidents, and past speakers, and past chairs of the Board of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.”

Background

This is a companion resolution to Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment.

This resolution seeks to amend the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Since 1989, past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity.

Beginning in 2002, the Board implemented a trial process of the immediate past president serving as chair of the Board. In 2005, the Council and the Board adopted Resolution 13(05) Election of Board Chair by the Board of Directors. This resolution amended the Bylaws to codify the position of chair of the Board, elected by the Board from among the current Board members.

Since 2005, the Board has elected eight individuals as chair of the Board who had not previously served as ACEP president; however, one was elected president-elect after serving as chair and this year’s chair is a candidate for president-elect. Adoption of this resolution will result in an additional seat on the Council floor (if these individuals are not serving as councillors) beginning in 2018 for: California (2 seats), Indiana, New Mexico, Florida, and Virginia.

Past chairs of the Board (as well as past presidents and past speakers) have an opportunity to serve as councillors or alternate councillors within their component bodies. However, some may not pursue this opportunity so that others can serve. Two past chairs of the Board, who did not serve as president, served as councillors in 2016.

As mentioned in the resolution, the Council encourages and values the participation of past leaders during Council discussions. The Council Standing Rules allow for seating of the current members of the Board on the Council floor and they are granted full floor privileges except the right to vote. Additionally, the Council Standing Rules “Debate” section, paragraph 4, state: “…other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual’s name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.” Testimony in a Reference Committee is allowed by any person recognized at the microphone by the Reference Committee chair.

There is a potential problem with adoption of this resolution by the Council prior to the adoption by the Board of Directors of companion Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment. The Council Standing Rules, “Amendments to Council Standing Rules” section, state: “These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.” (The Board does not act on amendments to the Council Standing Rules.) Bylaws amendments (Article XIII – Amendments, Section 3 – Amendment Under Initial Consideration), after adoption by a two-thirds vote of the Council, require an “affirmative vote of at least two-thirds of the members of the Board of Directors, then it shall be adopted and these Bylaws shall be
Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment
Page 3

so amended immediately.” There is not a contingency provision that Resolution 13(17), if adopted, would not take effect unless or until Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment is adopted by the Board of Directors.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to update and distribute the Council Standing Rules. Minimal additional costs for increasing the number of seats on the Council floor

Prior Council Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted. This Bylaws amendment formally created the position of chair of the Board, elected by the Board from among the current Board members.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for seating of Past Presidents and Past Speakers of ACEP with their delegations as non-voting participants in the Council.

Prior Board Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted.

June 2005, approved submitting the “Election of Board Chair by the Board of Directors” Bylaws resolution to the 2005 Council.

April 2005, directed the President-Elect Ramifications Task Force to prepare a Bylaws resolution to formalize the chair of the Board position.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.

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

Leslie Patterson Moore, JD
General Counsel

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION:  14(17)

SUBMITTED BY:  Pennsylvania College of Emergency Physicians

SUBJECT:  Unanimous Consent

PURPOSE:  Amends the Council Standing Rules “Unanimous Consent Agenda” section by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda and requiring a second for extraction.

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

WHEREAS, The ACEP Council is a deliberative body dedicated to shaping the policy and direction of the College; and

WHEREAS, Many resolutions are brought before the Council each year for consideration; and

WHEREAS, It is the responsibility of the Council to make informed decisions regarding the issues before them; and

WHEREAS, The Council has limited time in each session to conclude its business; and

WHEREAS, Council Reference Committees provide a forum for in-depth discussion regarding the issues before the Council and the merits of proposed resolutions; and

WHEREAS, Council Reference Committees, having heard all relevant testimony provided by interested parties then prepares a detailed report summarizing the testimony provided and makes recommendations for disposition of each resolution based upon the testimony; and

WHEREAS, Council Reference Committees may make amendments to resolutions as required to reflect the testimony provided; and

WHEREAS, It is the duty of the Council to protect the right of each councillor’s viewpoint to be heard and to present new information not considered by a Reference Committee or reflective of its recommendation; therefore be it

RESOLVED, That the “Unanimous Consent” section of the Council Standing Rules be amended to read:

Unanimous Consent Agenda

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

1.  Non-controversial in nature
2.  Generated little or no debate during the Reference Committee
3.  Clear consensus of opinion (either pro or con) was expressed at Reference Committee
Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report consisting of the committee’s summarization of testimony provided along with the committee’s and a recommendation for adoption, not adoption, or referral, or defeat for each resolution listed referred to the committee. Bylaws resolutions shall not be placed on a Unanimous Consent Agenda. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report and such resolution will be extracted upon a second by another credentialed councillor. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. Extracted resolutions shall then be discussed in the order presented on the Reference Committee report. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Background

This resolution Amends the Council Standing Rules “Unanimous Consent Agenda” section by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda with the Reference Committee’s recommendation for adoption, not adoption, or referral for each resolution and requiring a second for extraction.

The Unanimous Consent Agenda is used for resolutions that are non-controversial, or generated little/no debate, or had a clear consensus of opinion in favor, opposed, or for referral. If one person objects, then it is not unanimous and the item is removed from consent. This procedure is also discussed in ACEP’s parliamentary authority, The Standard Code of Parliamentary Procedure (aka “Sturgis”) and in the Council Standing Rules (CSR). The CSR supersedes Sturgis in the conduct of Council business.

Using the Unanimous Consent Agenda can greatly reduce the amount of time needed by the Council to act on resolutions. However, there are numerous extractions from the consent agenda each year. The Council Steering Committee has discussed revising the rule regarding the Unanimous Consent Agenda and submitted a resolution to the 2016 Council. That resolution sought to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction and a one-third affirmative vote of the councillors present and voting to remove the item from consent. A majority of the testimony in the Reference Committee was against adoption, although there was acknowledgment that the resolution was intended to create a more efficient process and respect the time of the Council and the efforts of the reference committees. Those expressing support testified that because this resolution requires the Council to provide its support, it exemplifies the democratic process and many times items are removed from the consent agenda even when the outcome is clear. Those opposed argued that limiting the ability to remove items from the Consent Agenda is undemocratic and stifles debate. Historically, select resolutions have been removed from the Consent Agenda by a single individual, whose testimony to the Council body has reversed the recommendation of the Reference Committee.

At their January 2017 meeting, the Steering Committee discussed the Council’s action on the 2016 resolution and decided not to resubmit a resolution to the 2017 Council. The Steering Committee discussed this resolution submitted by the Pennsylvania College of Emergency Physicians at their meeting in June 2017 and decided against cosponsorship. The committee expressed concerns expressed about placing all resolutions on the consent agenda.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted resources to update and distribute the Council Standing Rules.
Prior Council Action

Resolution 3(16) Unanimous Consent not adopted. The resolution sought to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction report and a one-third affirmative vote of the councillors present and voting to remove the item from consent.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. Revised several sections of the Standing Rules, including Unanimous Consent. The changes to this section were primarily editorial to provide clarity and also revised the section title from “Consent Calendar” to “Unanimous Consent Agenda.”

Resolution 19(02) Consent Calendar adopted. Removed the statement “At the speaker’s discretion, without objection, such an item is extracted from the consent calendar.” If any credentialed councillor can request an item to be removed from consent, it is not at the speaker’s discretion.

Prior Board Action

Not applicable.

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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 15(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ABEM Financial Transparency

PURPOSE: 1) Request detailed financial audit of ABEM; 2) provide all ABEM financial information to the ACEP Board at least every two years; 3) encourage ABEM to allow financial statements to be available to diplomates; 4) convene a meeting with ABEM to discuss financial transparency and responsiveness to diplomates; and 5) develop procedures to ensure anyone nominated by ACEP to serve on the ABEM Board will advocate for financial transparency and disclosure to diplomates.

FISCAL IMPACT: Budgeted Board of Directors and staff resources.

WHEREAS, Certification by the American Board of Emergency Medicine (ABEM) is a de facto requirement for practicing Emergency Medicine in most large communities; and

WHEREAS, Investigations of other American Board of Medical Specialties (ABMS) boards have revealed multi-million-dollar condos and exorbitant staff salaries, neither of which are appropriate; and

WHEREAS, ABEM is spending significant amount of the diplomates’ funds annually, with no accountability; and

WHEREAS, ABEM has a net worth of over $37 million without a reasonable need for such massive assets; and

WHEREAS, ACEP should use its small amount of influence to encourage ABEM to be more financially transparent; therefore be it

RESOLVED, That ACEP request a detailed financial audit of the American Board of Emergency Medicine; and be it further

RESOLVED, That the full results of any and all American Board of Emergency Medicine financial audits are to be shared with the ACEP Board of Directors at least every other year; and be it further

RESOLVED, That ACEP encourage the American Board of Emergency Medicine to allow full, legal financial statements to be available to their diplomates; and be it further

RESOLVED, That ACEP leadership initiate a meeting to discuss methods by which the American Board of Emergency Medicine will be transparent and responsive to its diplomates; and be it further

RESOLVED, That the ACEP Board of Directors develop procedures to ensure that anyone nominated by ACEP to serve on the American Board of Emergency Medicine Board of Directors shall advocate for financial transparency and financial disclosure to its diplomates.

Background
This resolution directs ACEP to request a detailed financial audit of the American Board of Emergency Medicine (ABEM), provide all ABEM financial information to the ACEP Board at least every two years, encourage ABEM to
allow financial statements to be available to diplomates, convene a meeting with ABEM to discuss financial transparency and responsiveness to diplomates, and develop procedures to ensure anyone nominated by ACEP to serve on the ABEM Board will advocate for financial transparency and disclosure to diplomate

The Internal Revenue Service requires all non-profit organizations to file a 990 tax return each year. Additionally, tax-exempt organizations are subject to a variety of disclosure and compliance requirements through various schedules that are attached to the Form 990. Filing of schedules by organizations supplements, enhances, and further clarifies disclosures and compliance reporting made in Form 990. Public Inspection IRC 6104(d) regulations state that an organization must provide copies of its three most recent Forms 990 to anyone who requests them, whether in person, by mail, fax, or e-mail. Non-profit organizations are not required by federal or state law to provide copies of their audited financial statements to the public, although it is good business practice to conduct an annual audit and provide copies to the organization’s Board of Directors. Per the 2016-2017 ABEM Annual Report (page 19), the ABEM Board of Directors reviewed the final audit report for the fiscal year ending June 30, 2016, at their February 2017 meeting.

When contacted about the subject of this resolution, ABEM provided the following response:

ABEM fully complies with federal financial reporting requirements. Detailed financial information is available publicly and provided in the Form 990. As reported in the 2016-2017 ABEM Annual Report, the fiscal year ending June 30, 2016, showed gross revenue totaling $14,324,783, and a revenue margin showing a loss from operations of ($170,548) for an operating margin of negative 1.3 percent. Equity holdings totaled approximately $32.8 million, most of which resulted from the stock market recovery that began in 2008. ABEM uses these funds strategically, much like an endowment, to hold initial certification and Maintenance of Certification (MOC) fees fixed. Though the cost of administering the Oral Certification Examination has more than doubled with the introduction of the eOral format, ABEM has not passed on any of the increased costs to physicians seeking initial certification.

By strategically using these equity holdings, ABEM has been able to offer the lowest application and written exam fees for initial certification. ABEM also has the lowest initial certification fees for those specialties that have an oral examination (14 of the 24 boards). ABEM’s MOC costs are at the mean for all specialties.

Though costs to ABEM-certified physicians are often emphasized, there is a financial benefit to being ABEM-certified for many physicians. The last ACEP/Stern survey (2015) showed that board-certified emergency physicians receive around $7,000 more in total annual compensation. This would result in over $240 million in annual compensation to the 35,000 physicians who are certified by ABEM.

Past editions of the ABEM annual report are available on the ABEM Website. The ABEM annual report is also provided to the Council in the distribution of the Council meeting materials, available at www.acep.myeventpartner.com.

ACEP, as one of the founding organizations of ABEM, has maintained a close and collegial relationship with ABEM. ACEP and ABEM officers meet at least twice each year, usually during the annual Society of Academic Emergency Medicine meeting and ACEP’s annual Scientific Assembly, to discuss issues and concerns of mutual interest and importance. While ACEP can request copies of audited financial information, and encourage that the audited financials also be released to diplomates, ACEP cannot compel ABEM to do so.

The ABEM Bylaws provide that three directors will be elected from nominees provided by ACEP. The nomination and election processes are governed by ABEM. The fiduciary duty of directors is to the organization for which they are serving as directors and not to the sponsoring or nominating organization. ACEP is supportive of financial transparency, but it would be inappropriate for ACEP to develop procedures (i.e., requirements to advocate for certain positions as a member of the ABEM Board) for nomination outside of the criteria established by ABEM.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective E – Promote leadership development among emergency medicine organizations and strengthen liaison relationships.
Fiscal Impact

Budgeted Board of Directors and staff resources.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 16(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ABEM Governance

PURPOSE: 1) Encourage ABEM to change its rules to allow the ABEM president to be elected by a vote of the diplomates from among the ABEM Board of Directors; 2) ACEP initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, ensuring those nominated by ACEP are in agreement with the need for a more democratic and responsive ABEM; 3) charge ABEM directors nominated by ACEP to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws.

FISCAL IMPACT: Budgeted Board of Directors and staff resources.

WHEREAS, Certification by the American Board of Emergency Medicine (ABEM) is a de facto requirement for practicing Emergency Medicine in most large communities; and

WHEREAS, ACEP, the American Medical Association (AMA), and the Society for Academic Emergency Medicine (SAEM) were sponsoring societies for ABEM; and

WHEREAS, ACEP nominates directors for ABEM to represent the College; and

WHEREAS, It is vital for ACEP to ensure the voice of the College is clearly heard; and

WHEREAS, ACEP should use its small amount of influence to encourage ABEM to be more democratic; therefore be it

RESOLVED, That ACEP encourage the American Board of Emergency Medicine to allow its diplomates to elect directly at least one-third of its Board of Directors; and be it further

RESOLVED, That ACEP encourage the American Board of Emergency Medicine (ABEM) to change its rules to allow the ABEM president to be elected by a vote of the diplomates from among the ABEM Board of Directors; and be it further

RESOLVED, That ACEP initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, that ensures that those nominated by ACEP to serve on the American Board of Emergency Medicine (ABEM) Board of Directors are in agreement with the need for a more democratic and responsive ABEM; and be it further.

RESOLVED, That ACEP charge the American Board of Emergency Medicine (ABEM) directors nominated by the College to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws.

Background

This resolution directs ACEP to encourage the American Board of Emergency Medicine (ABEM) to change its rules to allow the ABEM president to be elected by a vote of the diplomates from among the ABEM Board of Directors; initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, ensuring those nominated by ACEP are in agreement with the need for a more democratic and
responsive ABEM; and charge ABEM directors nominated by ACEP to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws.

ACEP is one of the original sponsors that created ABEM. The ABEM Bylaws provide that three directors will be elected from nominees provided by ACEP. The nomination and election processes are governed by ABEM. The fiduciary duty of directors is to the organization for which they are serving as directors and not to the sponsoring or nominating organization. ACEP is supportive of a democratic and responsive organization, but it would be inappropriate for ACEP to develop procedures (i.e., requirements to advocate for certain positions as a member of the ABEM Board) for nomination outside of the criteria established by ABEM.

As a sponsoring organization, and per the ABEM Bylaws, ACEP is notified at least 60 days in advance of any contemplated Bylaws changes. ABEM Bylaws do not require that the sponsoring organizations approve the Bylaws revisions, but they must give the sponsors notice and an opportunity to comment. Most proposed amendments in the past have been minor edits to language and ACEP has not opposed these changes. On a few occasions, ACEP has expressed concerns about proposed Bylaws changes. ABEM has either revised such proposals or implemented the changes after acknowledging ACEP’s concerns.

The nomination and election process for the ABEM Board of Directors and election of its president is also defined in the ABEM Bylaws. ABEM is a certifying organization and not a member organization. Although ACEP could encourage ABEM to change its Bylaws to allow for election of the president by the diplomates from among the ABEM Board, ACEP could not compel them to do so.

ACEP has maintained a close and collegial relationship with ABEM. ACEP and ABEM officers meet at least twice each year, usually during the annual Society of Academic Emergency Medicine meeting and ACEP’s annual Scientific Assembly, to discuss issues and concerns of mutual interest and importance. While ACEP can request ABEM to make changes in their Bylaws for election of the president, ACEP cannot compel ABEM to do so.

When contacted about the subject of this resolution, ABEM provided the following response:

“A substantial majority of the ABEM Board of Directors is selected from nominations coming from key EM organizations, such as ACEP. Twelve of ACEP’s 45 Past-Presidents have served on the ABEM Board of Directors.

Six of the current 19 ABEM directors were nominated by ACEP. ABEM has at least 16 seats at any given time, and can have up to 19 directors (when terms are extended due to leadership responsibilities). Of the current 19 directors, 15 were nominated from EM membership organizations and the AMA (four were nominated by multiple organizations). Only four of the 19 were self-nominated or nominated by other ABEM diplomates.

Currently serving on the board are two past ACEP directors, one of whom is an ACEP Past-President. Six of the directors are Past-Presidents of ACEP state chapters, and seven have served on state chapter boards. Seven ABEM directors have served on key ACEP committees, of whom five have served as committee chairs. Eight ABEM Board members have served as an officer in other major EM organizations such as the Society of Academic Emergency Medicine, the Council of Emergency Medicine Residency Directors, and the ACGME, often serving as chair.

In addition to ABEM directors, ABEM has a significant body of volunteers who serve in the interest of the specialty. These 500 ABEM volunteers serve in many capacities, such as oral examiners, item (question) writers for examinations, task force members, advisory panel members, standard-setting study participants, oral case reviewers, and focus group participants. These 500 volunteers have an active and influential voice in ABEM’s policies and practices.

Democratic governance is optimized when the organization is attentive to the voice of its stakeholders. ABEM solicited and received over 20,000 survey responses from our 35,000 diplomates this year. ABEM also monitors EM and other medical specialties’ social media sites to hear physicians’ thoughts and ideas about ABEM activities and requirements. In response to listening to our stakeholders, ABEM made 27 changes in the last three years that specifically benefit ABEM-certified physicians. Such improvements
include holding ABEM fees fixed, eliminating several penalty-based fees, modifying LLSA activities to broaden choices and strengthen learning, eliminating the patient safety LLSA and integrating patient safety into every LLSA (focusing on high-risk diagnoses), offering an easy way to receive credit for Improvement in Medical Practice (Part IV) requirements for physicians using CEDR for CMS quality reporting, and working supportively with physicians in recovery for substance use disorders.”

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective E – Promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Fiscal Impact

Budgeted Board of Directors and staff resources.

Prior Council Action

None

Prior Board Action

Reviews and comments on any proposed changes to the ABEM Bylaws.

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

Reviewed by: James Cusick, MD, FACHEP, Speaker
   John McManus, MD, FACHEP, Vice Speaker
   Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 17(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ACEP Membership and Status is Independent of Other Organizations

PURPOSE: Directs ACEP to remove references to other organizations and certification boards as criteria for membership and fellow status and review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from impacting ACEP’s membership eligibility.

FISCAL IMPACT: Budgeted committee and staff resources to update governance documents and policy statements. Unknown costs for potential loss of membership for those that disagree with any adopted changes in membership requirements. Unknown costs for changing computer programming, internal processes, online and printed membership materials, etc.

WHEREAS, ACEP is the professional organization for career emergency physicians; and

WHEREAS, Membership and status within the College should be determined directly and solely by the College; and

WHEREAS, Residency training and initial board certification is acknowledged as essential and valued by members beginning the practice of Emergency Medicine in the 21st century; and

WHEREAS, ACEP’s voice is not always heard clearly or timely by other organizations; and

WHEREAS, Other organizations may have different priorities than ACEP; therefore be it

RESOLVED, That status in any other organization, to include certification boards, should not be criteria for ACEP membership or fellowship; and be it further

RESOLVED, That no other organization should be referenced by name in the College Bylaws or rules delineating ACEP membership or fellowship status; and be it further

RESOLVED, That ACEP review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from unilaterally impacting membership eligibility for the College.

Background

Directs ACEP to remove references to other organizations and certification boards as criteria for membership and fellow status and review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from impacting ACEP’s membership eligibility.

Prior to January 1, 2000, active membership in ACEP was open to physicians “who devote a significant portion of their medical endeavors to emergency medicine.” Other medical specialty societies had long-standing membership criteria that were more restrictive and typically were linked to board certification in the specialty or residency training. After extensive, multi-year study, and discussions, the Board of Directors and the Council Steering Committee submitted a resolution to limit the College’s membership. The Council and the Board adopted Amended Resolution 2(97) College Membership that amended the Bylaws to include the following criteria for membership in ACEP:
“1) Satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME). 2) Satisfactory completion of an emergency medicine subspecialty training program accredited by ACGME. 3) Satisfactory completion of an emergency medicine residency training program accredited by the American Osteopathic Association (AOA). 4) Satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country. 5) Certification by an emergency medicine certifying body recognized by ACEP. or 6) Active membership in the College at any time prior to close of business December 31, 1999.”

Adoption of Amended Resolution 2(97) completed the evolution of the College to secure its place among other medical specialty societies. Additionally, it reinforced to residents the value of residency training and membership in the College. Residency training and board certification is the “gold standard” in emergency medicine.

The language was revised again based on adoption of Amended Resolution 9(14) Membership Classification Restructure, which changed the classifications of membership (from active to regular) and increased the flexibility and readability of the Bylaws without changes to the criteria for current members. It also closed a potential loophole for non-emergency medicine subspecialists to join the College.

ACEP’s policy statement “ACEP Recognized Certifying Bodies in Emergency Medicine,” reinforces that ACEP recognizes and supports the American Board of Emergency Medicine (ABEM) as the sole American Board of Medical Specialties (ABMS) certifying body for emergency medicine; the American Osteopathic Board of Emergency Medicine (AOBEM) as a certifying body in emergency medicine, under the jurisdiction of the American Osteopathic Association (AOA), limited to osteopathic physicians; and the American Board of Pediatrics (ABP) as an ABMS certifying body in pediatrics that provides subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine.

ACEP’s policy statement “Definition of an Emergency Physician,” developed as a direct result of Referred Amended Resolution 25(10) Definition of an Emergency Physician, states:

An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.

ACEP has adopted many policy statements that reference certification by ABEM, AOBEM, and ABP. (See prior “Board Action – Policy Statements.”) These policies (and potentially others) would need to be revised if ACEP’s membership and fellowship criteria are changed.

The Council has discussed fellow status ad nauseam (see prior “Council Action – Fellowship”). The criteria have evolved over time and it took many years for the Council to reach consensus.

A potential unintended consequence of adopting this resolution is a significant loss of membership. Changes to the ACEP Bylaws Article IV – Membership, Section 2.1 – Regular Members, paragraph one, and Article V – ACEP Fellows, Section 1 – Eligibility, will be required if this resolution is adopted.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
  Objective A – Increase total membership and transitioning resident retention.
Fiscal Impact

Budgeted committee and staff resources to update governance documents and policy statements. It is impossible to predict the fiscal impact of the potential loss of membership for those that disagree with any adopted changes in membership requirements. Unknown costs for changing computer programming, internal processes, online and printed membership materials, etc.

Prior Council Action – Membership Criteria

Amended Resolution 9(14) Membership Classification Restructure adopted. Restructured the Bylaws Article IV – Membership, Article V – Fellowship, and Article VIII – Council for increased flexibility and readability without changes to the criteria for current members and closed a potential loophole for non-emergency medicine subspecialists to join.

Resolution 11(13) Membership Restructuring referred to the Board of Directors.

Resolution 28(05) Active Membership Eligibility adopted. This Bylaws amendment altered the requirements for active membership to include physicians who were eligible for active or international membership prior to the close of business December 31, 1999.

Substitute Resolution 25(00) Membership not adopted. Called for an impact study and a suggested mechanism for an alternative membership status for physicians who practice emergency medicine by are not currently eligible for full membership in the College.

Amended Resolution 2(97) College Membership adopted. Changed the membership criteria, as of January 1, 2000.

Resolution 6(95) not adopted. It called for restricting new active membership to individuals certified in emergency medicine or an emergency medicine subspecialty by the American Board of Emergency Medicine or the Royal College of Physicians and Surgeons of Canada. Current members would have been allowed to continue membership. Certification by the American Board of Osteopathic Emergency Medicine was excluded. Candidate membership was expanded to allow for members to continue in that category for four years after completion of their program. Implementation would have occurred January 1997.

Resolution 5(95) Criteria for Active Members adopted. Removed the words “and must be eligible for a license to prescribe narcotics and dangerous drugs” from the membership criteria.

Resolution 15(94) not adopted. It called for limiting membership to emergency medicine board certified physicians as of January 1, 1995. There was no provision for allowing current non-certified members to retain their membership after that date.

Resolution 35(93) Criteria for Membership not adopted. Called for the analysis of current classes of membership and their requirements.

The criteria for active membership was proposed and approved in November 1972 (the inaugural year of the ACEP Council).

Prior Council Action – Fellowship

Resolution 4(16) Legacy Fellows – Housekeeping Change adopted. Amended the Bylaws to clarify that members who met the criteria for fellowship in ACEP under prior criteria retain their fellowship status.

Resolution 6(15) Fellowship Criteria adopted. Removed the requirement for a letter of recommendation from the chapter or two letters of recommendation from current Fellows to be submitted on behalf of the member seeking Fellow status, in addition to meeting the other criteria.
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Resolution 8(14) Fellow Status: Continued vs. Continuous Membership Requirement referred to the Board. The resolution stipulated retention of ACEP Fellow status is contingent on maintaining continuous membership (i.e., no lapse in membership after becoming a Fellow).

Resolution 7(14) Fellow Status – Housekeeping Changes Bylaws Amendment adopted. Removed language no longer applicable and clarified the terms “Fellow” and “Fellow Status” by removing the word “Fellowship.”

Resolution 10(08) Fellowship Criteria not adopted. Requested ACEP to appoint a task force to study modification and implementation of revised Fellow status criteria and provide recommendations to the 2009 Council.

Resolution 9(08) Fellowship adopted. Created a sunset date for Amended Resolution 11(07) closing the date for “legacy” fellowship applications and confirmation.

Amended Resolution 11(07) Fellowship adopted. Added a second set of criteria allowing non-board certified members to attain Fellow status, removed the requirement to maintain board certification to maintain Fellow status, deleted “Life Fellow” status as it was no longer necessary, and modified the membership requirement for Fellow status by adding, “Maintenance of Fellow status requires continued membership in the College.


Amended Resolution 4(06) Fellow Emeritus adopted. Created the Fellow Emeritus designation to allow esteemed ACEP members who might otherwise lose their Fellow status due to the loss of board certification, (e.g., after retirement from clinical practice).

Resolution 24(05) Fellowship and its Implications adopted. Called for the president to establish a task force to study the political, economic, and personal implications of opening ACEP fellowship eligibility to all active members of the College and to report to the College by April 1, 2006.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status not adopted. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. Called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. Called for a Bylaws amendment establishing a mechanism for a member who has attained fellow status to maintain it indefinitely in the event of permanent disability.

Resolution 1(00) Membership Requirement for Fellowship not adopted. called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. Called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Resolution 8(96) Fellowship Criteria not adopted. Sought to expand the fellowship criteria to recognize members who were certified in emergency medicine by AOBEM.

Amended Resolution 35(95) Fellow Status Extensions adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. Called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Resolution 13(95) Fellowship Criteria not adopted. Sought to add a five-year practice track plus certification in certain specialties as a pathway to fellowship.

Substitute Resolution 31(94) Fellow Status adopted. Called for the college to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status not adopted. Called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolution 26(94) Change in Fellowship Criteria not adopted. Sought alternative pathways to fellowship, including a 10-year practice track.

Resolution 5(92) Fellowship Status adopted. Called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. Called for refinement of the requirements for fellow status including the addition of the requirement for active involvement in emergency medicine as the physician’s chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. Called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. Called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took effect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. It directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. It called for additional professional criteria for fellow status eligibility.
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Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

**Prior Board Action – Council Resolutions and other Actions regarding Membership Criteria**

Amended Resolution 9(14) Membership Classification Restructure adopted.

June 2014, reviewed the final report from the Membership Restructuring Task Force and approved cosponsoring the Membership Classification Restructure Bylaws Amendment for submission to the 2014 Council.

April 2014, reviewed an interim report from the Membership Restructuring Task Force and provided guidance on development of a Bylaws Amendment for the 2014 Council to consider.

November 2013, appointed the Membership Restructuring Task Force to address Referred Resolution 11(13) Membership Restructuring.

Referred Resolution 11(13) Membership Restructuring assigned to the Membership Restructuring Task Force.

Resolution 28(05) Active Membership Eligibility adopted.

Amended Resolution 2(97) Membership Criteria adopted.

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

**Prior Board Action – Council Resolutions and other Actions regarding Fellowship**


Resolution 6(15) Fellowship Criteria adopted.


Referred Resolution 8(14) Fellow Status: Continued vs. Continuous Membership Requirement was assigned to the Membership Committee for review and to provide a recommendation to the Board of Directors regarding further action. The resolution stipulated retention of ACEP Fellow status is contingent on maintaining continuous membership (i.e., no lapse in membership after becoming a Fellow). The Membership Committee recommended to the Board in June 2015 to submit a resolution to the 2015 Council amending the Bylaws to stipulate retention of ACEP fellow status is contingent on maintaining “continuous” membership (no lapse in dues) instead of “continued” membership. The Board did not adopt the recommendation and the proposed resolution was not submitted to the 2015 Council.

Resolution 7(14) Fellow Status – Housekeeping Changes Bylaws Amendment adopted. Removed language no longer applicable and clarified the terms “Fellow” and “Fellow Status” by removing the word “Fellowship.”

Resolution 9(08) Fellowship adopted.

Amended Resolution 11(07) Fellowship adopted

Resolution 5(06) Eligibility Criteria for Fellow Emeritus adopted.
Amended Resolution 4(06) Fellow Emeritus adopted.

February 2006, the president appointed a task force to consider the political, economic, and personal implications of opening ACEP fellowship eligibility to all active members of the College. A preliminary report was submitted to the Board in June and will be provided to the 2006 Council for its information. The final report is expected in

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted the procedure that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, if their board certification and previous fellow status is current.

Resolution 1(99) Fellowship – AOBEM and ABP adopted.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted the first resolved and contested the second resolved.

Amended Resolution 35(95) Fellow Status Extensions adopted.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted.

Substitute Resolution 31(94) Fellow Status adopted and asked the Bylaws Committee to provide language for the 1995 Council.

March 1993 adopted a change to the deadline for reapplication for fellow status to May one of each year and allowed for members to reapply for fellow status as they recertify with ABEM.

January 1993 adopted a change to the deadline for new fellow applications to December 15.

Resolution 5(92) Fellowship Status adopted.


Endorsed Amended Resolution 6(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Resolution 8(89) Fellowship Requirements adopted.

Resolution 4(89) Fellow Requirements adopted.

Resolution 54(86) Fellow Status adopted.

Amended Resolution 4(81) Fellow Status adopted and referred to the Membership Committee for the development of procedures.

Substitute Resolution 7(74) amended and adopted.

Prior Board Action – Policy Statements

ABEM and other organizations are referenced in numerous policy statements. The following is a partial listing:


October 2016, approved the revised policy statement “Role of the State EMS Director;” revised and approved April 2009; originally approved October 2004.

April 2016, approved the policy statement “CME Burden.”

January 2016, approved the revised policy statement “Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment;” revised and approved April 2012; reaffirmed September 2005; revised and approved with the current title June 1999, June 1997, and August 1992; originally approved January 1984 with the title Certification in Emergency Medicine.”


June 2013, approved the revised policy statement, “Providers of Unsupervised Emergency Department Care;” revised and approved June 2013, reaffirmed October 2007; originally approved June 2001.

January 2012, approved the revised policy statement “Recognition of Subspecialty Boards in Emergency Medicine;” originally approved August 2007.


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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 18(17)

SUBMITTED BY: Arizona College of Emergency Physicians

SUBJECT: ACEP Wellness Center Services

PURPOSE: Explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Wellness Center and explore ways to better promote the resources provided.

FISCAL IMPACT: Budgeted committee, section, and staff resources. Approximately $50,000 to restore lab services.

WHEREAS, A decision (based largely on financial considerations) was made to eliminate certain wellness services (i.e., Screening Labs, Immunizations, Burnout Survey, BMI, etc.) traditionally available at the Wellness Center as part of the Annual ACEP Scientific Assembly; and

WHEREAS, The Wellness Center itself is being modified with limited information included in the Annual Conference materials and promotions; and

WHEREAS, Alternative funding options (e.g., use of personal insurance reimbursement, now mandated at no cost to the consumer via the ACA and/or sponsorship of the Wellness Center by third parties) may be possible; and

WHEREAS, Outsourcing of the Wellness Center “billable” services to a third party (who could assume responsibility for provision of services and billing) would result in a significant profit margin such that it could potentially offset the cost of booth space and personnel for a net INCREASE in revenue for ACEP; and

WHEREAS, Physician wellness has been the subject of passionate, hard fought, past Council debates in efforts to bring awareness to the many issues surrounding wellness; and

WHEREAS, There is no evidence ACEP members are not in need of such wellness efforts (i.e., we are all now perfectly healthy), and, perhaps to the contrary, a lack of awareness (despite traditional promotion) has apparently led to a dramatic decrease in utilization of the Wellness Center services and other ACEP wellness resources; and

WHEREAS, There is limited mention (as of June 2017) of wellness services in the current ACEP17 conference materials on the website or in print; and

WHEREAS, There have been several examples of ACEP members that have experienced life-saving and life-altering information via the Wellness Center over many years; therefore be it

RESOLVED, That ACEP explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Annual Conference Wellness Center; and be it further

RESOLVED, That ACEP explore ways to better promote available resources for the wellness center at the Annual Conference and in general throughout the year.

References
2. Policy on Physician Impairment (Revised 2013): {EXCERPT} ACEP endorses the following principles: Emergency
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physician groups, employers, and residency programs should promote wellness, burnout prevention, early recognition of and non-punitive mechanisms for reporting potential impairment, and early intervention and treatment or other forms of assistance to help prevent or resolve impairment.  

https://www.acep.org/clinical---practice-management/2017-policy-compendium

3. ACEP Vision Statement (Approved February 18, 2003): {EXCERPT} Emergency physicians practice in an environment in which their rights, safety, and wellness are assured.  

https://www.acep.org/clinical---practice-management/2017-policy-compendium

4. ACEP Wellness Booth Brings One Member a Health Warning. ACEP News. October 9, 2014  
http://www.acepnow.com/article/acep-wellness-booth-brings-one-member-health-warning/

Background

This resolution directs ACEP to explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Wellness Center and explore ways to better promote the resources provided.

In 1988, ACEP formed a Wellness Working Group that identified wellness topics upon which the College could focus. One year later, in 1989, ACEP formed a Wellness Task Force with wellness-related objectives. The task force paved the way for the formation of the committee. In 1990, ACEP officially formed the Personal & Professional Well-being Committee. The following year it was re-named the Well-Being Committee.

The ACEP Member Wellness Booth was established in 1992 by Richard Goldberg, MD, FACEP, and other members of the Well-Being Committee. Originally, the committee collaborated with the Department of Emergency Medicine at the Los Angeles County and University of Southern California Medical Center as well as ACEP’s California Chapter in establishing a wellness booth at the annual Scientific Assembly in Seattle, WA. Funding was provided by the Department of Emergency Medicine, LA County+USC and grants from outside entities. Originally, the services were offered free-of-charge to all physician registrants and included distribution of literature on wellness-related topics, measurement of blood pressure and body fat, measurement of serum cholesterol with a drop of blood, and a burnout survey. In 1995, ACEP took over the funding of the Wellness Booth as a member service and through the years, different offerings have been added based on member suggestions at the booth. Its historic purpose has been to provide health-screening services and promote awareness of the many factors impacting the physical and emotional health of emergency physicians.

The Well-Being Committee was charged to “monitor and make recommendations for offerings and services at the ACEP Wellness Booth and the promulgation of information to members for their individual wellness and health screening.” To provide the most informed set of recommendations possible, the committee collected data from the following sources: historic usage metrics and expenses; survey data compiled from ACEP members attending ACEP16; suggestions from members who utilized the Wellness Booth services at ACEP16; and suggestions made by committee members.

Historic Wellness Booth Usage Data and Financial Data

The first five years saw large numbers of members attending the Wellness Booth and utilizing its services. Peak attendance came in 2004, the year when there was a general shortage of flu vaccine, but availability of the vaccine at the Wellness Booth. Attendance and usage of specific services, including the burnout survey, has declined each year. Since 2010, total visits to the Wellness Booth declined ~ 49%. Labs and services have seen similar decreases.

<table>
<thead>
<tr>
<th>Year</th>
<th>Wellness Booth Sales</th>
<th>4-day Paid Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>752</td>
<td>4213</td>
</tr>
<tr>
<td>2008</td>
<td>579</td>
<td>4561</td>
</tr>
<tr>
<td>2009</td>
<td>763</td>
<td>4680</td>
</tr>
<tr>
<td>2010</td>
<td>567</td>
<td>5952</td>
</tr>
<tr>
<td>2011</td>
<td>488</td>
<td>5718</td>
</tr>
<tr>
<td>Year</td>
<td>Visitors</td>
<td>Surveys</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>2012</td>
<td>460</td>
<td>5413</td>
</tr>
<tr>
<td>2013</td>
<td>408</td>
<td>6224</td>
</tr>
<tr>
<td>2014</td>
<td>332</td>
<td>6535</td>
</tr>
<tr>
<td>2015</td>
<td>313</td>
<td>6508</td>
</tr>
<tr>
<td>2016</td>
<td>299</td>
<td>7461</td>
</tr>
</tbody>
</table>

**Visitors and Burnout Surveys Taken Over Time — ACEP Wellness Resource Center**

Member ticket prices have increased over time:

- 2003, 2004: $10
- 2005, 2006: $15
- 2007 – 2010: $20
- 2011, 2012: $30
- 2013 – 2015: $50

Historic costs vary due to the volume of participation, as do increases in the costs of labs. Direct annual expenses:

- 2012-13: $67,708
- 2013-14: $48,409
- 2014-15: $46,206
- 2015-16: $43,787
- 2016-17: $47,235

ACEP’s corporate development team has tried to secure sponsorship for the Wellness Booth for many years with limited success (only twice in seven years). In 2016, a total of $10,000 in external funding was received.

The Wellness Booth, now called the “Wellness Resource Center” (WRC) has provided benefits to ACEP members for the last 17 years. However, the overall number of members taking advantage of the benefit is steadily diminishing, and the WRC has operated at a financial deficit since FY 12-13.
Approximate Financial Loss Summary (Direct expenses less ticket sales and any sponsorship)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>($51,598)</td>
</tr>
<tr>
<td>2013-14</td>
<td>($22,909)</td>
</tr>
<tr>
<td>2014-15</td>
<td>($28,566)</td>
</tr>
<tr>
<td>2015-16</td>
<td>($27,987)</td>
</tr>
<tr>
<td>2016-17</td>
<td>($28,585)</td>
</tr>
</tbody>
</table>

Survey Data
In an attempt to obtain the most updated opinions from the ACEP membership, a survey about the WRC was sent to all ACEP members who attended ACEP16. The survey population included all 4-day registrants who are ACEP members, life members, honored guests, and faculty. Medical student and resident attendees were not included in the survey. The survey consisted of 12 questions, many with the option of providing open-ended answers. The survey was sent to a total of 4,043 attendees on December 7; the survey closed December 22, for a survey period of 2 weeks. Non-respondents received a reminder notification mid-way through the survey period. There were a total of 336 responses, for a response rate of 8.3%.

Highlighted items from the survey:
- Reasons why people have not used the WRC:
  - Didn’t know it existed/unaware of it
  - Receive care from own primary care physician (63% see PCP--see Q 10)
- $50 cost is perceived as good value by 67% of respondents
- 59% of respondents would be more likely to use the WRC if hours were earlier and if it were located more conveniently
- Only 40% of respondents would be interested if WRC services were available to spouses/children/guests
- Additional offerings of most interest (question 12) were: personal resiliency (41%), sleep survey (39.6%), mindfulness workshop (39%), one-on-one session with professional life coach (34.6%), and exercise-related activities (34%)
- Question 5 asked about services respondents would like to continue (see graph).

Suggestions for the Wellness Resource Center
Suggestions on how to update the WRC were solicited from ACEP members who used the WRC at ACEP16 and from members of the Well-Being Committee and the Wellness Section. Not surprisingly, this group is overwhelmingly in
support of sustaining the WRC and having it remain at the annual meetings. Suggestions grouped into a few major categories:

- **Accessibility:** Many requested that the WRC be more accessible by placing it outside the Exhibit Hall and provide earlier hours for those fasting for blood work. Other comments suggested providing services to spouses/partners/guests for a fee (to be determined).

- **More targeted labs/vaccines:** Many suggested deleting the flu vaccine, but replacing it with a pneumonia vaccine. Others indicated certain labs were not useful (as supported by specific lab usage data from 2012-16.) and some labs could be dropped to reduce expenses.

- **Advertising and Sponsorship:** Many suggested that more aggressive and broader advertising/marketing of the WRC to ACEP members would help increase attendance and usage of the benefit. Marketing, in conjunction with improved WRC location at the meeting, was also suggested. Furthermore, some suggested that broader industry support of the WRC would be appropriate.

- **Expanded Range of Services:** The meaning of “wellness” and “well-being” has changed in the last 17 years. Wellness previously referred primarily to physical health and the WRC services reflected that general meaning. Wellness now refers to much more than just physical health; it refers to many inter-related life components including social, mental, emotional, vocational, financial, and spiritual well-being. The current format of the WRC does not address many elements of the expanded concept of wellness. Many suggested changes to the WRC called for an expansion of services that address all areas of wellness. Suggestions included offering the following:
  - Painting classes
  - Mini-Yoga sessions
  - Qi Gong demonstrations
  - Exercise-related activities: yoga, morning jog coordination, guided meditation, fitness sessions
  - Poetry writing classes
  - One-on-one sessions with a professional coach
  - Cooking classes (healthy recipes with an in-booth chef)
  - Personal Resiliency Survey with recommendations
  - Hands-on seminars for de-escalation of workplace violence techniques
  - Group counseling on how to de-stress (without alcohol)
  - Jazz music sessions
  - Personal Sleep Survey with recommendations
  - Invited speakers to present wellness topics
  - Mindfulness workshop

Based upon the wide-ranging collection of information on the WRC, the Well-Being Committee recommended, and the Board approved in January 2017:

1. Changing the name of the Wellness Booth to the Wellness & Resiliency Center (WRC).
2. The WRC mission statement: “To promote wellness and resiliency in Emergency Physicians by providing resources and access to quality resources and services.”
3. Renew and uplift the WRC so that members truly have a “wellness experience.”
   a. Move the wellness center out of the exhibit hall and to a high-profile area.
   b. Market and promote the WRC aggressively.
   c. Retain the labs at the WRC for one more year (except for flu shots) and open lab services to non-ACEP members.
   d. Open the WRC prior to *ACEP17* and be available for Council meeting attendees and Board members during the Council meeting, providing a laboratory premium package, with the ability to open earlier (and therefore close earlier) for those needing to fast for blood work.
   e. Discontinue administration of flu shots.
   f. Provide most/all of the other services mentioned on the survey to include fitness opportunities, education, assessment tools, and other assorted wellness services.

The committee also recommended conducting another in-depth assessment of the WRC after *ACEP17*. If it is determined that usage of the WRC continues to drop, additional considerations and actions would be warranted.
Resolution 18(17) ACEP Wellness Center Services

Page 6

Upon further review and discussion with key stakeholders, there was critical information discovered that was not available to the Board in January 2017 to make a thoroughly informed decision. The space at the Walter E. Washington Convention Center in Washington, DC, and current space assignments, make it impossible to expand or move the Wellness Booth outside of the exhibit hall. Additionally, after consultation and discussion with Well-Being Committee leaders and staff, there was consensus to recommend discontinuing the laboratory services as part of the WRC since the use of lab services has been declining in the last several years. It has become easier for members to obtain lab services, especially flu shots, and when obtained at the booth there is additional paperwork involved to document the services. Providing lab services results in a $50,000 loss to ACEP as the fee charged does not cover the actual cost. Exhibit booths surrounding the Wellness Resource Center have already been sold at a premium price because of its proximity and those premiums would need to be refunded if the Wellness Resource Center is moved.

In April 2017, the Board rescinded their decision to relocate the WRC outside the exhibit hall, retain the laboratory services for one more year, and provide access to the WRC during the Council meeting.

Staff are working with the Well-Being Committee to rework the Wellness & Resiliency Center inside the Member Resource Center and will offer many new and innovative elements to promote wellness among members and other ACEP17 attendees:

1. #meetupatWellness Twitter account
2. Wellness Center TV – contains a loop of wellness videos
3. “Your Space in the ED” – Static set-up of ergonomic ED with standing desks, lighting, ergonomic chairs, sound cancelling headphones, computer screens, age-related adaptations, pregnancy, breast feeding, etc.
4. Wellness Center Story Booth “Come Tell your Story” will feature the ability to record 90-second stories with one of 4 prompts
5. Wellness Center Mural – “Come Share your Imagination” “Wellness is________” Show your happy place.
   Markers on 20 x 10 board (or larger), guided by an artist.
6. Wellness Center Montage – “Come Take Your Picture with your Residency Class” – grouped by regions of the country (states) with designated times to meet.
   – post videos of wellness activities
   – large screen printed with “BEING WELL IN EMERGENCY MEDICINE ACEP 2017”
7. “Legends of the College” – Wellness Champions will feature 5-minute talks by several prominent ACEP members. Wellness TED Talks at the Wellness Center, provided by Well-Being Committee members, Wellness Section members, and EMRA members. These will be recorded and used for the 2018 Wellness Week.
8. Morning Workouts:
   No Joe, Wake Up and Go
   Skip the coffee and enjoy a 30-minute stretch session that begins with breathing awareness, meditation, and simple stretches to energize your body. No special workout clothes or shoes needed.
   Ways to Tell If You Might Have a Food Allergy?
   Simple 5-minute assessment tool to see if you have a food allergy.
   Personal Assessment investment
   Looking for some personal attention to improve your health and well-being. Drop in for a 5-minute VEST test and learn where to begin with living optimally. Includes:
   - Visual postural alignment (exercise)
   - Eating IQ (nutrition)
   - Sound sleep assessment (recovery)
   - Total plan for optimal health (receive ¼ plans to start living better)
9. Interactive Wellness Sessions:
   Performing at Your Best
   Simple ways to improve your health, diet, sleep and sex life. Break down the barriers to feel your best in every area of your life.
   Traveling Tips for Healthy Eating with and without Food Sensitivities
   Is prepping meals and making good choices taking a toll on your waistline? Learn simple ways to make a fast breakfast, lunch and dinner plus why eating out may keep your belly and wallet trimmer.
   5 Ways to Improve Your Energy Balancing work, family and free time can zap your energy pool. Let’s peel away what’s dragging you down and learn 5 strategies for putting some pep in your step.
10. Interactive Food Demos:
   **All Juiced Up**
   No time for eating your fruits and veggies? Simple ways to juice up your diet and discover nuts in a new way.
   **Yogurt for Dinner**
   Greek yogurt is a good source of calcium, probiotics, and protein… but why save it only for breakfast? Learn the sweet and savory side of eating Greek.
   **Get Jerky**
   The latest trend on fast food snacks is protein. Taste the latest flavors that are beefing up this portable snack.

Staff did explore the possibility of having the lab testing company file insurance claims for members. The company declined citing that it would be necessary to set up a contract with every major insurance carrier, some insurers do not like for wellness vendors to compete with their internal offerings, and there are varying reimbursement rates and some carriers will not pay for any testing except a lipid panel.”

**ACEP Strategic Plan Reference**

Goal 2 – Enhance Membership Value and Member Engagement
   Objective C – Promote member well-being and improve resiliency.

**Fiscal Impact**

Budgeted committee, section, and staff resources. Approximately $50,000 to restore lab services. The actual cost in FY 2016-17 for lab services was $46,297.

**Prior Council Action**

Substitute Resolution 13(99) Wellness Booth not adopted. Called for ACEP to promote the Wellness Booth in the exhibit hall at each Scientific Assembly and make every effort to ensure that adequate funding for the booth continues annually, regardless of financial support from corporate sponsors.

**Prior Board Action**

April 2017, rescinded the decision to relocate the Wellness Booth outside the exhibit hall, retain the laboratory services for one more year, and provide access to the booth during the Council meeting.

January 2017, approved several recommendations from the Well-Being Committee regarding the Wellness Booth, including relocating it from the exhibit hall to another location.

June 1992-present approved budget for the Wellness Booth.

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

**Reviewed by:** James Cusick, MD, FACEP, Speaker
   John McManus, MD, FACEP, Vice Speaker
   Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 19(17)

SUBMITTED BY: Emergency Medicine Research Section

SUBJECT: Advocacy and Support for “Scholarly Activity” Requirements for Emergency Medicine Residents

PURPOSE: Work with several stakeholders to develop a uniform, consistent approach towards the scholarly activity for residents using a consensus approach.

FISCAL IMPACT: Budgeted staff resources. Additional travel costs of approximately $15,000 to convene one in-person meeting.

WHEREAS, Scholarly activity is a requirement for Emergency Medicine residents in allopathic programs and osteopathic programs; and

WHEREAS, Scholarly activity has been left to the interpretation of residency programs, and there exists vast variability in its interpretation; and

WHEREAS, A research curriculum should be in place as a part of the scholarly activity requirement; and

WHEREAS, The research curriculum is ill defined in most residencies, with very little dedicated time during residency training for research; and

WHEREAS, Institutions should provide support to residents completing scholarly activity; therefore be it

RESOLVED, That ACEP work with the Council of Emergency Medicine Residency Directors, the Society for Academic Emergency Medicine, the American College of Osteopathic Emergency Physicians, the American Osteopathic Association, the Emergency Medicine Residents’ Association, and the Residency Review Committee for Emergency Medicine to develop a consensus derived, uniform, consistent approach towards scholarly activity for residents to foster the future of Emergency Medicine research.

References
1. ACGME Common Program Requirements (ACGME approved focused revision: September 29, 2013; effective: July 1, 2016)
2. AOA Basic Documents for Postdoctoral Training, Effective 7/1/2016
3. Accreditation Council for Graduate Medical Education (ACGME) Resident/Fellow Scholarly Activity, Updated 10/2016

Background

This resolution asks ACEP to work with several stakeholders to develop a uniform, consistent approach towards the scholarly activity for residents using a consensus approach.

Scholarly activity has been required of residents for many decades. Program requirements for both the Accreditation
Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA)/American College of Osteopathic Emergency Physicians (ACOEP) include a scholarly activity as one of the requirements for the resident.

An early argument against board recognition for emergency medicine was that there was not a unique body of knowledge. Initially, the requirement for a scholarly activity, and for scholarship by faculty, was to produce that body of knowledge and foster improvement in patient care.

The program requirements of the AOA/ACOEP state:

“The resident shall complete a research project during the course of the emergency medicine training program that will be sent to the ACOEP in the following manner. The resident shall submit an outline for the project by the end of the osteopathic graduate medical education (OGME)-2 training year, implementation and data collection methods and provide an interim report by the end of the OGME-3 year, and a final product suitable for publication six months prior to the completion of the OGME-4 year of residency. A permanent copy shall be retained in the resident’s file at the institution. All research projects shall be approved by the program director.”

The program requirements of the ACGME state:

“IV.B.1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
IV.B.2. Residents should participate in scholarly activity.
IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.”

Interpretation of what constitutes a scholarly activity has largely been left up to the individual program. In 1999, the Society for Academic Emergency Medicine (SAEM) attempted to define the requirement by defining the goals of the scholarly activity. The consensus of that group was that the primary role of the scholarly project is to “instruct residents in the process of scientific inquiry, to teach problem-solving skills, and to expose the resident to the mechanics of research.” In this same document they suggested that the project “should include the general elements of hypothesis formulation, data collection, analytic thinking, and interpretation of results” and that it should be written up with a literature review.

In 2014, the ACGME, the AOA, and the American Association of Colleges of Osteopathic Medicine (AACOM) announced that there would be a single accreditation system for graduate education. The consolidated program would be phased in over several years, becoming fully adopted July 1, 2020. This change allows for a reexamination and possible reinterpretation of the scholarly activity.

In 2013, ACEP’s Research Committee, with assistance from the Council of Emergency Medicine Residency Directors (CORD), conducted a survey of program or research directors of allopathic and osteopathic emergency medicine residency programs. The survey demonstrated high variability in the interpretation of the requirements for scholarly activity. Only 39% of the responding programs required a formal research project. There was no difference in the number of residents who went on to academic careers between programs that required a research project and those that did not. At that time, 76% of the respondents said they would support a national initiative to define the scholarly activity. The committee recommended that ACEP collaborate with CORD to develop a standardized definition of the scholarly activity requirement. An article was published in the July 2015 issue of Academic Emergency Medicine titled “Improving the Emergency Care Research Investigator Pipeline” as a collaborative effort with SAEM’s Research Committee.

In 2017, SAEM revisited the consensus document from 1999. That group has just finished its work and has a publication pending. Its focus is on the primary role/outcome of the scholarly project and the general elements as outlined above.
Currently, the interpretation of “scholarly activity” is determined by the individual residency director. Because of the ambiguity of the requirement, some residents may fulfill the requirement by giving a lecture or doing a literature review. Other programs require that the residents complete a research project with IRB approval that is potentially publishable. Providing direction to residency directors and residents would allow a more consistent education.

References

ACEP Strategic Plan Reference
None

Fiscal Impact
Budgeted staff resources. Additional travel costs of approximately $15,000 to convene one in-person meeting.

Prior Council Action
None

Prior Board Action
June 2014, approved dissemination of the “Pipeline Survey on Research” results on resident scholarly activity and resident research curriculum and supported implementation of proposed strategies.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 20(17)

SUBMITTED BY: Douglas Char, MD, FACEP
Marco Coppola, DO, FACEP
Henderson McGinnis, MD, FACEP
Jamie Shoemaker, MD, FACEP
Annalise Sorrentino, MD, FACEP
Jennifer L'Hommedieu Stankus, MD, JD, FACEP
Arlo Weltge, MD, FACEP
Anne Zink, MD, FACEP

SUBJECT: Campaign Financial Reform

PURPOSE: Directs the Council Steering Committee to: 1) create expenditure limits in the Candidate Campaign Rules; 2) amend the Rules regarding chapter visits by candidates; 3) consider other changes in the election process such as financial disclosures, other campaign expenditure limitations, prohibiting chapter and residency visits during the period of declared candidacy, restricting publication of non-scholarly work in non-peer reviewed journals, and restricting the use of social media.

FISCAL IMPACT: Budgeted Council and staff resources for the Council Steering Committee, updating the Candidate Campaign Rules, and distributing the updated Rules to candidates.

WHEREAS, The American College of Emergency Physicians (ACEP) is the world’s premier and leading organization representing emergency medicine and its members; and
WHEREAS, It is an honor and a privilege for an ACEP member to serve in leadership roles; and
WHEREAS, The founders of ACEP made every attempt to “level the playing field” so that pursuing leadership opportunities would not be hindered because of exorbitant financial obligations and hardship; and
WHEREAS, In recent years, many candidates for Council Officer, the Board of Directors, and the President-Elect have increased expenditures to appear at chapter annual meetings to “campaign” for their candidacy; and
WHEREAS, Appearances at chapter annual meetings would hinder the candidacies of qualified individuals from geographically remote areas; and
WHEREAS, Also in recent years, many candidates for Council Officer, the Board of Directors, and the President-Elect have increased expenditures for professional “coaches,” fashion consultants, and high quality video presentations; and
WHEREAS, Such need for increased expenditures would limit the variety of candidates for leadership positions to those who are older in age and have more financial resources; and
WHEREAS, Such need for increased expenditure would also exclude members from a younger demographic and those from academic circles who may lack financial means; and
WHEREAS, The Leadership Development Advisory Group, the National/Chapter Relations Committee, and the Compensation Committee have long recognized the financial concerns and hardships of members considering candidacy; and
WHEREAS, The campaign rules of the American Medical Association state, “Candidates for AMA office should not attend meetings of the state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.;” therefore be it

RESOLVED, That the Council Steering Committee create expenditure limitations in the Candidate Campaign Rules to allow younger members to consider candidacy for leadership positions without the concern for financial means; and be it further

RESOLVED, That the Candidate Campaign Rules be amended by adding: “Candidates will not attend annual chapter meetings unless officially invited, on the meeting’s agenda for a planned educational endeavor, and accept reimbursement of travel expenses in accordance with the chapter’s policies.;” and be it further

RESOLVED, That the Council Steering Committee consider changes in the election process such as:

• requiring candidates to disclose financial expenditures on their candidacy;
• capping the monetary amount that can be used on all candidate-related expenditures, including travel, “coaches,” videos, etc.;
• prohibit ACEP residency and ACEP chapter visits for each candidate during the period of declared candidacy;
• restricting publication of non-scholarly work in non-peer reviewed journals such as ACEP Now and other Emergency Medicine open subscription media; and
• restricting social media “public service announcements.”

Background

This resolution directs the Council Steering Committee to: 1) create expenditure limits in the Candidate Campaign Rules; 2) amend the Rules regarding chapter visits by candidates; 3) consider other changes in the election process such as financial disclosures, other campaign expenditure limitations, prohibiting chapter and residency visits during the period of declared candidacy, restricting publication of non-scholarly work in non-peer reviewed journals, and restricting the use of social media.

The Candidate Forum Subcommittee, a subcommittee of the Council Steering Committee, is tasked with the responsibility of reviewing the Candidate Campaign Rules each year and recommending any changes to the Steering Committee. The subcommittee is also responsible for developing the requirements for candidate campaign material and implementing the annual Candidate Forum. The intent of creating and implementing the Campaign Rules is to ensure fairness in the campaign process for all candidates. This process has been in place for decades, although the Campaign Rules have evolved over the years to address campaign issues that have arisen and also based on feedback from councillors and the candidates. The intent is not to be proscriptive or prevent members from learning as much as they can about each candidate.

The Council Steering Committee has discussed campaign expenditure limitations many times over the years and has attempted to make changes that are reasonable and fair to all candidates. Many individuals who have considered seeking nomination have reported that the expense for being a candidate is a barrier.

The Steering Committee has struggled with prohibiting, or limiting, the amount of travel for candidates. Visits to various chapters by candidates is typically self-funded, although some candidates may receive a portion of their travel costs paid by the chapter if serving as faculty for the meeting. Some smaller chapters have expressed concerns because the candidates do not necessarily give equal consideration for attending the smaller chapter meetings. Attending chapter meetings is a great opportunity to learn about the chapter and not just an opportunity for campaign purposes. There may be unintended consequences if chapter visits by candidates are banned and it may be difficult to enforce such a rule, particularly if a candidate (or candidates) is invited to participate in their program. However, it may be an unfair advantage to the candidate(s) invited to attend a chapter meeting and other candidates are excluded.
The last Resolved asks the Steering Committee to consider additional campaign limitations. Some of these suggestions are addressed in the Campaign Rules, but not to the extent that is requested. This year, the candidates were required to disclose the financial expenditure for developing a video (if one was submitted). Limiting residency visits by candidates could have unintended consequences. Residency programs can select whomever they want for the visit, and their selection is probably not because the individual is a candidate for ACEP president-elect or the ACEP Board of Directors. The current Campaign Rules prohibit communications and/or interviews regarding candidacy in emergency medicine newsletters or publications other than those published by ACEP, but allows publication on issues other than candidacy. Restrictions regarding the use of social media are also included.

**ACEP Strategic Plan Reference**

Goal 2 – Enhance Membership Value and Member Engagement

**Fiscal Impact**

Budgeted Council and staff resources for the Council Steering Committee, updating the Candidate Campaign Rules, and distributing the updated Rules to candidates

**Prior Council Action**

Each year the Council Steering Committee reviews and approves the Candidate Campaign Rules. All action taken by the Steering Committee is subject to final approval by the Council at the next regularly scheduled meeting. This action occurs by the Council ratifying the minutes of the Steering Committee meetings.

Resolution 16(14) Freedom of Speech not adopted. Requested the Council to revoke the Candidate Campaign Rule prohibiting communications or interviews in non-ACEP publications by candidates and encourage candidates to conduct such interviews.

1992, the Council Speaker appointed a Council Steering Committee Subcommittee on Election Norms to develop a paper on Norms of Behavior for Elections.

Resolution 19(76) Expenditure of Funds for Campaigning adopted. Limitation of campaign expenditures provided by the College in its official publications.

**Prior Board Action**

None. The Board does not take action on the Candidate Campaign Rules.

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

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 21(17)

SUBMITTED BY: Emergency Medicine Informatics Section

SUBJECT: Creation of an Electronic Council Forum

PURPOSE: Seeks to create a year-round forum to introduce, debate, and vote on resolutions, use the results of the votes in the electronic Council forum as nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues, and that the electronic Council forum feature include a user experience that can be used during the Council meeting to receive and display proposed amendments in real time during discussion and voting.

FISCAL IMPACT: Unknown actual costs to create a new electronic forum. Also unknow at this time whether ACEP’s Technology Services staff would be used to create the forum or if an outside firm would be required. Costs of the project depend on the scope of work. Additional staff resources would be needed to monitor the forum.

WHEREAS, ACEP is the largest organization in the world for addressing the concerns of Emergency Physicians; and

WHEREAS, ACEP addresses a broad range of physician practice, regulatory, and practice environment issues and challenges on a dynamic basis; and

WHEREAS, The Council meets only one time a year, creation of an electronic Council forum would afford a forum for issues that occur at times not conveniently addressed by the current annual meeting; and

WHEREAS, The ACEP annual meeting allows the Council body to offer guidance to the Board of Directors; and

WHEREAS, The leadership does an able job, but by using electronic methods, the Council’s membership could be afforded the opportunity to provide interim guidance, input and feedback on emergent issues, as well as offering a venue for broader pre-meeting debate of annual meeting resolutions; and

WHEREAS, We are maturing as a specialty and have grown significantly as a Council, we should move to the 21st century communication methods in an effort to be more inclusive and democratic to encourage thoughtful input from the entire Council body; and

WHEREAS, There can be confusion during the Council meeting as to what is being discussed and being called to question leading to unnecessary delays and even errors; therefore be it

RESOLVED, That the Board of Directors task the appropriate committees to create a year-round forum for councillors to introduce, debate, and vote on resolutions; and be it further

RESOLVED, That the results of the votes in the electronic Council forum be nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues; and be it further

RESOLVED, That the electronic Council forum product feature include a user experience that can be used during the annual Council meeting to receive and display proposed amendments in real time during discussion and voting.
Background

This resolution seeks to create a year-round forum to introduce, debate, and vote on resolutions, use the results of the votes in the electronic Council forum as nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues, and that the electronic Council forum feature include a user experience that can be used during the Council meeting to receive and display proposed amendments in real time during discussion and voting. The authors of the resolution have provided a description of how they envision the forum would work and additional commentary for the Council to review and understand their proposal (Attachment A).

In 2013, the Council Steering Committee considered a similar proposal as described in this resolution. A subcommittee was assigned to review the proposal and provide a recommendation to the Steering Committee. The subcommittee received information regarding Texas law, which governs ACEP’s operations. Texas law specifies that there is no better process than face-to-face deliberation where everyone has the opportunity to participate and receive the same information. After much discussion regarding the pros and cons, the Steering Committee determined that a change in the current resolution process was not needed at that time.

There are several process issues for the Council in considering this resolution. The traditional format of the annual Council meeting is a time-honored tradition. While some may favor a new electronic means of conducting Council business, the traditional method continues to provide the Council an effective means of operation.

A comprehensive analysis needs to be conducted to determine the financial and human resource costs. A new electronic forum may create a substantial increase in the amount of work for the Council officers, councillors, and staff. Additional staffing may be needed to implement the electronic forum. Potential unintended consequences in implementing a new system could be “Council work fatigue” and discouraging members’ willingness to participate in the Council if additional work is required beyond the current timeframe.

ACEP’s Bylaws and Council Standing Rules may need to be amended to facilitate a new process for the Council Forum. The Bylaws require component bodies to certify (provide the names) their councillors and alternates (those who are eligible to vote) 60 days prior to the annual Council meeting. Having the Council Forum active year-round could be problematic since the designated councillors would be changing as component bodies determine their councillors and alternates. The timing of submitting a resolution and who is eligible to vote would be inconsistent. The integrity of the voting process could be compromised. Although the results of the electronic forum are nonbinding, it is unknown whether it would enhance or detract from the current process of in-person debate in the Reference Committees and on the Council floor at the annual meeting. The processes for Reference Committees and Council floor debate would need to be revised to accommodate the electronic Council Forum discussions and votes.

Additional processes and criteria for submitting resolutions would need to be developed. The current resolution process requires that background information be prepared by staff on all resolutions submitted by the deadline. The background information is vitally important to inform the Council and it is unclear whether the new electronic forum would include time for staff to prepare background information. It is also unclear whether this new system would be required to submit resolutions to the Council, or whether the traditional process of submitting resolutions would also continue. If both processes are in place, it could be duplicative work.

The Council currently has the ability to discuss issues, and resolutions once they are released to the Council, via the Council e-list (c-mail). Although this is a simple email system, its creation was intended to serve as a forum for councillors to communicate throughout the year on any relevant topic. Its use has declined in recent years, perhaps because individuals experience “email fatigue” from the volume of various email accounts. Several councillors expressed concerns earlier this year, prior to the Council resolution submission deadline, when there were multiple messages posted about some draft resolutions and cosponsors were being sought. Unfortunately, several individuals requested to be removed from c-mail because of the increased number of messages.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Resolution 21(17) Creation of an Electronic Council Forum
Page 3

Fiscal Impact

Unknown actual costs to create a new electronic forum. It is also unknown at this time whether ACEP’s Technology Services staff would be used to create the forum or if an outside firm would be required. The costs are dependent on the scope of work. Additional staff resources would be needed to monitor the forum.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
ACEP is an organization of over 35,000 physicians, residents and medical students operating in an intensely dynamic environment. As councillors, we meet once a year to consider and debate several dozen resolutions to offer guidance to the organization and express the concerns of the rank and file.

Regardless of the presence of 20 or 50 resolutions, the time frame for the management of the resolutions is relatively static: a single weekend. It is an impressive feat, but this structure cannot effectively addresses issues that are emerging in our practice environment.

The concept for this forum started in 2012, about 3 months before our annual meeting in Denver, there was a mass shooting less than 20 miles from where we were meeting. Resolutions were introduced on an emergency basis, but one line of argument against considering the resolutions were the haste with which they were brought and being considered. By the next year, nothing more was introduced on the subject.

Now, this is not about gun control or any single issue. So as a second example consider what we are currently dealing with, the health care act replacement. The evolving stance of ACEP regarding the emerging provisos in the bill is difficult at best given how little information is being provided. Leadership, for example, ultimately came out strongly against any bill that would not support coverage of emergency care, but it took time for the issue to become apparent.

In something so dynamic and immense, the collective Council would have greater resources than the leadership alone in evaluating information and offering feedback to create the strongest possible response and advocacy for our constituents.

Consider that our ability to discuss the current health care act in October will not impact the current conversation and votes this Summer.

LEGAL ISSUE- It has been suggested that under Texas state law that an electronic forum may not be employed to conduct the affairs of an entity incorporated under Texas state law. For this reason the deliberations would be considered NONBINDING.

How the forum works.

For the more visually inclined I have attached PPT slides, but as briefly as I can:

1) Resolutions are introduced either on a rolling basis or in batches, weekly or the 1st and 15th of every month. The latter allows for a clean slate on a regular basis. Emergency resolutions can be introduced at any time.

2) The resolutions go through a vetting process to determine if they are lawful and appropriate. If we go with the batched introduction approach, emergency resolution will be assessed to see if they meet criteria.

3) Councillors with a voting key can then consider the resolution. If any member considers the subject worthy of discussion they second the resolution and debate begins. If no one seconds the resolution in a fixed amount of time (TBD) the resolution “Dies” and cannot be reintroduced for a fixed period of time (TBD- three months in the example).
4) Discussion/debate is open for a period of 1 week in a discussion forum format. Debate can be extended if needed. That mechanism can be a vote to extend or simply empower the moderator to extend it. The latter is simpler in the context of not getting bogged down in sub discussions. There will be one of three outcomes:

1) Quorum not obtained. To have a quorum at the annual meeting, a certain number of councillors must be in attendance. If this number of votes is not obtained, the quorum not met and the resolution dies.

2) The resolution is tabled to the general meeting.

3) An up or down vote.

Certainly, a possible 4th outcome is to defer to the Board. While this would run counter to the point of the forum, circumstances that I cannot see could make that a potential outcome.

In sum, this is a starting point. I don't imagine that this is what the forum will actually look like, but for conceptualization purposes, it should suffice.
Proposal for Electronic Voting Forum for Addressing Emergent Issues while Council is not in Session
Process
Resolution Proposal

Rolling
Batched monthly

Councillors with verification
• ie Voting key number on secure website

Second

Discussion opens

Set time frame (1 week)

Discussion automatically closes 168 hours after second is made

Issue: i.e. Unlawful resolution

No second after fixed time = dies

Voted down-not eligible for reconsideration X3 months

Quorum vote not obtained*

Up or down vote

Table to general meeting

*Since there are a certain number of councillors required to have a quorum, if this many votes are not registered, the quorum is not met and the measure fails.
RESOLVED: 2(12)
SUBJECT: Commendation for Gregory House, MD, FACEP

1 WHEREAS, Gregory House, MD, FACEP, has served the American College of Emergency Physicians in many leadership roles since his election to the Board of Directors, including Secretary-Treasurer, Vice President, President-Elect, and Immediate Past President; and
2 WHEREAS, Dr. House has shown exemplary leadership and outstanding service to the College for his dedication, tireless efforts, and skills on various committees, the ACEP Council, and the ACEP Board;
3 RESOLVED, That the American College of Emergency Physicians commends Dr. Gregory House, MD, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

SUBMITTED BY: California Chapter
SECOND BY: Kel Brackett MD, CA

Seen by
Josiah Barlett
Lyman Hall
Matthew Thornton
Ben Rush

Yeas: NY1 NY2 NY3 MD5 C09
Nays: MA 7 NY 9

Table: MI 4
Abstain: HI 1

Number left to quorum vote achieved #150
Forum interface example 2
Amendments for
RESOLUTION: 2(18)
SUBJECT: Commendation for Kelly Brackett, MD, FACEP

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<td>11 Department of Emergency Medicine at the University of Rochester, serving 14 years as its founding Chair; and</td>
<td>11 Department of Emergency Medicine at Harvard serving 14 years as its founding Chair; and</td>
<td>No</td>
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Pro

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Submitted by: California Chapter
Second by: Kel Brackett MD, CA

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Line as it will read if passed:

*Department of Emergency Medicine at HARVARD, serving 14 years as its founding Chair; and*

Line as it will read if it doesn’t pass:

*Department of Emergency Medicine at University of Rochester, serving 14 years as its founding Chair; and*
"Look, the herd instinct has gotten us this far—why do we need parliamentary procedure now?"
RESOLUTION: 22(17)

SUBMITTED BY: Dual Training Section

SUBJECT: Emergency Medicine Residency Training Requirements for Dual Training Programs

PURPOSE: Work with ABEM and possibly ABMS to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of dual training periods.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Initial Residency Period (IRP) determines the reimbursement received by the hospital where the training takes place; and

WHEREAS, For emergency medicine the IRP is established by the American Board of Emergency Medicine and currently the IRP is listed as either 3 or 4 years; and

WHEREAS, These IRPs were established before dual training programs such as Emergency Medicine-Pediatrics, Emergency Medicine-Internal Medicine, or Emergency Medicine-Critical Care were common; and

WHEREAS, An IRP that does not reflect more extended periods of training may be a financial disincentive to the creation of additional dual training programs; therefore be it

RESOLVED, That ACEP work with the American Board of Emergency Medicine, and possibly the American Board of Medical Specialties, to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of residency, including dual training periods.

Background

This resolution calls for ACEP to work with ABEM and possibly ABMS to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of dual training periods.

Historically, Medicare has been the primary funding source for graduate medical education (GME). 47 states also provide support as a secondary GME funding source. Since its inception in 1965, Medicare has reimbursed teaching hospitals for their portion of the direct GME costs (DME) or DME. DME costs include resident stipends and fringe benefits, faculty salaries and fringe benefits, and administrative overhead.

With the advent of diagnosis-related groups (DRGs) in 1983, Medicare began to include reimbursement for indirect GME costs (IGME or IME). IME payments compensate teaching hospitals for greater inpatient costs from treating higher acuity patients, and indirect costs of GME programs such as decreased faculty productivity and increased lab and diagnostic tests ordered by residents in training.

Over the years, Congress has changed the law upon which formulas for determining DME and IME payments were based. In 1985, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) began to limit DME payments to a resident's period of board eligibility plus one year, with a maximum of five years. After that, Medicare pays 50% of the per resident amount (PRA). For emergency medicine, the initial residency period (IRP) limitation was three years. Considering the recent movement of osteopathic residencies into ACGME, ABEM now affirms an IRP of 3 or 4 years.
For physicians who want to train in more than one specialty (EM/IM, EM/Peds, etc.), CMS notes that “counting for GME purposes, a physician would be limited by his/her ‘initial residency period’ which generally limits full funding to a first residency only. Generally, for a second residency, for direct GME purposes, he/she would be weighted at 0.5 FTE.” The initial residency period rules do not apply for IME and thus, he/she would be counted at 1.0 FTE for IME regardless of how long he/she trains.

Dual training has significant advantages; creating a workforce that can bridge two specialties and provide a perspective otherwise lost. Individuals who practice these dual specialties often receive less reimbursement, yet remain enthusiastic about their practice environment. However, because of the reduced payment, some institutions that provide the training have begun to question this investment. A recent closure of a long-standing EM/IM program for financial reasons raises questions of the financial viability of dual programs.

ABEM sets the IRP, but CMS determines the rules by which the IRP is paid. In addition to ABEM and ABMS, it will be important to advocate with CMS to enact changes to the IRP to reflect dual training.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Emergency Care

Objective D – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Called for the College to address workforce shortage by lobbying for increased EM residency slots and meeting with appropriate organizations to address development of an EM fellowship.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to lobby Congress and pertinent government agencies to reduce the shortage of board certified emergency physicians and lobby Congress and the federal government to eliminate barriers to creating adequate emergency medicine residency positions and achieving optimal funding for those positions.

Prior Board Action

October 2012, approved the revised policy statement “Financing of Graduate Medical Education in Emergency Medicine;” reaffirmed September 2005; originally approved September 1999.

April 2012 reaffirmed the policy statement “Emergency Medicine Workforce;” reaffirmed June 2006; revised and approved September 1999; originally approved November 1987 with the title “Manpower.”

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted.


Background Information Prepared by: Sandra M. Schneider, MD, FACEP

Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 23(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships

PURPOSE: Implement processes enhancing chapter relationships and information sharing; assign Board members and an appropriate staff member to participate in regular contact with chapters; explore concept of developing regional state chapter relationships; provide a report to the 2018 Council.

FISCAL IMPACT: Budgeted staff resources. Additional travel expenses for Board members and staff to attend chapter and regional meetings.

WHEREAS, ACEP and its constituent state chapters have converging interests as expressed in their mutual mission and vision; and

WHEREAS, ACEP and state chapters function philosophically as an integrated goal oriented group of allied intertwined organizations seeking to support Emergency Physicians, assure access for their patients and inform and protect the general citizenry; and

WHEREAS, The directors and leadership of ACEP and state chapters are necessarily changing annually, creating an additional challenge to communication between the national and state organizations; and

WHEREAS, A framework for building and maintaining relationships between and among national and state chapters will allow for collaboration on future projects; and

WHEREAS, In our current 24/7 news cycle, with social media at the forefront of interactions, having a framework to communicate relevant information rapidly and receive feedback from stakeholders quickly is essential; therefore be it

RESOLVED, That ACEP make it a primary goal of the upcoming year to work with state chapters to identify, develop, and implement processes that enhance the relationship, optimizing appropriate and timely information sharing; and be it further

RESOLVED, That individual Board members and an appropriate staff member participate in regular contact with state chapters and report back to the Council in 2018; and be it further

RESOLVED, That ACEP explore the concept of developing Regional State Chapter relationships and report back to the Council on the feasibility and usefulness of doing so.

Background

The resolution requests that ACEP implement processes that enhance chapter relationships and information sharing, assign national ACEP Board members and an appropriate staff member to participate in regular contact with chapters, explore the concept of developing regional state chapter relationships, and provide a report to the 2018 Council.

ACEP has 53 chartered chapters, each governed independently by its own elected Board of Directors. Chapters
advocate for the rights of physicians and their patients, provide CME and other educational resources, news, and leadership opportunities. As would be expected, due to geography and demographics, chapters vary widely in size and available resources. ACEP provides a broad array of resources to chapters consistent with our joint mission on behalf of our specialty and our patients.

ACEP’s Chapter Services Department has responsibility for coordination with and among chapter staff and member leadership. The department conveys ACEP information and resources to the chapters through a variety of programs, including functioning as a liaison between chapter and national ACEP staff, planning for chapter executive forums and audio conferences, and otherwise sharing information to meet chapter needs.

ACEP also promotes leader visit and residency visit programs through which ACEP officers and Board members attend chapter meetings and residencies on a rotating basis. The leader visit program was created in 1989. During his presidency, Jay Kaplan, MD, FACEP, asked staff to prioritize planning of leader visits to all chapters that had not received a visit within the last five years. The objective was achieved.

The concept of assigning Board Liaisons to chapters has been implemented and revisited several times, beginning in June 1997 when the Board decided to submit a resolution to the Council to close the membership of the College as of December 31, 1999. A campaign was undertaken to contact councillors and other chapter leaders to discuss the resolution and encourage its adoption. Each Board member was assigned specific chapters to contact. The campaign, along with many communication strategies, was successful and the 1997 Council ultimately adopted the resolution. The Board decided to continue with the concept of Chapter Board Liaisons for the next few months and provide reports at each Board meeting regarding any concerns or issues facing chapters. Board members often reported on the difficulty in contacting chapter leaders and the program was discontinued in June 1998.

In January 2010, the Board again considered establishing Board Liaisons to chapters. There was consensus to delay implementing such a program at that time. The potential program was discussed again in January 2012. There were mixed reactions to establishing a formal program and questions were raised about the potential responsibilities for the Board and chapter leaders. A workgroup was assigned to further investigate establishing a program.

In May 2012, the National/Chapter Relations Committee discussed the concept of Board liaisons to chapters. There was unanimous and strong support from the committee and their recommendations were presented to the Board in June 2012 to develop a pilot program with the goal of improving communications between national and chapters. The Board approved establishing a one-year pilot program with the chapters most likely to benefit from such a program (identified as small chapters and unstaffed or utilizing part-time staffing).

Chapter Liaison Pilot Program Description

1. Pilot program for two years.
2. Send program information to all chapters; participation is optional.
3. Communication with chapters will be by email or phone call.
4. Chapters will absorb the cost for the Board liaison to visit the chapter.
5. Pilot program would not replace the Leader Visit Program. A chapter in the rotation schedule for the year may request whomever they wish for the leader visit.
6. Board liaison assignments made by the president.
7. Board liaisons contact designated chapters quarterly and provide feedback to the Chapter & State Relations Department.
8. At the end of each year of the pilot program a survey will be sent to chapters for feedback. The Board of Directors will evaluate the results of the program survey.

Eleven chapters were approved by the president to participate in the pilot program: AR, DE, ID, KS, MS, ND, NH, NM, PR, SD, and WY. The expectations for the program included: provide information, serve as a resource, and bring issues from these chapters to the Board as needed. On their April 17, 2013, conference call, the Board reviewed the Criteria for Board Liaisons to Chapters, recommendations for Board Liaison assignments, and information about each of the 11 chapters identified for the program. In June 2013, the Board approved the criteria and duties of the Chapter Board Liaison Pilot Program with implementation to begin after the 2013 Scientific Assembly.
Staff attempted to contact each of the chapters to confirm their willingness to participate in the pilot program. After many months of effort trying to contact the chapter leaders and formalize the program, it was abandoned for lack of response.

Some pros and cons to consider in creating a formalized chapter contact program are:

**Pros**
1. Reinforces that relations with chapters are a priority.
2. Provides a specific Board member for chapters to contact.
3. Enhances ongoing communications with chapters.

**Cons**
1. Time constraints of Board members and chapter leaders.
2. Difficulty in making contact, either by phone or e-mail.
3. Additional workload for national and chapter leaders.
4. Unintended negative consequences.
5. Potentially creates an expectation that a particular chapter’s issues have higher priority than other chapters (such as those who were not able to be contacted) or issues facing national ACEP.
6. Potentially circumvents the role of the Chapter & State Relations staff, the National/Chapter Relations Committee, the Membership Committee, the Executive Director, and ACEP President if chapters perceive there is a prescribed or expected method to voice questions and concerns.
7. May create expense concerns for ACEP’s budget or awkwardness if chapters want to invite the ACEP President, President-Elect, or another director for whatever reason, but the designated director liaison to the chapter expects to be invited and wants to attend.

Some chapters work together on joint regional meetings. For example, an annual Southeastern Chapters (SEC) conference is a collaboration of the Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee chapters. Similarly, the states of Georgia, North Carolina, and South Carolina have collaborated for the last five years on their Coastal Emergency Medicine Conference. The Alaska and Washington chapters have also begun working on joint meetings.

For the 2017-18 year, the National/Chapter Relations Committee, with assistance from the State Legislative/Regulatory Committee has been assigned an objective to “identify opportunities for regional collaboration and conferences.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective A – Increase total membership and member retention.

Fiscal Impact

Travel expenses for Board members and staff to travel for purposes of participating in regular contact with state chapters; budgeted staff resources for supporting and promoting these efforts.

Prior Council Action

Substitute Resolution 45(95) Leader Visits to Chapters adopted. The resolution directed ACEP leadership to prioritize communication with state chapters and investigate technologies for improved communications.

Substitute Resolution 28(90) Leadership Visits to Chapters adopted. Directed ACEP to continue to investigate options for providing national physician/staff leader visits to chapters, including the option of conducting annual visits to chapters.
Resolution 23(17) Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships

Page 4

Prior Board Action

June 3013, approved the criteria and duties of the Chapter Board Liaison Pilot Program with implementation to begin after the 2013 Scientific Assembly.

April 2013, reviewed the Criteria for Board Liaisons to Chapters, recommendations for Board Liaison assignments, and information about each of the 11 chapters identified for the program.

June 2012, approved establishing a one-year Chapter Board Liaison pilot program to the chapters most likely to benefit from such a program.

January 2012, discussed the potential of establishing a Chapter Board Liaison. A workgroup was assigned to further investigate establishing a program.

January 2010, discussed establishing Board Liaisons to chapters. There was consensus to delay implementing a program at that time.

Substitute Resolution 45(95) Leader Visits to Chapters adopted.

Substitute Resolution 28(90) Leadership Visits to Chapters adopted and with a revised budget to change from a three year to a two year rotation schedule.

Background Information Prepared by:  Harry J. Monroe, Jr.
    Chapter & State Relations Director

    Sonja Montgomery, CAE
    Governance Operations Director

Reviewed by:  James Cusick, MD, FACEP, Speaker
    John McManus, MD, FACEP, Vice Speaker
    Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 24(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Maintenance of Certification for Practicing Emergency Physicians

PURPOSE: 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. 3) Develop a report for the 2018 Council.

FISCAL IMPACT: Creation of a task force with four in person meetings and 10-12 conference calls, plus staff resources to support the task force, approximately $80,000 – $100,000.

WHEREAS, Residency training and American Board of Emergency Medicine (ABEM) certification is the gold standard for entry into the practice of Emergency Medicine in the 21st century; and

WHEREAS, The American Board of Medical Specialties (ABMS) is the oversight organization that sets the standards and requirements for primary board certification and for the continued certification of physicians by its member specialty boards including ABEM; and

WHEREAS, ABMS has demonstrated its disdain of professionals actively engaged in the practice and profession of medicine who have completed residency training and requirements for board certification as not competent to recognize their own needs for their practice or their own ability to maintain their professional skills and competence thereby necessitating proscribed requirements of learning, practice assessment, “high stakes” recertification tests that are “secured,” leading to the implication that all these physicians are dishonest, lazy, and disinterested; and

WHEREAS, The practice of Emergency Medicine is already highly regulated, requires state medical board license and oversight, medical staff and hospital review of practice and privileges, active ongoing practice quality review, insurance and third-party payor monitoring, and a host of other regulatory oversights in addition to the ongoing threat of medical malpractice liability lawsuits; and

WHEREAS, There are clear examples where unregulated, non-competitive monopolies on professional standards and practice can lead to egregious and unrealistic standards, substantial increased costs, self-dealing and lack of connection to realistic professional practice expectations, creating significant disruption and unnecessary barriers to the practice of medicine and the care of the patients we serve; and

WHEREAS, There are a host of other options for these unregulated professional standard monopolies short of turning the responsibility over to government control and oversight, including appropriate oversight and review of the organizational activities, creation of alternative or parallel organizations, and formal direct input and demands for proof of effectiveness and justification for regulatory requirements; therefore be it

RESOLVED, That ACEP study the needs, and cost-effective evidence-based requirements that would support practicing board-certified emergency physicians to legitimately demonstrate their ongoing competence and skills necessary for their own practice settings and develop appropriate minimum guidelines for appropriate “maintenance of competence” with minimum and legitimate barriers to continued practice, and present a report for consideration at the 2018 Council meeting.
Background

This resolution calls for ACEP to study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians to demonstrate their ongoing competence and skills necessary for their own practice setting. It also calls for ACEP to develop appropriate minimum guidelines for appropriate “maintenance of competence” with minimum and legitimate barriers to continued practice and present a report at the 2018 Council meeting.

When ACEP was formed in 1968, it was decided to pursue the formation of a specialty, with residency training programs and board certification. In fact, the original logo of ACEP shows emergency medicine as the “missing” piece in the box portraying the recognized specialties. After nearly a decade of work, emergency medicine was recognized by the American Medical Association (AMA) and the American Board of Medical Specialties (ABMS), and a conjoint board was formed. ACEP heavily supported the formation of the American Board of Emergency Medicine (ABEM) and even provided funding through donations by ACEP members. Members eagerly sat for the board exam to not only prove their individual competence, but also to validate the decision to create the specialty.

Emergency medicine was among the first specialties to develop a time-limited certification process (Family Medicine offered the first time-limited certification in 1971). By the late 70’s, progress in medical science had accelerated, and there was a recognition of the need for a process to ensure that physicians would continue to remain current with medical knowledge. In time, other specialties created time-limited certifications, although some older physicians in some specialties still retain their life-long certification.

The American Board of Internal Medicine was one of the first to suggest that the 10-year gap between certifications was too long, and developed an elaborate, comprehensive, and expensive yearly assessment process involving the Medical Knowledge Self-Assessment Program (MKSAP). ABMS adopted this philosophy suggesting yearly maintenance of certification (MOC) was beneficial and in the public interest. ABEM created its life-long self-assessment program (LLSA), which provides for open book exams on a limited number of articles. Some other specialties have a process that is more burdensome and costly. No certifying board has firm evidence that their approach is superior.

ABEM now requires completion of four components for MOC: 1) license in good standing; 2) LLSA; 3) a ConCert recertification exam every 10 years; and 4) attestation of participation in a quality performance improvement activity. ABEM’s approach to MOC is considered more reasonable and less burdensome than many other specialties, yet for some diplomates, ABEM’s MOC is viewed as onerous and expensive.

ABEM believes that MOC participation reassures the public that the physician is engaged in rigorous and continuous professional development. ABEM believes that multiple-choice exams are the best tools, as well as the most efficient and cost-effective methods, to evaluate cognitive knowledge and assess complex domains (clinical synthesis and diagnostic processes). A study in 2016 showed that of the physicians who did not study for the ConCert exam, 86% passed. The study also reported that more than 90% of physicians who had just completed the ConCert exam felt that the preparation had added to or reinforced their medical knowledge.¹ A Harris poll showed that 83% of the public believed that emergency physicians should be required to pass a recertification exam. ABEM also raises the concern that absence of physician professional self-regulation would result in governmental intervention. They note that there is support in the literature that ABEM certification is associated with improved patient care.² The average cost per year for ABEM MOC is $265, and that cost has been fixed for the past five years. On average, diplomates devote 15 hours per year to complete all MOC activities, according to ABEM.

The vast majority of ACEP members participate in MOC. Legacy members are not board certified and cannot participate. Those certified by the American Osteopathic Board of Emergency Medicine have a similar process called Osteopathic Continuous Certification (OCC). That Board has similar requirements – initial certification, followed by Continuous Osteopathic Learning Assessment, Practice Assessment (including chart reviews from at least 10 patients), and a Cognitive Assessment every 10 years.

At the same time MOC was evolving, board certification took on new importance. In the 70’s, many medical students opted for one year of training (or in fewer cases, no further training). Some surgical programs were pyramidal,
assuring that 50% or more of the trainees would not complete the program and therefore not be eligible for board certification. The doctor draft during the Vietnam war often interrupted residency education. Now, board certification is required for academic faculty and increasingly for hospital privileges. MOC and the ConCert exam now are viewed by some emergency physicians as “high stakes” programs.

Critics of MOC find that parts of the test are not relevant to their individual practice. It can be expensive for some; the cost is not only that of the exam, but time away from work for preparation and taking the exam, as well as materials and courses to prepare for the exam.

ABMS was not the only group to become interested in maintenance of knowledge. Continuing medical education (CME) became more formalized around this same period of time, with the development of the AMA categories of CME and a more stringent process for programs offering education. Now, any organization providing CME must undergo a complicated process to be certified itself. State licensing boards and individual hospitals developed minimum CME requirements. Along with the movement to verify CME content, self-declaration of CME was replaced with the requirement to produce a certificate for each hour of CME. This additional complexity in the CME process added to the CME providers’ costs to produce the educational material, and to the costs for the physicians receiving it.

In addition to requirements for CME, most states and hospitals have additional educational requirements for physicians. Some states now require verifiable education in topics such as child abuse, infection control, palliative care, opioid prescribing, and a host of other topics. Emergency physicians, because of the breadth of their knowledge base, may have requirements from many different specialties.

Basic and Advanced Cardiac Life Support courses were developed in the mid-1970s, after development of CPR in the late-1960s and the beginnings of resuscitation research. Other merit badge courses were added. Many hospitals require these merit badge courses to work in certain areas of the hospital such as the ICU or ED, and to perform certain procedures such as intubation and sedation. In the early years, the requirement for merit badges was beneficial as it accelerated the dissemination of resuscitation and critical interventions. However, the value of repetitive courses over decades has not been established. ABEM has been working with ACEP and other ED organizations against the requirement for such merit badges, arguing that residency training and board certification are superior to any merit badge course.

MOC should not be confused with the requirements for CME, merit badge courses, and other certification requirements. However, the combined education, time, and financial burden from these processes is significant to the practicing physician.

Discontent with MOC first surfaced in relation to the requirements of the American Board of Internal Medicine. The discontent spread and has led to resolutions at the AMA and action by state legislatures. Concern has been raised regarding the value of the requirement for MOC, its cost, and whether the public really understands the process or value of MOC.

There has been pressure to create alternatives to the once-a-decade, one-size-fits-all, high-stakes exam. The majority of ABMS certifying boards have either eliminated the high stakes recertification exam, are offering options as an alternative to the exam, or they are piloting options. Some of these alternatives are similar to MOCA 2.0 created by the American Board of Anesthesiology. MOCA 2.0 delivers questions on a weekly basis, about 30 questions every 3 months. This has been well received by anesthesiologists; however, the participation rates are lower than expected, and failure rates are higher than the ConCert exam. If the physician does not meet the MOCA 2.0 standard, they must still pass the 10-year high-stakes exam. ABMS has developed a platform similar to MOCA 2.0, but it is anticipated that this platform will increase the cost of MOC, as it would add item-writers. The American Board of Obstetrics and Gynecology requires the completion of LLSAs (45-50 articles per year) in lieu of the high-stakes exam.

ABEM allows a diplomat to take the ConCert exam several years earlier than the year in which their certification expires, and to re-take it. Starting in 2013, ABEM has allowed each diplomate to get the full 10 years of certification regardless of whether the exam is passed early. This provides an incentive to take the ConCert early and to lessen the high-stakes nature of the exam.
While we would like to believe that all emergency physicians remain up-to-date and provide quality care, there is evidence suggesting there are some emergency physicians, even within ACEP, who exhibit practice patterns that are at odds with current evidence.

ACEP has been discussing MOC with ABEM over the past year in response to last year’s Referred Resolution 8(16). Opposition to Required High Stakes Secured Examination for Maintenance of Certification. During this time, ACEP has relayed the growing discontent among some ACEP members with the MOC process and particularly the high-stakes ConCert exam.

ABEM has been active in exploring alternative approaches to physician assessment. This exploration includes detailed analyses of every pilot project in which other specialty boards are involved. ABEM informs ACEP that it is participating in direct discussions and research consortia with other ABMS specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited.

ABEM has assembled panels of senior ABEM leaders to explore modification and options to the ConCert examination. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination. ABEM will hold a national ConCert Summit October 2-3, 2017, that will include representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is also looking to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates.

Additionally, ACEP, along with dozens of other specialty societies and state medical societies will meet with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

ACEP believes in lifelong learning, physician competency, and periodic assessment. It is important that the specialty of emergency medicine not lose the right of professional self-regulation to state governments or the federal government.

References

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Emergency Care
  Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement
  Objective B – Provide robust communications and educational offerings including novel delivery methods.

Fiscal Impact

Creation of a task force with four in person meetings and 10-12 conference calls, plus staff resources to support the task force, approximately $80,000 – $100,000

Prior Council Action

Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification referred
to the Board. Directed ACEP to oppose mandatory, required, high stakes, secured examination for Maintenance of Certification in emergency medicine and work with members, other interested organizations, and certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in emergency medicine.

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

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 ABEM, AOBEM, and/or sub-board on Pediatric Emergency Medicine of the ABP, 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.

Prior Board Action

In response to Referred Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification, ACEP has had multiple meetings and conversations with ABEM regarding MOC concerns from ACEP members.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted.


Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 25(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Resolution Co-sponsorship Memo

PURPOSE: Directs the Council Steering Committee to develop and promote a standardized format for a “co-sponsorship memo” that can be distributed through the Council elist or other platform so that councillors may collaborate and further refine resolutions prior to submission.

FISCAL IMPACT: Budgeted Steering Committee and staff resources.

WHEREAS, The time that our councillors; members; Steering Committee; Tellers, Credentials, & Elections Committee; Board members; and staff donate to drafting and reviewing resolutions is both valuable and limited; and

WHEREAS, Often multiple resolutions on a single issue, with overlapping concerns, are brought before the Council; and

WHEREAS, Time on the Council floor is limited and best used by discussing issues, rather than wordsmithing; and

WHEREAS, Collaboration in drafting a resolution leads to more refined and better resolutions; therefore be it

RESOLVED, That the Council Steering Committee develop and promote a standardized format for a “co-sponsorship memo” that can be distributed through the Council listserv or other platform so that councillors may collaborate and further refine resolutions prior to submission.

Background

This resolution directs the Council Steering Committee to develop and promote a standardized format for a “co-sponsorship memo” that can be distributed through the Council elist or other platform so that councillors may collaborate and further refine resolutions prior to submission.

The Council e-list, “c-mail,” was created to serve as a forum for councillors to communicate throughout the year on any relevant topic, including resolutions. Using c-mail is a simple way to discuss resolutions, whether in the early stages of development, in draft form, or after the resolutions have been released to the Council for the annual meeting. C-mail use has declined in recent years, perhaps because individuals experience “email fatigue” from the volume of various email accounts. Several councillors expressed concerns earlier this year, prior to the Council resolution submission deadline, when there were multiple messages posted about some draft resolutions and cosponsors were being sought. Unfortunately, several individuals requested to be removed from c-mail because of the increased number of messages.

In any given year, there may be multiple resolutions submitted on the same topic. Once the resolutions are received, staff attempt to work with the authors of similar resolutions to combine them, or submit one in lieu of another. Most often, the authors prefer to submit their initial resolution because of nuanced differences and/or the inability to reach consensus on the final wording of a single resolution.
Resolution 23(17) Resolution Co-Sponsorship Memo
Page 2

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted Steering Committee and staff resources.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 26(17)

SUBMITTED BY: Angela Mattke, MD, FACEP
Eric Maur, MD, FACEP
Howard Mell, MD, MPH, FACEP

SUBJECT: Study the Impact & Potential Membership Benefits of a New Chapter Representing Locums Physicians

PURPOSE: Study the impact and potential membership benefit of a new chapter representing locums physicians and provide a report to the 2018 Council.

FISCAL IMPACT: Budgeted committee and staff resources. Potential additional costs if an outside consultant is engaged to conduct the study, approximately $5,000-$10,000.

WHEREAS, Emergency physicians are unique in their practice mobility; and

WHEREAS, Anecdotal evidence suggests that an increasing number of newly graduated resident physicians are choosing to enter the workforce as locums physicians; and

WHEREAS, Anecdotal evidence suggests that a large number of emergency physicians either currently work as locum physicians, have worked as locums physicians in the past, or will work as locum physicians in the future, including as internal locums for larger companies; and

WHEREAS, It has been suggested that locums physicians are disproportionately under represented within the College membership; and

WHEREAS, Locums physicians have a unique position in the College and are often not served by the current chapter structure as they often work in states other than their states of residence, have administrative and practice issues that are unlikely to be prioritized by state chapters, and often have difficulty accessing chapter leadership positions; and

WHEREAS, Social media commentary and discussions with staff indicate that some locums physicians do not join ACEP due to the increased costs of joining multiple state chapters and a belief that their needs are not met under the current chapter structure; and

WHEREAS, The founders of the College acknowledged that physicians who frequently change work location may have unique needs by including a provision for a Government Services Chapter that represents physicians in a non-geographic distribution; and

WHEREAS, A membership section is unlikely to encourage locums physicians to join ACEP as it does not address the barriers of cost and access to leadership opportunities; therefore be it

RESOLVED, That the ACEP Board study the impact and potential membership benefit of a new chapter representing locums physicians and report back to the Council at the 2018 meeting.

Background

This resolution requests ACEP to study the impact and potential membership benefit of a new chapter representing locums physicians and provide a report to the 2018 Council.
ACEP has not chartered a new chapter in many years. Conducting a study of the impact and potential benefits of creating a locums physicians chapter could be completed internally, or by engaging an outside consult.

Leadership opportunities are cited as an advantage of a new chapter instead of a section because sections have a much smaller leadership structure than a chapter with a Board of Directors and officer structure. Many locums physicians find it difficult to achieve leadership in the state chapter because they do not typically work in that state. Another advantage could be an increase in ACEP membership if some emergency physicians have declined to join or dropped membership because of the requirement to join a state chapter.

One potential disadvantage of creating a new chapter would be the effect on state chapter memberships. It is unknown whether locums physicians would designate the state chapter as a secondary chapter.

Some of the questions to address in a study include:

1. How many ACEP members identify themselves as locums physicians?
2. How many ACEP members would potentially join a locums physicians chapter?
3. Does ACEP have any data on the number of emergency physicians who have declined to join ACEP or dropped membership in ACEP because they work as locums physicians?
4. Would a locums physicians chapter have a negative effect on the membership of state chapters?
5. Would locums physician members designate the state chapter in which they reside as a secondary chapter?
6. What are the potential benefits that a locums physicians chapter could provide?
7. Could a chapter better meet the needs of locums physicians instead of a section?
8. What are the unique administrative and practice issues that could be addressed by a locums physicians chapter?

Chartering new chapters is addressed in the ACEP Bylaws, Article VI – Chapters, Sections 1-3:

Section 1 — Charters

This corporation may grant charters to chapters of the College according to procedures described in the College Manual.

Section 2 — Chapter Bylaws

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

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

Section 3 — Qualifications

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter’s jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member’s next anniversary date.
A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who retires from medical practice regardless of membership class and changes his/her state of residence may retain membership in a chapter of prior professional practice/residence.

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

Additional guidance about chartering chapters is provided in the College Manual:

### III. Chartering Chapters

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

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

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

### ACEP Strategic Plan Reference

**Goal 2 – Enhance Membership Value and Member Engagement**

**Objective A – Increase total membership and transitioning resident retention.**

### Fiscal Impact

Budgeted committee and staff resources. Potential additional costs if an outside consultant is engaged to conduct the study, approximately $5,000-$10,000.

### Prior Council Action

None

### Prior Board Action

None

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

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
2017 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 27-41

Michael Lozano, MD, FACEP (FL), Chair
Daniel Freess, MD, FACEP (CT)
Nathaniel T. Hibbs, DO, FACEP (CO)
Jeffrey F. Linzer, MD, FACEP (GA)
Heather A. Marshall, MD, FACEP (NM)
John Matheson, MD, FACEP (WA)

Harry Monroe
Ryan McBride, MPP
RESOLUTION: 27(17)

SUBMITTED BY: Alaska Chapter
EMS-Prehospital Care Section
Illinois College of Emergency Physicians
Missouri College of Emergency Physicians
Oklahoma College of Emergency Physicians
West Virginia Chapter

SUBJECT: 9-1-1 Number Access and Prearrival Instructions

PURPOSE: Develop a policy statement to support and advocate to achieve 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point or EMS dispatch center provides appropriate medical pre-arrival instructions with EMS physician oversight. Work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that includes EMS physician involvement.

FISCAL IMPACT: Budgeted committee and staff resources. Additional staff resources to inventory PSAP funding models and working with stakeholders to develop model 9-1-1 funding legislation.

WHEREAS, 9-1-1 number access to Public Safety Answering Points (PSAP) is not uniformly available nationwide; and

WHEREAS, 240 million calls are made to 9-1-1 annually in the US, of which >70% of calls were through wireless carriers (2011 data); and

WHEREAS, 29.7% of U.S. households relied on wireless communication as their primary service (2011) and it is expected that number is considerably higher now, therefore, maximizing benefit of wireless communication by capitalizing on the ability to determine exact call location, and using this location determination to route calls to the responsible call center, are critical capabilities for PSAPs; and

WHEREAS, A call to 9-1-1 is not necessarily routed to a local PSAP, as some areas do not provide access to their PSAP through the 9-1-1 number and this results in delays (which may be considerable) to appropriate resource deployment as calls are routed to the PSAP that serves that emergency call location; and

WHEREAS, PSAPs, regardless of 9-1-1 or 10 digit dial access number, have different capabilities with regard to being able to verify emergency call location using wireless technology and those with basic or enhanced 9-1-1 service do not have the ability to use GPS location to pinpoint call location and must rely on the caller’s knowledge and ability to describe the location accurately, which can be significantly problematic if the caller is in distress, or in an unfamiliar location (i.e. Interstate, rural road); and

WHEREAS, PSAP and EMS dispatch point ability to provide any (or appropriate) medical prearrival instruction is inconsistent; and

WHEREAS, Medical prearrival instructions for bystander aid in life threatening medical emergencies are a critical element for survival in some time critical diagnoses (TCD) and in cardiac arrest; therefore be it

RESOLVED, That ACEP create a policy statement supporting 9-1-1 number access to a Public Safety Answering Points for 100% of the U.S. population at next generation 9-1-1 level; and be it further
RESOLVED, That ACEP create and advocate for broad recognition of a policy statement supporting every Public Safety Answering Point or EMS dispatch point be able to give appropriate medical prearrival instruction for bystander aid, including CPR and hemorrhage control, and include EMS physician involvement in their creation, implementation, and quality improvement activities; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to inventory and summarize models for 9-1-1 and Public Safety Answering Point funding as a resource for areas in need of increased service levels; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to engage in development of model legislation incorporating enduring funding stream for 9-1-1 call centers/Public Safety Answering Points incorporating key elements including: bringing systems to at least the next generation 9-1-1 level, providing medically appropriate prearrival instructions, and incorporating EMS physician involvement in quality oversight, response profiles, and prearrival instructions.

Background

This resolution directs ACEP to advocate and promote efforts that support achieving 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point (PSAP) or EMS dispatch center provides appropriate medical pre-arrival instructions with EMS physician oversight. It also directs the College to work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that incorporates EMS physician involvement.

Currently, more than 99% of the U.S. is covered by 9-1-1 service and many communities are working to implement the Next Generation 9-1-1 (NG911) level. The current 9-1-1 system includes a single number to access emergency services for a given area that provides caller location, name, and telephone number. Some of the limitations of the current system include the inability to transfer calls and data between PSAPs and the lack of routing to the appropriate PSAP based on actual caller location versus the cell phone tower location that was accessed.

The NG911 system will greatly enhance and upgrade the 9-1-1 infrastructure and includes enhanced coverage for wireless calls, more accurate caller location detection for wireless callers, receiving text messages, and data images and videos. It will be able to receive electronic data directly from programs such as Advanced Automatic Collision Notification (AACN) systems, medical alert systems, and safety sensors of various types. NG911 will also allow the PSAP to issue emergency alerts to wireless devices in a specific area via voice or text messages and to highway alert systems.

The type and detail of medical pre-arrival instructions provided to callers varies greatly across the country. While there are only a few standardized medical pre-arrival systems in use today, there is a lack of uniformity on how they are used and the kind of information provided to the caller by individual PSAPs or EMS services. There is also a lack of uniformity in the involvement of an EMS physician in the medical directions provided and in quality oversight.

ACEP’s policy statement “Physician Medical Direction of EMS Dispatch Programs” partially addresses both the NG911 and medical pre-arrival instructions.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
Fiscal Impact

Budgeted committee and staff resources. Additional staff resources to inventory PSAP funding models and working with stakeholders to develop model 9-1-1 funding legislation

Prior Council Action

None

Prior Board Action

June 2017, revised and approved the policy statement “Physician Medical Direction of EMS Dispatch Programs;” reaffirmed June 2010; revised and approved September 2003; and originally approved October 1998.

Background Information Prepared by:  Rick Murray, EMT-P
                                 EMS & Disaster Preparedness Director
                                 Deanna Harper, EMT-I
                                 Coordinator, EMS & Disaster Preparedness

Reviewed by:  James Cusick, MD, FACEP, Speaker
              John McManus, MD, FACEP, Vice Speaker
              Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 28(17)

SUBMITTED BY: New York Chapter
Observation Medicine Section

SUBJECT: Coverage for Patient Home Medication While Under Observation Status

PURPOSE: Support the coverage of self-administered medications in observation patients and support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

FISCAL IMPACT: Budgeted committee and staff resources to support regulatory efforts.

WHEREAS, The number of emergency department patients being placed under observation status is continually increasing; and

WHEREAS, There is an increasing focus on cost shifting to patients especially the uninsured/under insured and traditional Medicare patients; and

WHEREAS, The average cost of “self-administered” home medications is greater than $100 USD per observation visit for Medicare patients as Medicare Part B does not cover them; and

WHEREAS, There is not a standard way of dealing with billing for patient “self-administered” home medications across hospitals; and

WHEREAS, The Joint Commission regulation of hospitals identifying, verifying, and securing patient medication is time consuming and resource intensive; and

WHEREAS, Patients with Medicare Part D coverage can submit claims for their medications given in observation but must pay out of pocket initially; and

WHEREAS, The Office of the Inspector General’s report recommends that Centers for Medicare and Medicaid Services (CMS) explore methods to protect patients from variable outpatient costs; therefore be it

RESOLVED, That ACEP support the coverage of medications for patients under observation status; and be it further

RESOLVED, That ACEP support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

Background

This resolution calls for ACEP to support the coverage of self-administered medications in observation patients and to support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

The Centers for Medicare & Medicaid Services (CMS) 2016 final rule for the Outpatient Prospective Payment System (OPPS) included important changes to observation billing on the facility side. Specifically, it retired facility payment observation code APC 8009 and introduced C-APC 8011, a more comprehensive payment that increased
reimbursement by almost $1,000 and bundled in previously separately reported services such as diagnostic imaging, stress testing, and medication infusions. However, the new rule does not address long-standing observation-related issues, including lack of coverage for self-administered medications (SAM). For example, if an insulin dependent diabetic patient is admitted to observation for a heart condition, the cost of the facility providing the insulin would not be covered. This lack of coverage exposes patients to the cost of medications as listed in the hospital charge master, which can be many times higher than the cost for those same drugs outside the hospital. The mark up can be as high as several hundred percent, a significant hardship on patients, and particularly individuals with a fixed income. The Medicare Payment Advisory Commission (MedPAC) estimated that in 2012 hospitals billed patients, on average, approximately $209 for self-administered drugs, compared to an average actual cost to the hospitals of $43. At their April 2015, public meeting, MedPAC Commissioners voted to recommend that outpatient observation beneficiaries no longer be subject to out-of-pocket costs related to self-administered drugs. CMS did not implement that recommendation.

Despite the lack of guidance by CMS, a patient’s self-administered drugs may be covered by a Part D prescription drug plan if the following criteria are met: 1) The drug must be a prescription and not an over-the-counter drug; 2) the prescription cannot be received “in an outpatient [setting] or emergency department on a regular basis;” and 3) the drug must be either included in the Part D prescription drug plan’s formulary or covered as an exception in the plan. However, since most hospital pharmacies do not participate in Part D, the patient would likely have to pay the hospital bill and file a Part D claim to be reimbursed.

In October 2015, the HHS office of the Inspector General (OIG) released a statement that it would not administratively sanction hospitals if they discount or waive charges for an outpatient’s self-administered drugs, but it does not compel them to do so.

In the hospital’s defense, drug spending per capita in the hospital inpatient setting is increasing at a pace far exceeding reimbursement increases. Growth in annual inpatient drug spending between FY2013 and FY2015 increased on average 23.4%, and 38.6% on a per admission basis. Growth in spending in the inpatient setting exceeded the growth in retail spending, which increased 9.9% during this period. However, CMS’s update to hospital rates through the IPPS increased by only 2.7%. Large and unpredictable increases in the price of drugs used in the inpatient setting significantly impacted hospitals’ ability to manage costs within a fixed price based payment system.

The other important cost to Medicare patients placed in observation rather than inpatient admission is that patient costs, other than self-administered drugs, are covered after the inpatient 2017 Part A $1,316 deductible, whereas the observation patient is responsible for 20% of Medicare approved charges and could theoretically face substantial extra costs if they are admitted to a skilled nursing facility (SNF) without a three-day hospital stay prior to that SNF admission. Such additional costs, though uncommon for patients in the ED or in Observation units, would potentially have to be addressed to achieve the goal of true patient out-of-pocket costs being equal between observation and inpatient stays.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources to support regulatory efforts.

Prior Council Action

Amended Resolution 36(05) Medicare Requirement of Three-Night Hospital Stay referred to the Board of Directors.

Prior Board Action

January 2015, approved supporting legislation to rescind the 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2014, approved supporting legislation to rescind the 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2013, assigned Referred Resolution 25(13) to the Public Relations Committee

January 2005, assigned Amended Referred Resolution 36(05) to the Federal Government Affairs Committee.

Background Information Prepared by: David A. McKenzie, CAE
Reimbursement Director

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 29(17)

SUBMITTED BY: Pennsylvania Chapter

SUBJECT: CPR Training

PURPOSE: Draft model state legislation to assist chapters in advocating for mandatory CPR training in schools and work with other stakeholder organizations to draft and advocate for federal legislation and support to mandate CPR training in schools and increased CPR training for laypersons.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Over 300,000 Americans die from sudden cardiac arrest each year; and

WHEREAS, Bystander CPR (layperson CPR) is an important intervention that can double the chance for patients to be discharged to home neurologically intact; and

WHEREAS, Less than 20% of Americans feel that they are adequately trained in CPR; and

WHEREAS, An increase in the rate of CPR training is associated with an increase in survival for sudden cardiac arrest; and

WHEREAS, 37 states and the District of Columbia have some CPR mandate in schools; therefore be it

RESOLVED, That ACEP draft model state legislation and assist chapters in advocating for mandatory CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations, including the American Heart Association and the American Red Cross, to draft and advocate for federal legislation and support to mandate CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations, including the American Heart Association and the American Red Cross, to advocate for increased CPR training by laypersons.

References
Background

This resolution directs the College to draft model state legislation to assist chapters in advocating for mandatory CPR training in schools and work with other stakeholder organizations to draft and advocate for federal legislation and support to mandate CPR training in schools and increased CPR training for laypersons.

Each year more than 350,000 individuals will suffer a cardiac arrest outside of a hospital. Bystander CPR has been shown to have a positive impact on survival of out-of-hospital cardiac arrest victims. The amount of time that elapsed between the cardiac arrest and CPR being administered by a bystander is identified as a critical factor in survival rates. Studies show a survival rate of 12% and higher when bystander CPR was performed compared to below 5% when no bystander CPR was given.

The American Heart Association (AHA) has identified the benefits of CPR training in schools and developed a specially designed training program for this audience. There are many documented cases where school children have performed CPR successfully on both adults and other children. Many schools are already adopting CPR training into their required curriculum but it is not uniform or widespread currently.

ACEP has supported layperson CPR training for many years, starting with the first policy statement “Public Training in CPR” that was approved by the Board in 1984. The current policy statement “Public Training in Cardiopulmonary Resuscitation and Public Access Defibrillation” was last revised and approved in 2013. The College has also taken an active role in supporting and sponsoring layperson CPR training through partnering with the Texas College of Emergency Physicians for the Texas Two-Step Hands-Only CPR training in 2017 where 6,500 were trained across the state. During EMS Week 2017, the College partnered with the International Association of Fire Chiefs (IAFC) and American Medical Response (AMR) to sponsor the World CPR Challenge where more than 68,000 bystanders were trained nationwide.

Bystander CPR is a priority for the College and especially for EMS medical directors and EMS systems as they experience firsthand the benefits of early CPR performed by bystanders. The resolution would extend that focus to support increased CPR training, particularly in schools.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

Background Information Prepared by: Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Deanna Harper, EMT-I
Coordinator, EMS & Disaster Preparedness

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 30(17)

SUBMITTED BY: James Antinori, MD, FACEP
John Bibb, MD, FACEP
Fred Dennis, MD, FACEP
Ramon Johnson, MD, FACEP
Lawrence Stock, MD, FACEP
California Chapter

SUBJECT: Demonstrating the Value of Emergency Medicine to Policy Makers & the Public

PURPOSE: Demonstrate the value of EM: 1) request EMF and EMRA to prioritize funding for EM faculty and resident research, competitions, and resident prizes for focused EM economic and operational material; 2) accelerate development of a multi-year public relations campaign; 3) utilize viral marketing techniques; 4) develop an online repository of PR materials; 5) develop specific public relations materials for legislators; and provide a report on these efforts to the 2018 Council.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources. Additional funding (unknown amount) would be needed to expand the scope of current initiatives to demonstrate the value of emergency medicine. Costs are dependent on the type and scope of activities undertaken.

WHEREAS, Emergency Medicine (EM) in the United States has a unique medical business model in that all persons seeking care are evaluated and stabilized without regard for their ability to pay for care; and

WHEREAS, Acute care Emergency Departments (ED) provide medical care 24 x7 x365; and

WHEREAS, Healthcare premiums and costs including co-pays and deductibles are virtually unaffordable for a large number of payers including employers, the government and individuals; and

WHEREAS, Charges for ED services are predominately the facility component vs. the professional component by a ratio range of approximately 7:1 to 10:1; and

WHEREAS, Recent studies such as the Johns Hopkins study alleging price gouging are debated in the press without similar studies demonstrating the essential safety net that EDs provide. [http://www.hopkinsmedicine.org/news/media/releases/emergency_room_patients_routinely_overcharged_study_finds](http://www.hopkinsmedicine.org/news/media/releases/emergency_room_patients_routinely_overcharged_study_finds)

WHEREAS, Social media is currently the most powerful means of reaching and influencing public opinion but the format favors sound bites and small pieces of information; and

WHEREAS, Legislators and their tech savvy staff are busy and suffer information overload and innovative and amusing electronic media may be more useful to reach them with our information; therefore be it

RESOLVED, That ACEP request the Emergency Medicine Foundation and the Emergency Medicine Residents’ Association to prioritize funding for emergency medicine faculty and resident research, emergency medicine resident competitions, and emergency medicine resident prizes for focused emergency medicine economic and operational material including studies and reports that can be used to educate policy makers and the general public to demonstrate the value of emergency medicine; and be it further

RESOLVED, That ACEP accelerate the development of a multi-year public relations campaign to educate the
public and policy makers regarding the value of emergency medicine; items to emphasize should include (but are not
limited to) the cost effectiveness of timely emergency care; the value of high level medical care and medical opinions
available 24 x 7 to patients and referring physicians; and the threats posed by overzealous cost cutting by insurers and
others who try to discourage or limit patient access to Emergency Departments; and be it further

RESOLVED, That a public relations campaign educating the public and policy makers regarding the value of
emergency medicine utilize viral-marketing techniques such as mementos, short video clips, and humor to expand
outreach to all appropriate demographic groups including Gen X, Y, and Z as well as Millennials; and be it further

RESOLVED, That a repository of public relations materials demonstrating the value of emergency medicine,
including printed, video, and other information including emergency medicine economic research be assembled on the
ACEP web site and such materials would be accessible to all members of ACEP who wish to reach specific target
markets; and be it further

RESOLVED, That specific public relations materials regarding the value of emergency medicine be developed
for legislators, which would include printed material and materials in various electronic formats; and be it further

RESOLVED, That the ACEP Board of Directors provide a report to the 2018 Council on the development and
distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the
public.

Background

This resolution provides specific direction to ACEP to demonstrate the value of EM: 1) request EMF and EMRA to
prioritize funding for EM faculty and resident research, competitions, and resident prizes for focused EM economic and
operational material; 2) accelerate development of a multi-year public relations campaign; 3) utilize viral marketing
techniques; 4) develop an online repository of PR materials; 5) develop specific public relations materials for
legislators; and provide a report on these efforts to the 2018 Council.

ACEP’s Public Relations Department employs multiple communications tools and campaigns to promote the value of
emergency medicine to policymakers and general public audiences.

- ACEP’s parody video (of the Cigna TV commercial) went viral, generating more than 300,000 views on YouTube
  and Facebook (using active social media ACEP members, Facebook ads, Forbes, and earned media with news
  value of “real” emergency physicians who must be prepared for anyone and anything. ACEP is filming another
  parody video during ACEP17 in Washington, DC.
Saving Millions campaign. ACEP has conducted this campaign since 2013, starting with promotion of the results of the RAND report in 2013. The campaign was designed to promote the value of emergency medicine and to increase the visibility of emergency physicians as leaders in health care and in controlling health care costs. Advertising has appeared in policymaker publications, such as the Hill and Roll Call, and consumer publications, including daily newspapers. The messages of the campaign have been included in the briefing packets for ACEP members to distribute to legislators and their staff on Capitol Hill during the Leadership & Advocacy Conference. The infographic, video, and advertisements are at www.acep.org/SavingMillions and have been shared internally with ACEP’s chapters and all members through the daily electronic email, plus PR spokespersons and 911 Network members.


In 2014 and 2015, ACEP re-launched the Saving Millions campaign with a multi-media news release which embedded the content, messages, and infographic in thousands of websites. The campaign was featured on a 22-story electronic billboard in New York’s Times Square. ACEP also published ads in Politico and Roll Call (driving people to the Saving Millions website) in conjunction with the Leadership & Advocacy Conference. The multi-media release included the Infographic — “Emergency Medicine is America’s Most Essential Medical Specialty.” ACEP also promoted the campaign through social media and an ad in the Boston Globe, in conjunction with Scientific Assembly.

In 2016, ACEP reinvented the campaign and refreshed the website with new ads and updated the Infographic and video. ACEP promoted thru Twitter and YouTube https://www.youtube.com/watch?v=lsx3rnD9mbE.

In 2017, ACEP promoted the updated campaign through web and print ads to policymakers in Washington, DC. The digital campaign was to drive awareness of key ACEP messaging on Capitol Hill and generate clicks to the Saving Millions page on ACEP’s website. ACEP’s exclusive sponsorship of TheHill.com healthcare content during an historic week in Congress for the Affordable Care Act provided an outstanding opportunity to reach decision makers looking for the latest ACA information. The actual impressions of 2.6 million exceeded expectations, resulting in more than 800 clips to ACEP’s Saving Millions landing page in seven days.

Each year ACEP conducts a marketing campaign to general public audiences to promote the value of emergency medicine. This year’s campaign was about opioid abuse. The objectives of this campaign were to promote emergency physicians as experts and as leaders in finding solutions. The campaign tools included a press release, a flyer, website and web banner ads on Facebook, and generated results that exceeded estimates with a click-through rate of 3.15%, which is four times Facebook’s benchmark for health care campaigns. It generated 12,000 click-throughs to ACEP’s consumer website EmergencyCareforYou.org
In 2014, ACEP launched a campaign about educating the public about the differences between emergency care and urgent care and to promote the value of emergency care. It generated scores of news stories and an editorial by ACEP’s president, which was published more than 25 times in newspapers across America.

In 2016, ACEP launched a Top ER Tips for Mom’s campaign.

In 2017, ACEP’s ongoing Fair Coverage campaign has generated scores of positive stories in news organizations including Politico, Modern Healthcare, NBC News, Kaiser Health News, USA Today Radio Network, Washington Examiner, Fierce Healthcare, Becker’s Hospital Review, and Yahoo Finance, ACEP placed ads in the Hill publication (widely read by policymakers and staff in Washington, DC), generated more than 3.7 million impressions and about 8,000 click throughs to www.faircoverage.org. In 2016, ACEP published an ad in USA Today.

The objectives of the campaign included neutralizing health insurance industry statements portraying medical providers as “predatory” billers. Coverage included CBS Radio, Medscape, Forbes, HealthLeaders, Fierce Healthcare, and Kaiser Health News. ACEP engaged 20 spokespersons who conducted 26 radio interviews that aired 733 times. The Audio News Release aired more than 6,100 times, reaching an estimated audience of 92.9 million.

A major media campaign was conducted to promote fair payment for emergency care and the effects of the ACA on emergency departments. It generated significant national press coverage, including The Wall Street Journal, USA Today (front page), Fox News, and CNBC. The campaign also sparked an editorial response from former White House staffer Ezekiel Emanuel in The New York Times. Senator John Barroso (R-WY) referred to the poll results on the Senate floor, as part of discussions about the budget.

In 2016-17, Public Relations Committee members conducted scores of news interviews, many promoting the value of emergency medicine and contributing to the more than 300,000 media hits (including the Cigna parody video) that ACEP achieved from July 1, 2016, to May 30, 2017. The quick turnarounds from committee members enables ACEP to be nimble in the fast-paced media environment where most reporters are on deadline in a very short timeframe, often only a few hours. Members offered advice and information in breaking news situations to help public relations staff refute myths and correct misinformation. Many committee members also participated in a “letters to the editor campaign” promoting ACEP’s key fair coverage messages.
Examples of Taking Advantage of Breaking News to Promote Value of EM

In 2014, as the Ebola crisis unfolded, public relations staff focused media relations efforts at ACEP14 to promote the value of emergency medicine in responding to disasters. As a result, more than 50 reporters came to ACEP14, including television crews from CBS, ABC and NBC, with ACEP’s public relations staff coordinating scores of interviews and filming against the backdrop of innovatED. Fox Business News did live shots from the convention floor and CBS did live shots outside the center.

Promoted “I look like an ER Doc” Diversity Campaign with YouTube video and a press release.

Promoted Safe Citizen Day on May 23, 2017, as part of EMS Week. This campaign was a direct result of Amended Resolution 29(14) Safe Citizen Day, which was assigned to the Public Relations Committee for implementation.

• ACEP filmed emergency physicians telling patient stories to promote the value of emergency medicine, which were produced into videos and posted on ACEP’s YouTube Channel.

Social Media

ACEP’s external Twitter feed — @EmergencyDocs — has grown to more than 12,000 followers, which include policymakers and national health policy reporters. News is tweeted every day to promote news that ACEP is issuing or a news story that is positive or meaningful about emergency medicine.

ACEP’s YouTube Channel focuses on policy and consumer issues. Most of the campaigns ACEP has conducted to promote the value of EM have associated videos, generating more than 400,000 views.

https://www.youtube.com/user/EmergencyCareForYou

• ACEP’s consumer website, EmergencyCareforYou.org, promotes the value of emergency medicine to general public audiences. Each month, ACEP produces a consumer press release on a health and safety topic, which also refreshes the content on this site. Traffic to ACEP’s consumer website has doubled since January 2016. As part of this site, ACEP members write blogs on consumer topics. Top blogs in the past year include one on surprise billing (nearly 5,000 views), fading light of heroes (822 views), and holiday heart (640 views).

ACEP’s commitment to demonstrating the value of emergency medicine continues to be a priority objective and is essential for the specialty. ACEP and EMF are currently working on a major grant proposal regarding the Value and Cost Effectiveness of Emergency Care, which will be discussed by the ACEP and EMF Board of Directors during their meetings at ACEP17 in October.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective G – Establish the value of emergency medicine as an important component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee, staff, and consultant resources. Additional funding (unknown amount) would be needed to expand the scope of current initiatives to demonstrate the value of emergency medicine. Costs are dependent on the type and scope of activities undertaken.

Prior Council Action

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted. Directed ACEP to continue efforts to promulgate the value and role of emergency medicine.
Resolution 30(17) Demonstrating the Value of EM to Policy Makers & the Public
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Prior Board Action

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

Background Information Prepared by: Laura Gore
Public Relations Director

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 31(17)

SUBMITTED BY: Donald Stader, MD, FACEP
Erik Verzemnieks, MD

SUBJECT: Endorsement of Supervised Injection Facilities

PURPOSE: Work with the AMA in supporting the development of Medically Supervised Injection Facilities where patients can inject self-provided drugs under medical supervision and endorse such facilities as a public health intervention in areas affected by high IV drug use.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources.

WHEREAS, The opioid epidemic has become a major cause of preventable death in America, with 33,000 Americans dying of opioid overdose in 2015 and overdose from all drugs now becoming the number one killer of Americans under the age of 50; and

WHEREAS, Heroin use and IV drug use has grown exponentially with the opioid epidemic causing increasing mortality from IV opioid use (12,000 deaths in 2015) and dramatic increases in morbidity (Hepatitis C, HIV, Soft Tissue Infections, Endocarditis, Epidural abscess, etc.) from poor injection technique and sharing injection materials; and

WHEREAS, According to the Centers for Disease Control and Prevention (CDC) injection drug use accounts for one in ten new HIV diagnosis and is the leading cause of new Hepatitis C virus (HCV) diagnosis which, according to the CDC, have increased 300% in the last seven years; and

WHEREAS, Of people who inject drugs, an estimated 40% share syringes and injection materials; and

WHEREAS, Every case of HIV, Hepatitis C, soft tissue infection and overdose death is nearly 100% preventable with good injection technique and practices among people who inject drugs (PWID); and

WHEREAS, Supervised Injection Facilities (SIFs) represents a step of care above that of Syringe Service Programs (SSPs) and allow PWID to inject in a safe environment before a medical professional; and

WHEREAS, SIFs are currently active in 63 cities and 102 sites total and are extremely effective at reducing drug overdose and death, with no deaths occurring from overdose in any SIF during their entire history; and

WHEREAS, Numerous peer-reviewed scientific studies have proven the positive impacts of SIFs and these benefits include: reduced public disorder, reduced public injecting, and increased public safety as well as cost savings resulting from reduced disease, overdoses and need for emergency medical services, and increased preventive healthcare and drug treatment utilization; and

WHEREAS, SIFS have been shown not to increase community drug use, not increase initiation into injection drug use, and not increase drug-related crime; and

WHEREAS, The American Medical Association supports SIFs stating recently “In an effort to consider promising strategies that could reduce the health and societal problems associated with injection drug use, the AMA today voted to support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision;” therefore be it
RESOLVED, That ACEP join their partner organization, the American Medical Association, in supporting the
development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical
supervision and endorse Supervised Injection Facilities as an effective public health intervention in areas and
communities heavily impacted by IV drug use.

Background

This resolution directs ACEP to join the American Medical Association in the development of pilot facilities where
people can inject self-provided intravenous drugs under medical supervision, and to endorse such Supervised
Injection Facilities (SIFs) as an effective public health intervention in communities affected by high IV drug use.

Resolution 37(17) Medically Supervised Injection Facilities is similar in that it addresses supervised injection
facilities. Much of the background information is the same for both resolutions.

The abuse of, and addiction to, various opioids, both prescription medication and illegal substances, has become a
serious global health problem. It is estimated that more than two million people in the United States suffer from a
substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin.

The White House Office of National Drug Control Policy (ONDCP) has made the opioid abuse issue a top priority
and is identifying additional opportunities for collaboration between government agencies and external stakeholders
to combat this growing national crisis. On March 29, 2017, President Donald Trump signed an Executive Order
establishing the President’s Commission on Combating Drug Addiction and the Opioid Crisis, with the commission
chaired by Governor Chris Christie. In August 2017, President Trump indicated he would declare the opioid epidemic
a national emergency though as of September 11, 2017, an official declaration is yet to be made.

The Centers for Disease Control and Prevention (CDC) recently reported that the 2015 age-adjusted rate of drug
overdose deaths in the U.S. was more than 2.5 times the rate in 1999. This is part of a 16-year trend of increasing
opioid overdose deaths that are directly related to overdoses from prescription opioids. The CDC also noted the
percentage of opioid deaths involving heroin was triple the percentage in 2010. Since 1999, the amount of opioids
sold has nearly quadrupled and deaths from prescription opioids have had a corresponding increase.

The concept of Medically Supervised Injection Facilities (MSIFs or SIFs) have been proposed as a public health
intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, Hepatitis C, and soft
tissue infections. These facilities provide sterile injection equipment under medical supervision to prevent the sharing
of syringes and injection materials, with many offering counseling and informational services as well. According to
the Drug Policy Alliance, there are approximately 100 SIFs operating in 66 cities throughout the world, though none
currently exist in the U.S. The establishment of SIFs in the U.S. remains a controversial topic as critics argue such
policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related
crime, while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced
overdose rates that help contribute to a reduced need for emergency services. There are also additional legal aspects
regarding possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that
will need to be addressed if SIFs are to be established in the U.S.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot
SIFs in the U.S. that are designed, monitored, and evaluated to generate data to inform policymakers on the
feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug
use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)).

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective B – Promote quality and patient safety, including continued development and refinement of quality
measures and resources.
Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 32(17)

SUBMITTED BY: New York Chapter

SUBJECT: Essential Medicines

PURPOSE: Designate essential emergency medications, request a meeting with FDA to ensure adequate supply of essential medicines at all times, work with other medical organizations to speak to government agencies and elected officials on urgent need, make developing federal legislation a priority for ACEP’s legislative agenda, and submit a resolution on essential medicines to the AMA House of Delegates.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP position to federal lawmakers and to support development and introduction of legislation. Potential travel costs for ACEP members to conduct in-person meetings with FDA, approximately $1,000 per person per trip.

WHEREAS, The World Health Organization (WHO) has a definition of essential medicines which states “Essential medicines are those that satisfy the priority healthcare needs of the population and are intended to be available at all times in adequate amounts in the appropriate dosage forms;” and

WHEREAS, The WHO compiled a list of essential medicines that can be found at http://apps.who.int/medicinedocs/documents/s16198e/s161983.pdf; and

WHEREAS, The essential medications list has been tailored specifically for Emergency Medicine and EMS (provided as an addendum to this resolution); and

WHEREAS, U.S. hospitals and EMS systems continually suffer from national essential drug shortages frequently used in the care of critically ill patients, including but not limited to calcium gluconate and carbonate, atropine, epinephrine and D50, and other drugs available as pre-filed syringes; and

WHEREAS, Lack of availability constitutes a significant risk to patients; and

WHEREAS, Shortages last for months until significant productions resume; therefore be it

RESOLVED, ACEP considers any medication that is used to treat or correct a life threatening condition for which there is no adequate substitute to be an essential emergency medication, examples of such medications include but are not limited to epinephrine, sodium bicarbonate, and naloxone; and be it further

RESOLVED, That ACEP request a meeting with the FDA requesting adequate amounts of essential emergency medications be in supply at all times; and be it further

RESOLVED, That ACEP collaborate with other medical organizations to speak with a unified voice to government agencies and elected officials as to the urgent need for resolution of the on-going crisis of lack of access to emergency drugs; and be it further

RESOLVED, That the ACEP Board of Directors make developing and promoting federal legislation to ensure adequate drug supply of critical medications a priority for ACEP’s legislative agenda; and be it further

RESOLVED, That ACEP submit a resolution to the AMA House of Delegates regarding essential medicines for consideration.
Addendum – Emergency Medicine and EMS Essential Medications List:

- Antiallergics and Medicines used in Anaphylaxis
- Antidotes and other Substances used in Poisoning
- Anticonvulsants/ Antiepileptics
- Anti-infective Medicines
  - Anthelmintics
  - Antibacterials: Beta Lactam Medicines, other Antibacterials, Antileprosy Medicines, Antituberculosis Medicines
  - Antifungal Medicines
  - Antiviral Medicines: Antiherpes, Antiretrovirals, Nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors
  - Antiprotozoal Medicines: Antiamoebic and Antigiardiasis Medicines, Antileishmaniasis, Antimalarial (curative and prophylaxis), Anti-pneumocystosis and Anti-toxoplasmosis Medicines, Antirypansomal Medicines
- Medications Affecting Coagulation
- Blood Products and Plasma Substitutes
- Cardiovascular medicines: Antianginal, Antiarrhythmic, Antihypertensive, Medicines used in Heart Failure, Vasoconstrictors (Sympathomimetics),
- Antithrombotic Medicines
- Diuretics
- Insulin and Other Antidiabetic Agents
- Thyroid Hormone and Antithyroid Medicines
- Vaccines: Diphtheria, tetanus and pertussis, Rabies inactivated tissue culture vaccine injection
- Emergent Psychotherapeutic Medicines
- Medicines Acting on the Respiratory Tract: Antiasthmatic and Chronic Obstructive Pulmonary Disease Medicines
- Solutions Correcting Water, Electrolyte, Acid-Base and Nutritional Disturbances: Solutions Correcting Water, Electrolyte and Acid-Base Disturbances (Oral and Parenteral), Intravenous Nutrition, Vitamins and Minerals
- General Anaesthetics and Oxygen: Local Anaesthetics, Perioperative Medications and Sedation for Short-Term Procedures
- Analgesics, Antipyretics, Non-Steroidal, Anti-Inflammatory Medicine

Background

This resolution calls for ACEP to consider medications used to treat or correct life-threatening conditions for which no adequate substitutes are available to be an essential emergency medication, request a meeting with the FDA to request adequate amounts of these medications be in supply at all times, to work collaboratively with other medical organizations to speak to government agencies and elected officials on the urgent need to address this lack of access, make developing and promoting federal legislation on this issue a priority for ACEP’s legislative agenda, and submit a resolution on essential medicines for consideration to the AMA House of Delegates.

Resolution 34(17) Generic Injectable Drug Shortages is similar in that it addresses drug shortages. Much of the background information is the same for both resolutions.

Shortages of commonly-used but essential medications continue to grow and have become a more acute problem throughout the health care system, but these shortages tend to disproportionately affect emergency medicine (both hospital and pre-hospital) due to its reliance upon generic medications for rapid sequence intubation, seizures, antidotes, resuscitation, as well as analgesics, antiemetics, and anticoagulants. Examples of such drugs currently listed in shortage (as of September 2017) by the FDA include sterile injectables such as saline, epinephrine, and dextrose-filled syringes. These drug shortages can be further exacerbated by the “gray market,” where distributors purchase any remaining drugs on the shortage list and then sell their stock at significantly higher prices.

Reasons cited for the increase in drug shortages include greater scrutiny on the manufacturing process and quality controls; however, additional factors include consolidation of manufacturers (especially for generic injectables), low profit margins, shortages of raw materials, absences of redundancy in the supply chain, increased demand, and discontinuations, among others. With that said, the root causes of shortages are often unclear.

In the Prescription Drug User Fee Act (PDUFA) of 2012, known as the Food and Drug Administration Safety and
Innovation Act (FDASIA), ACEP helped secure language related to emergency drug shortages. The law eliminated the requirement that a company be the sole manufacturer of a drug to be subject to the drug shortage requirements. Additionally, FDASIA explicitly made drugs used in emergency medical care or during surgery subject to the drug shortage notice requirements. FDASIA established an annual report to Congress by the FDA on drug shortage statistics, communication within FDA on addressing shortages and actions taken by FDA to prevent or mitigate shortages. This legislation called for regular Government Accountability Office (GAO) reports to Congress on the cause of drug shortages and on recommendations on how to prevent or alleviate shortages. The most recent report was published in July 2016. PDUFA was reauthorized in August 2017, though few substantial changes were made to specifically address drug shortages.

ACEP is also a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC also has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is also developing bi-partisan, market-based solutions to lower drug prices in the United States.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the Board of Trustees appointed a 13-member Task Force on Pharmaceutical Costs consisting of representatives of AMA councils, state medical associations, and national medical specialty societies, to provide guidance on AMA advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The task force reached agreement that the first phase of the AMA grassroots campaign should focus on increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. Board of Trustees Report 10-1-16 summarized the work of the task force and described the first phase of the grassroots campaign. An online petition calling on Congress to demand that pharmaceutical companies, pharmacy benefit managers, and health plans introduce greater transparency in the processes for determining prescription drug prices was promoted in late summer 2016 on the AMA’s Patients’ Acton Network (PAN) and other cause-oriented websites (e.g., standunited.org and care2.org). On November 1, 2016, consistent with the recommendations of the task force, the AMA launched TruthInRx.org, which seeks to highlight the lack of transparency and inherent unfairness involved in prescription drug pricing. The interactive microsite allows supporters to take action – from sending a message to Congress, to sharing content with their own social networks. Notably:

- The overall design of the microsite uses pharmaceutical, scientific and technical industries as inspiration for creative design, and vibrant, energetic colors help emphasize important points throughout the site, such as facts, figures and callouts
- The homepage immediately takes the user through an interactive experience after he/she lands on the site, scrolling through the labels of a drug box to learn about the lack of transparency in drug pricing.
- The interior pages include a campaign page that opens with a striking visual related to understanding the issue; a “your stories” page that engages the audience to share content with their social networks, including a meme generator, prepopped tweets/Facebook posts and a traditional submit your own story option for users; a “get involved” page that houses the traditional take action features, allowing users the ability to contact Congress via email, phone and social media; and a “get informed” page that houses a variety of resources for the user to explore to gain more knowledge on the issue.

An AMA press statement announcing TruthInRx.org was also released. ACEP promoted the link to the microsite via the PAN and the Physicians’ Grassroots Network, and used other online and social media promotion to aid in the launch. The microsite was also featured at the AMA grassroots booth at the AMA Interim Meeting in November 2016 and related materials were distributed to the AMA House of Delegates.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
Objective F – Establish the value of emergency medicine as an important component of the health care system.

**Fiscal Impact**

Budgeted staff and consultant resources to convey ACEP position to federal lawmakers and to support development and introduction of legislation. Potential travel costs for ACEP members to conduct in-person meetings with FDA, approximately $1,000 per person per trip.

**Prior Council Action**

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and provide a report to the 2016 Council.

Amended Resolution (33)11 Medication Shortages adopted. Directed ACEP to work with appropriate entities to devise and support a solution to the medication shortage problem and the resulting patient safety issues.

**Prior Board Action**

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted.

Amended Resolution (33)11 Medication Shortages adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Senior Congressional Lobbyist

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 33(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Immigrant and Non-Citizen Access to Care

PURPOSE: 1) Develop model hospital safe zone policy language opposing federal and state initiatives requiring physicians and healthcare facilities to refuse care or report suspected undocumented persons to immigration authorities. 2) Make the model available for physicians to access and present to their hospital systems. 3) Provide a “Safe Zone” statement in multiple languages relevant to the patient population.

FISCAL IMPACT: Budgeted committee and staff resources to develop model policy language. Additional costs (unknown amount) for translation services. The cost will depend on the number of languages for translation.

WHEREAS, Access to emergency medical care is critically important to both individual and public health; and

WHEREAS, The fear of immigration authorities has been shown to be highly predictive of epidemiologically significant delays in seeking care for patients with communicable diseases such as tuberculosis; and

WHEREAS, Early quarantine and treatment of communicable diseases such as Ebola can prevent an isolated case from becoming an epidemic, and emergency departments are likely places of first contact for such patients; and

WHEREAS, Access to emergency medical care is the only universally mandated form of health care in the US, and is thus a foundational element of the social and public health safety nets; and

WHEREAS, Emergency physicians are patient advocates with ethical and legal obligations to care for all patients; these obligations include a moral imperative to combat disparities in care; and

WHEREAS, Immigrants face significant disparities in health care outcomes; and

WHEREAS, The potential presence of federal immigration enforcement agents is likely to discourage immigrants from seeking care and thus worsen disparities in care for this population; and

WHEREAS, Hospital policies requiring federal immigration enforcement agents to obtain a warrant prior to entering a hospital or medical campus facility could help ameliorate fears which prevent immigrants from accessing care, particularly if effectively communicated to these populations; and

WHEREAS, ACEP affirms support for immigrants in its policy “Delivery of Care to Undocumented Persons,” which “opposes federal and state initiatives which require physicians and health care facilities to refuse care to undocumented persons or to report suspected undocumented persons to immigration authorities” and expands upon this policy to strengthen and broaden it; therefore, be it

RESOLVED, That ACEP develop model hospital policy language similar to the “Delivery of Care to Undocumented Persons” policy that physicians can access and present to their hospital systems for implementation; and be it further

RESOLVED, That ACEP make available online for public use, in multiple languages, a “Safe Zone” statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physicians can ensure the policy is communicated in the languages most relevant to their patient populations.
Background

This resolution calls for the College to develop model hospital safe zone policy opposing federal and state initiatives that require physicians and healthcare facilities to refuse care or report suspected undocumented persons to immigration authorities. The model is to be available for physicians to access and present to their hospital systems. This resolution also calls for ACEP to provide a “Safe Zone” statement in multiple languages relevant to the patient population.

There has long been concern that undocumented immigrants do not seek medical care or report crimes due to fears of being reported to immigration officials and being deported. In 2011, US Immigration and Customs Enforcement (ICE) issued a memorandum on “Enforcement Actions at or Focused on Sensitive Locations.” The document states, “This policy is designed to ensure that these enforcement actions do not occur at nor are focused on sensitive locations such as schools, and churches…” The ICE memorandum identifies hospitals as a sensitive location and outlines exceptions to enforcement actions at sensitive locations. The Department of Homeland Security also considers hospitals as sensitive locations and provides further guidance on enforcement actions at or focused on sensitive locations in its policy.

A bill was introduced into the California state senate to prevent state and local law enforcement agencies from enforcing immigration laws in “safe zones” that include hospitals. As currently written, this bill would not prohibit law enforcement from transferring violent offenders into federal custody. The bill is referred to as the California Values Act and is still under consideration. Similar legislation filed in Texas this year did not receive a hearing. In all, thirty-six states and the District of Columbia considered over 100 bills this year addressing sanctuary jurisdictions.

ACEP has two existing policies that address concerns raised in this resolution. The policy statement “Delivery of Care to Undocumented Persons” “…opposes federal and state initiatives which require physicians and health care facilities to refuse care to undocumented persons or to report suspected undocumented persons to immigration authorities.” The policy statement “Non-Discrimination and Harassment” opposes all forms of discrimination and harassment against patients and emergency medicine staff of the basis of individual’s race, age, …citizenship…” etc.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective G – Establish the value of emergency medicine as an important component of the health care system.

Fiscal Impact

Budgeted committee and staff resources to develop model policy language. Additional costs (unknown amount) for translation services. The cost will depend on the number of languages for translation.

Prior Council Action

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. It directed ACEP to produce a white paper addressing the impact of foreign nationals and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in the ED.

Prior Board Action


April 2012, approved the policy statement “Non-Discrimination and Harassment;” previously approved October 2005 as “Non-Discrimination;” originally approved October 2005.
Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

**Background Information Prepared by:** Margaret Montgomery, RN, MSN
Practice Management Manager

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 34(17)

SUBMITTED BY: Rick Blum, MD, FACEP
Mark DeBard, MD, FACEP
Nicholas Jouriles, MD, FACEP
Brian Keaton, MD, FACEP
Robert Solomon, MD, FACEP
West Virginia Chapter

SUBJECT: Generic Injectable Drug Shortages

PURPOSE: Work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of ongoing shortages of generic injectable drugs; educate members, other stakeholders, and the public about the issue and how to solve it; seek a legislative repeal of the safe-harbor protections for Group Purchasing Organizations.

FISCAL IMPACT: Budgeted staff and consultant resources.

WHEREAS, The U.S. healthcare system in general, and Emergency Medicine/EMS systems in particular, as well as the millions of patients we serve, continue to suffer from a severe, ongoing shortage of numerous vital generic injectable drugs; and

WHEREAS, The American Society of Healthcare Pharmacists (ASHP) currently lists more than 130 drugs in active shortage, including such critical drugs as normal saline, epinephrine, sodium bicarbonate, nitroglycerin, succinylcholine, vancomycin, and many more; and

WHEREAS, The drug supply chain, and the group purchasing organizations (GPOs) that dominate that chain, have been unwilling, unmotivated, or unable to solve this long-running, pernicious, and deadly issue; and

WHEREAS, The very existence of these persistent shortages violates the most basic free-market law of supply-and-demand, which indicates that something significant has perverted the free-market system that would otherwise serve to correct such shortages; and

WHEREAS, Hospital GPOs were originally created in 1910 as cooperatives to reduce the cost of hospital goods, including drugs, medical devices, supplies, capital equipment and other items, by obtaining volume discounts, a model that worked well for more than 80 years, and

WHEREAS, In 1987, at the behest of GPOs and hospital lobbyists, Congress enacted the Medicare Anti-Kickback Safe Harbor provision as an amendment to the Social Security Act, which exempted GPOs from criminal penalties for taking kickbacks from suppliers, and in 1991 the Office of the Inspector General of the Department of Health and Human Services issued the safe harbor rules; and

WHEREAS, GPOs constitute a virtual buyer’s monopoly for the vast majority of all supplies purchased by the nation’s 5,000 acute care hospitals and these same 5,000 hospitals (along with EMS and oncology centers) constitute nearly the entire market for generic injectable drugs; and

WHEREAS, Only four of these giant GPOs account for over 90% of the total annual GPO contract volume of $300 billion dollars per year; and
Resolution 34(17) Generic Injectable Drug Shortages

WHEREAS, Since receiving that safe harbor protection, the GPO industry has developed a complex and opaque scheme of literally selling market share in exclusionary, sole-source, long-term contracts to the highest bidder and being paid for that by having a significant portion of the artificially inflated price of such drugs kicked back to them in the form of GPO fees, thereby subverting normal free market economic forces; and

WHEREAS, These GPO fees (aka “legalized” kickbacks), under the safe harbor model, are based on a percentage of sales revenue; GPOs have little or no incentive to negotiate better prices for hospitals, or choose lower priced generic drugs over higher priced non-generic alternatives, since lower prices actually result in lower revenues for GPOs; and the result is that GPOs actually inflate the cost of health supplies by as much as 39%, according to government studies and independent research; and

WHEREAS, The only way for generic injectable drug producers to find relief from these low margin, long-term contracts, are to quit making the drug altogether; and

WHEREAS, The GPO industry has concealed this root cause of the shortages in a well-financed public relations and lobbying campaign that promulgates the fiction that these shortages are “complex and multifactorial;” and

WHEREAS, All of the multiple causative factors offered by the GPOs have been easily debunked and in February 2014, the Government Accountability Office (GAO) study on this issue concluded that the anti-kickback safe harbor for GPOs was likely the key underlying factor in these drug shortages; and

WHEREAS, The public and the medical community have largely been silent on this critical problem, primarily because they do not understand it and therefore have not achieved consensus on the root cause or the solution necessary; therefore be it

RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of the shortage of generic injectable drugs and educate our members, the general medical community, and the public on this critical issue and how to solve it; and be it further

RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to seek Congressional legislative repeal of the pernicious and unsafe Group Purchasing Organizations safe-harbor protection.

Background

This resolution calls for ACEP to work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of ongoing shortages of generic injectable drugs, educate members, other stakeholders, and the public about the issue and how to solve it, seek a legislative repeal of the safe-harbor protections for Group Purchasing Organizations.

Resolution 32(17) Essential Medicines is similar in that it addresses drug shortages. Much of the background information is the same for both resolutions.

Shortages of commonly-used but essential medications continue to grow and have become a more acute problem throughout the health care system, but these shortages tend to disproportionately affect emergency medicine (both hospital and pre-hospital) due to its reliance upon generic medications for rapid sequence intubation, seizures, antidotes, resuscitation, as well as analgesics, antiemetics, and anticoagulants. Examples of such drugs currently listed in shortage (as of September 2017) by the FDA include sterile injectables such as saline, epinephrine, and dextrose-filled syringes. These drug shortages can be further exacerbated by the “gray market,” where distributors purchase any remaining drugs on the shortage list and then sell their stock at significantly higher prices.

Reasons cited for the increase in drug shortages include greater scrutiny on the manufacturing process and quality
controls; however, additional factors include consolidation of manufacturers (especially for generic injectables), low profit margins, shortages of raw materials, absences of redundancy in the supply chain, increased demand, and discontinuations, among others. With that said, the root causes of shortages are often unclear.

Additionally, the role of Group Purchasing Organizations (GPOs) in the drug pricing and shortage debate has received more scrutiny over the past several years. In 2014, the Government Accountability Office (GAO) issued a report, “Group Purchasing Organizations: Funding Structure Has Potential Implications for Medicare Costs,” which noted the inherent conflict of interest created by the GPO safe harbor protections, and how hospitals could be underreporting administrative fee revenue. The report also noted that repealing the safe harbor could eliminate the effects of the GPO funding structure on Medicare payment rates, but also recognized that doing so could create disruption within the health care supply chain in at least the near term. Further, many others have raised questions about how existing policies and incentives have contributed to skyrocketing costs for generic injectables and why shortages for common, essential drugs persist in throughout the country.

In the Prescription Drug User Fee Act (PDUFA) of 2012, known as the Food and Drug Administration Safety and Innovation Act (FDASIA), ACEP helped secure language related to emergency drug shortages. The law eliminated the requirement that a company be the sole manufacturer of a drug to be subject to the drug shortage requirements. Additionally, FDASIA explicitly made drugs used in emergency medical care or during surgery subject to the drug shortage notice requirements. FDASIA established an annual report to Congress by the FDA on drug shortage statistics, communication within FDA on addressing shortages and actions taken by FDA to prevent or mitigate shortages. This legislation called for regular Government Accountability Office (GAO) reports to Congress on the cause of drug shortages and on recommendations on how to prevent or alleviate shortages. The most recent report was published in July 2016. PDUFA was reauthorized in August 2017, though few substantial changes were made to specifically address drug shortages.

ACEP is also a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC also has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is also developing bi-partisan, market-based solutions to lower drug prices in the United States.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the Board of Trustees appointed a 13-member Task Force on Pharmaceutical Costs consisting of representatives of AMA councils, state medical associations, and national medical specialty societies, to provide guidance on AMA advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The task force reached agreement that the first phase of the AMA grassroots campaign should focus on increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. Board of Trustees Report 10-I-16 summarized the work of the task force and described the first phase of the grassroots campaign. An online petition calling on Congress to demand that pharmaceutical companies, pharmacy benefit managers, and health plans introduce greater transparency in the processes for determining prescription drug prices was promoted in late summer 2016 on the AMA’s Patients’ Acton Network (PAN) and other cause-oriented websites (e.g., standunited.org and care2.org). On November 1, 2016, consistent with the recommendations of the task force, the AMA launched TruthInRx.org, which seeks to highlight the lack of transparency and inherent unfairness involved in prescription drug pricing. The interactive microsite allows supporters to take action – from sending a message to Congress, to sharing content with their own social networks. Notably:

- The overall design of the microsite uses pharmaceutical, scientific and technical industries as inspiration for creative design, and vibrant, energetic colors help emphasize important points throughout the site, such as facts, figures and callouts
- The homepage immediately takes the user through an interactive experience after he/she lands on the site, scrolling through the labels of a drug box to learn about the lack of transparency in drug pricing.
- The interior pages include a campaign page that opens with a striking visual related to understanding the issue; a “your stories” page that engages the audience to share content with their social networks, including a meme
generator, prepopulated tweets/Facebook posts and a traditional submit your own story option for users; a “get involved” page that houses the traditional take action features, allowing users the ability to contact Congress via email, phone and social media; and a “get informed” page that houses a variety of resources for the user to explore to gain more knowledge on the issue.

An AMA press statement announcing [TruthInRx.org](https://TruthInRx.org) was also released. ACEP promoted the link to the microsite via the PAN and the Physicians’ Grassroots Network, and used other online and social media promotion to aid in the launch. The microsite was also featured at the AMA grassroots booth at the AMA Interim Meeting in November 2016 and related materials were distributed to the AMA House of Delegates.

**ACEP Strategic Plan Reference**

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective F – Establish the value of emergency medicine as an important component of the health care system.

**Fiscal Impact**

Budgeted staff and consultant resources.

**Prior Council Action**

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and provide a report to the 2016 Council.

Amended Resolution (33)11 Medication Shortages adopted. Directed ACEP to work with appropriate entities to devise and support a solution to the medication shortage problem and the resulting patient safety issues.

**Prior Board Action**

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted.

Amended Resolution (33)11 Medication Shortages adopted.

**Background Information Prepared by:** Ryan McBride, MPP
Senior Congressional Lobbyist

**Reviewed by:** James Cusick, MD, FACEP, Speaker
  John McManus, MD, FACEP, Vice Speaker
  Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 35(17)

SUBMITTED BY: Undersea & Hyperbaric Medicine Section

SUBJECT: Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment

PURPOSE: Work with the Undersea and Hyperbaric Medical Society and ACEP’s Undersea and Hyperbaric Medicine Section to advocate that CMS require hyperbaric facilities be accredited to receive federal payment.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP’s position to CMS and relevant regulators.

WHEREAS, Undersea and hyperbaric medicine is recognized by the American Board of Medical Specialties as a subspecialty of emergency medicine; and

WHEREAS, Fewer and fewer (now less than 50 of more than 1,400) hyperbaric centers are offering 24/7 emergency care for all approved indications; and

WHEREAS, Many hyperbaric centers that do not offer 24/7 emergency care are receiving profits through non-emergent (and sometimes non-indicated) treatments, which pulls patients and revenue from those centers struggling to offer 24/7 emergency availability to their patient populations; and

WHEREAS, It appears that CMS considers hyperbaric medicine to be overutilized and/or abused, which is evidenced by the identification of hyperbaric medicine as the number one priority on the 2017 OIG work plan; and

WHEREAS, It is unlikely that emergency applications of hyperbaric medicine are wasteful or overutilized; and

WHEREAS, Other medical societies, such as the American Academy of Sleep Medicine (AASM), have decreased waste and/or overutilization, as well as improved patient care, by requiring sleep center accreditation for federal payment; and

WHEREAS, While the Undersea & Hyperbaric Medical Society (UHMS) has an existing accreditation system, it is underutilized (only 205 of more than 1,400 hyperbaric medicine centers are accredited), likely due in part to lack of incentives; and

WHEREAS, Under a current proposal by the UHMS, supported by the ACEP Undersea & Hyperbaric Medicine Section, facility accreditation requirements would be bolstered to mandate (i) board-certified medical directors, (ii) expanded training requirements for all providers, and (iii) 24/7 emergency availability (or create partnerships with other 24/7 facilities); and

WHEREAS, If accreditation was required for federal payment, there would be a subsequent increase in demand for fellowship training and board certification in Undersea & Hyperbaric Medicine; and

WHEREAS, If federal payment was contingent on facility accreditation and training demand thus increased, the UHMS, the Council of [Undersea & Hyperbaric Medicine] Fellowship Directors (COFD), and ACEP could work to create new fellowship opportunities and improve training programs to help decrease non-indicated applications of undersea and hyperbaric medicine; and

WHEREAS, The UHMS plans to utilize funds collected through the accreditation program to support
RESOLVED, That ACEP work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea & Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to receive federal payment.

Background

The resolution directs ACEP to work with the Undersea & Hyperbaric Medical Society (UHMS) and ACEP’s Undersea & Hyperbaric Medicine Section to ask CMS to require that hyperbaric facilities be accredited to receive federal payment.

Under current policy, accreditation is not required by CMS for federal payments to be made to hyperbaric centers. According to UHMS, there are currently 203 accredited hyperbaric centers in the United States.

There is recent precedent for requiring accreditation for federal payment that is relevant to this resolution. In 2017, Local Coverage Determination (LCD) L36839 was issued by Wisconsin Physicians Services, a Medicare Administrative Contractor (MAC), that required sleep centers and staff credentials to be accredited by the American Academy of Sleep Medicine (AASM), The Joint Commission (TJC), or the Accreditation Commission for Health Care (ACHC). WPS indicated that this LCD was simply a clarification of existing policy, though some facilities were caught off guard by this revision, particularly those who were accredited by TJC, but had not specifically requested the ambulatory care accreditation.

It is worth noting that requiring accreditation may create additional burdens for facilities, both in terms of costs and the delays associated with the accreditation timeline, which can take as long as six months to complete. Additionally, the process for implementing this policy is worth considering as well. The MAC process of issuing Local Coverage Determinations has been subject to criticism from a wide variety of stakeholders, primarily due to a lack of transparency of how determinations are made and inconsistency in payment policies throughout the country. MACs have recently received more scrutiny from federal lawmakers as well, and the lessons learned from the WPS decision may be helpful for determining the most appropriate strategy for securing the changes sought by this resolution.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources

Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP’s position to CMS and relevant regulators.

Prior Council Action

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted. Directed ACEP to work with Undersea and Hyperbaric Medical Society and the Divers Alert Network to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the US to provide appropriate and timely care to patients in need.

Resolution 33(10) Support of Subspecialty Certification and Fellowships in Undersea and Hyperbaric Medicine adopted. Called for ACEP to support ABEM subspecialty certification in Undersea and Hyperbaric medicine (UHM) for physicians board certified in emergency medicine and promotion and development of ACGME accredited fellowship program in UHM.
Resolution 35(17) Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment
Page 3

Prior Board Action

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted.

Resolution 33(10) Support of Subspecialty Certification and Fellowships in Undersea and Hyperbaric Medicine adopted.

October 2004, reviewed ACEPs liaison relationships with outside organizations. Members of the UHM Section were active members in the UHMS and the current liaison personally funded travel for liaison activities. The Board approved discontinuing funding for the liaison relationship.

November 1987, established an official liaison relationship with UHMS and the American College of Undersea and Hyperbaric Medicine.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 36(17)

SUBMITTED BY: AAWEP Section
Emergency Medicine Residents’ Association
Diana Fite, MD, FACEP
Sarah Hoper, MD, FACEP
Iowa Chapter
Fotini Manizate, MD
Missouri College of Emergency Physicians
Washington Chapter
Young Physicians Section

SUBJECT: Maternity and Paternity Leave

PURPOSE: Advocate for paid parental leave, develop a policy statement in support of paid parental leave, conduct an environmental survey, and develop a paper on best practices regarding maternity and paternity leave for emergency physicians.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy, develop a paper, and advocating for adoption of paid parental leave policies. Unknown costs for conducting an environmental survey (depends on the resources needed).

WHEREAS, the United States is one of six out of 193 countries in the United Nations that does not mandate paid maternity leave\(^1\) and 50 countries provide six months or more of paid leave;\(^2\) and

WHEREAS, 40% of American workers do not meet the requirements for 12 weeks of unpaid leave provided by the Family Medical Leave Act (FMLA) because they have not worked 1,250 hours in the past year or they do not work for an employer with more than 50 employees;\(^3\) and

WHEREAS, Only 12% of workers in the private sector get paid maternity leave through their employers;\(^4\) and

WHEREAS, 23% of surveyed women reported taking two weeks or less of maternity leave because they could not afford more;\(^5\),\(^6\) and

WHEREAS, Women with 12 weeks of paid leave are more likely to breastfeed for six months,\(^7\) women with 12 weeks or more of paid maternity leave have lower rates of post-partum depression,\(^8\) and paid maternity leave is associated with lower infant mortality rates;\(^9\) and

WHEREAS, Fathers that take paternity leave have higher satisfaction with parenting,¹⁰ are more engaged in the care of their children nine months after birth,¹¹,¹²,¹³ children with engaged fathers have fewer behavioral and mental health problems,¹⁴ and longer paternity leave with fathers caring for young children is associated with higher cognitive test scores,¹⁴,¹⁵ and

WHEREAS, Some academic emergency medicine programs provide paid maternity and paternity leave of differing number of weeks or days; and

WHEREAS, A few private emergency medicine practice groups have developed innovative ways to help with paid maternity and paternity leave that should be shared with other groups; and

WHEREAS, Despite the Equal Pay Act of 1963 prohibiting discrimination on account of sex in the payment of wages by employers, there is still an approximately $20,000 wage gap between men and women in medicine even when adjusted for factors that may impact compensation; and

WHEREAS, Offering only paid maternity and not paternity leave may increase the wage gap; therefore be it

RESOLVED, That ACEP advocate for paid parental leave, including but not limited to supporting the American Medical Association’s effort to study the effects of the Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); and be it further

RESOLVED, That ACEP conduct an environmental survey and develop a paper on best practices regarding maternity and paternity leave for emergency physicians; and be it further

RESOLVED, That ACEP develop a policy statement in support of paid parental leave.

Background

This resolution directs the College to advocate for paid parental leave, develop a policy statement in support of paid parental leave, conduct an environmental survey, and develop a paper on best practices regarding maternity and paternity leave for emergency physicians.

The Family and Medical Leave Act (FMLA) entitles eligible workers to take job-protected, unpaid leave of up to 12 weeks for the birth of a child or to care for a child within one year of birth. Those eligible for this protection are workers with at least 1,250 hours of service during the previous 12 months at an employer with at least 50 employees. At least 14 states and some major cities have enacted laws that expand on the FMLA protections, most typically by increasing the length of leave allowed and/or expanding coverage to a larger number of employees.

At least four states have implemented paid parental leave programs. Typically funded by employee payroll taxes, these state programs mandate paid coverage of various lengths and amounts. For example, a New York law that goes into effect January 1, 2018, provides maximum leave benefit of 50% of an employee’s weekly wage for up to eight weeks.

Several cities also have mandatory paid parental leave programs for private employers. In 2016, San Francisco became the first major U.S. city to mandate fully paid parental leave, requiring employers with 20 or more employees to offer six weeks paid time off for new mothers and fathers.

Increasingly, private employers have voluntarily initiated or expanded paid parental leave programs, including several hospitals. New York Presbyterian Hospital recently expanded its leave policy to provide six to eight weeks of paid disability leave for the birth mother and an additional six weeks paid parental leave. Children’s National Health System provides six to eight weeks paid maternity leave and two weeks paid paternity leave.

Several studies have concluded that extended paid maternity leave results in improved physical and mental health for the mother as well as health and developmental improvements for the child. While proponents claim the programs also improve worker morale, loyalty, and productivity, opponents raise concerns about the increase in taxation required to fund such programs and potential unintended consequences, such as employers becoming less likely to hire women due to concerns of higher costs and loss of productivity if new mothers can take extended periods of paid leave.

Regarding parental leave time for emergency physicians, ACEP first adopted a policy on “Parental Leave of Absence” in 1990. The current version of that policy statement, now entitled “Family Leave of Absence”, states in part that:

“Emergency physician groups, employers, and emergency medicine residency programs should have written policies that support family leaves of absence. These policies should apply to a personal serious illness, both parents for the birth or adoption of a child, the care of a seriously ill family member, or to situations involving either the safety or cohesion of the family (including mental health emergencies). The leaders of physician groups and residency programs, as well as employers, should actively support these policies by informing physicians of them and making their provisions available without undue delay or administrative burden. Flexible work schedules and the use of compensatory leave time (where applicable) should be made available to affected physicians whenever it is possible to do so without disrupting the availability of patient care.”

In 2016, the AMA adopted a policy entitled “Parental Leave” (H-405.954), which states:

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.”

The initial resolution that led to this policy, Resolution 215 (I-16), asked the AMA to conduct the patient study described in Number 1 above, but the House of Delegates adopted a revised resolution that the AMA would encourage such a study.

Regarding the physician study referenced in the second Whereas statement, AMA staff indicated that a report was scheduled for presentation to the AMA Board of Trustees in September 2017. At the time this background was written, AMA staff indicated that the report would conclude that there is no information available related to FMLA’s specific effect on physicians distinct from anyone else and trying to determine the impacts of various possible expansions of the FMLA on physicians in different practice environments would be highly speculative.

The AMA has an additional relevant policy, entitled “Paid Sick Leave” (H-440.823). That policy, adopted earlier in 2016, states:

“Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time
Resolution 36(17) Maternity and Paternity Leave

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off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care
for themselves or a family member; and (3) supports employer policies that provide employees with unpaid
sick days to use to care for themselves or a family member where providing paid leave is overly
burdensome.”

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective C – Promote member well-being and improve resiliency.

Fiscal Impact

Budgeted committee and staff resources to develop a policy, develop a paper, and advocating for adoption of paid
parental leave policies. Unknown costs for conducting an environmental survey (depends on the resources needed).

Prior Council Action

Amended Resolution 44(88) Perinatal Leave for Emergency Physicians adopted. The resolution called for the College
to develop educational guidelines for emergency physicians regarding maternal/paternal/adoption leave and associated
issues for emergency physicians and emergency medicine residents.

Prior Board Action

April 2012, reaffirmed the policy statement “Family Leave of Absence;” previously revised and approved October

September 1988, Resolution 44(88) adopted.

Background Information Prepared by: Craig Price, CAE
   Senior Director, Policy and Finance

Reviewed by: James Cusick, MD, FACEP, Speaker
   John McManus, MD, FACEP, Vice Speaker
   Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
WHEREAS, Heroin injection as a means of satisfying opioid dependence or use disorder has doubled nationally in the past decade; and

WHEREAS, The number of deaths attributed to heroin injection overdoses have quadrupled nationally since 2010; and

WHEREAS, Persons who inject drugs (PWID) are less likely to access health care or call emergency services in the case of lethal overdose in part due to fear of criminal penalties and are more likely to contract infectious diseases such as HIV, hepatitis C, and soft tissue infections; and

WHEREAS, Medically supervised injection facilities (MSIFs) are sites providing sterile injection equipment where adults may consume pre-obtained controlled substances under medical supervision in a hygienic facility; and

WHEREAS, In areas where they are established, MSIFs reduce the number of overdose deaths, reduce transmission rates of infectious disease, increase the number of individuals initiating substance use therapy, improve access to care for those that would not otherwise access the health care system, and to date have had no documented fatalities; and

WHEREAS, MSIFs effectively attract and provide services for PWID who are at greatest risk due to homelessness, daily use, and recent nonfatal overdose; and

WHEREAS, MSIFs do not increase overall illicit drug use, encourage drug use, or promote first-time drug experimentation; and

WHEREAS, MSIFs create significant health care savings due to averted infections and deaths and provide social benefits of reducing public injecting, syringe litter, and local crime including vehicle break-ins and thefts; and

WHEREAS, ACEP should make combating the opioid use epidemic one of its core priorities; therefore be it

RESOLVED, That ACEP support the legalization, authorization, and implementation of medically supervised injection facilities in coordination with state and local health departments; and be it further

RESOLVED, That ACEP support the decriminalization of the possession of illegal substances in medically supervised facilities, as well as legal and liability protections for persons working or volunteering in such facilities.
Background

This resolution directs ACEP to support the legalization, authorization, and implementation of Medically Supervised Injection Facilities (MSIFs or SIFs) in coordination with state and local health departments, and that ACEP support decriminalization of the possession of illegal substances in such facilities, as well as legal and liability protections for persons working or volunteering in such facilities.

Resolution 31(17) Endorsement of Supervised Injection Facilities is similar in that it addresses supervised injection facilities. Much of the background information is the same for both resolutions.

The abuse of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin.

The White House Office of National Drug Control Policy (ONDCP) has made the opioid abuse issue a top priority and is identifying additional opportunities for collaboration between government agencies and external stakeholders to combat this growing national crisis. On March 29, 2017, President Donald Trump signed an Executive Order establishing the President’s Commission on Combating Drug Addiction and the Opioid Crisis, with the commission chaired by Governor Chris Christie. In August 2017, President Trump indicated he would declare the opioid epidemic a national emergency though as of September 11, 2017, an official declaration is yet to be made.

The Centers for Disease Control and Prevention (CDC) recently reported that the 2015 age-adjusted rate of drug overdose deaths in the U.S. was more than 2.5 times the rate in 1999. This is part of a 16-year trend of increasing opioid overdose deaths that are directly related to overdoses from prescription opioids. The CDC also noted the percentage of opioid deaths involving heroin was triple the percentage in 2010. Since 1999, the amount of opioids sold has nearly quadrupled and deaths from prescription opioids have had a corresponding increase.

The concept of Medically Supervised Injection Facilities has been proposed as a public health intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, hepatitis C and soft tissue infections. These facilities provide sterile injection equipment under medical supervision to prevent the sharing of syringes and injection materials, with many offering counseling and informational services as well. According to the Drug Policy Alliance, there are approximately 100 SIFs operating in 66 cities throughout the world, though none currently exist in the U.S. The establishment of SIFs in the U.S. remains a controversial topic as critics argue such policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related crime, while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced overdose rates that help contribute to a reduced need for emergency services. There are also additional legal aspects with regard to possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that will need to be addressed if SIFs are to be established in the U.S.

This resolution also directs ACEP to support the decriminalization of the possession of illegal substances in MSIFs, as well as legal and liability protections for persons working or volunteering in such facilities. Decriminalization is also a controversial topic, and providing new legal and liability protections adds a layer of complexity throughout the policymaking process at both the state and local levels.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot SIFs in the U.S. that are designed, monitored and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)).

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
Fiscal Impact

Budgeted committee, staff, and consultant resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 38(17)

SUBMITTED BY: Connecticut College of Emergency Physicians
Emergency Medicine Residents’ Association
Geriatric Emergency Medicine Section

SUBJECT: Prescription Drug Pricing

PURPOSE: Create a policy statement: 1) recognizes how the threat of unaffordable prescription drug prices affects patients; 2) supports Medicare drug price negotiation in Part D; 3) supports importation of prescription drugs; 4) supports value-based pharmaceutical pricing; and 5) work with the AMA to support regulatory and legislative efforts.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources.

WHEREAS, Per capita prescription drug spending in the United States is the highest in the world1; and

WHEREAS, Spending for prescription drugs constitutes nearly one-fifth of total health care costs in the United States1; and

WHEREAS, The price of prescription drugs continues to rapidly increase, outpacing spending increases for other health care expenditures1; and

WHEREAS, Cost-related medication non-adherence is associated with increased emergency department utilization2; and

WHEREAS, Prices continue to skyrocket for medications necessary for the prehospital treatment of life-threatening conditions, such as naloxone for opioid overdose3 and epinephrine auto-injectors for anaphylaxis4, where cost-related unavailability may lead to unnecessary preventable death; and

WHEREAS, The Medicare Modernization Act of 2003 created Medicare Part D, which currently pays for 30% of all national prescription drug expenditures, but prohibits the Secretary of the Department of Health and Human Services (HHS) from negotiating prices1; and

WHEREAS, The majority of Americans believe that lowering the cost of prescription drugs should be a top health care priority5; and

WHEREAS, Consistent with public opinion6, the American Medical Association has adopted policies to encourage prescription drug price and cost transparency7, to support negotiation of drug prices under Medicare Part D8, to allow wholesalers and pharmacies to import prescriptions drugs9, and to support the creation of objective, independent entities to determine value-based prices of pharmaceuticals10; therefore be it

RESOLVED, That ACEP create a policy statement that:
• recognizes the threat that unaffordable prices of medications used to treat acute and chronic diseases poses to our patients and the challenges this imposes upon the emergency medical system;
• supports the negotiation of drug prices under Medicare Part D;
• supports the importation of prescription drugs; and
• supports value-based pharmaceutical pricing; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholders to support regulatory and legislative efforts to address these issues.
Resolution 38(17) Prescription Drug Pricing
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References

Background

The resolution calls for ACEP to create a policy statement that: 1) recognizes how the threat of unaffordable prescription drug prices affects patients; 2) supports Medicare drug price negotiation in Part D; 3) supports importation of prescription drugs; 4) supports value-based pharmaceutical pricing; and 5) work with the American Medical Association to support regulatory and legislative efforts to address these issues.

The rising costs of prescription drugs is a multifaceted problem that has garnered greater attention from patients, providers, and lawmakers over the past several years. A 2016 report in the Journal of the American Medical Association (JAMA) found that per-capita prescription drug spending in the U.S. has increased at rates “far beyond the consumer price index.” The report cites market exclusivity as the most important factor, with the main method of reducing prices – the availability of generic drugs – subject to years of intentional delays. The report also indicates another key contributor to drug spending is physician prescribing choices when cheaper alternatives are available. Many have also pointed to the growth in spending on new specialty or breakthrough drugs as a major contributing factor in overall drug spending in the U.S.

Others note factors like the rapid growth of pharmacy benefit managers (PBMs) and a lack of transparency about their role in negotiating drug prices and providing rebates, with questions about conflicts of interest arising as more PBMs have been acquired by insurers or pharmacy companies. And while pharmaceutical manufacturers often cite the high costs of research and development as a factor in pricing determinations, there appears to be little independent evidence that these costs account for drug prices.

Efforts to curb spending growth and reduce drug prices are varied. The resolution calls for price negotiation in Medicare Part D, which was prohibited through a “noninterference” provision when the program was established in the Medicare Modernization Act (MMA) of 2003. While calls to allow for price negotiation have been a common policy position for many Democrat legislators, Republican lawmakers have largely opposed such efforts. However, as candidate, and now as President, Donald Trump also voiced support for direct price negotiation throughout the Medicare program. This line of thinking appears to be popular among the public as well – the Kaiser Family Foundation notes that this policy is supported by 82 percent of the public, including 68 percent of Republicans.
However, previous estimates from the nonpartisan Congressional Budget Office (CBO) suggest that allowing Medicare to negotiate prices would have a negligible effect on federal spending.

This resolution also calls for the importation of prescription drugs, which is not currently allowed under U.S. law. Supporters point to lower patient costs in other countries for the same drugs available in the U.S. as a substantial benefit for consumers. For opponents of importation, safety and efficacy are the predominant concerns, as it becomes more difficult to monitor the supply chain and ensure the quality of the drugs. While President Trump has in the past declared support for importation, influential members of his administration, including Health & Human Services Secretary Tom Price, MD, and Food & Drug Administration Commissioner Scott Gottlieb, are on record as longtime opponents of drug importation.

ACEP is a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC also has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is also developing bi-partisan, market-based solutions to lower drug prices in the United States. Additionally, the ACEP Foundation also worked with Pfizer in 2010 as a supporter of the Partnership for Prescription Assistance to ensure that emergency department patients know that assistance is available, especially for those who are uninsured, unemployed, or on fixed incomes.

The AMA has multiple policies addressing this issue: Pharmaceutical Cost H-110.987; Cost of Prescription Drugs H-110.997; Price of Medicine H-110.991; Reducing Prescription Drug Prices D-110.993; Prescription Drug Prices and Medicare D-330.954; Prescription Drug Importation and Patient Safety D-100.983; and Incorporating Value into Pharmaceutical Pricing H-110.986.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee, staff, and consultant resources.

Prior Council Action

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and provide a report to the 2016 Council.

Prior Board Action

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted.

Background Information Prepared by:  Ryan McBride, MPP
Senior Congressional Lobbyist
Margaret Montgomery, RN, MSN
Practice Management Manager
Craig Price, CAE
Senior Director, Policy and Finance

Reviewed by:  James Cusick, MD, FACEP, Speaker
              John McManus, MD, FACEP, Vice Speaker
              Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 39(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Prohibition on ACEP Interference in State Legislative Activities

PURPOSE: Develop a policy addressing ACEP involvement in state level regulatory and legislative initiatives separate from a chapter’s request or a conflict with ACEP policy and present that policy for discussion at the 2018 Council meeting.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP is the premier professional organization representing the practice and specialty of Emergency Medicine and is among one of the best organizations in the country in promoting the specialty and interests of Emergency Medicine, and the patients we serve, at the national level; and

WHEREAS, One of the greatest strengths of the national organization, ACEP, is the vibrant, independent, active state chapters that can best represent the interests of the local practicing Emergency Physicians at the grassroots state level; and

WHEREAS, One of the key strengths of any professional organization is the ability to be responsive and connected to the grassroots members and their issues; and

WHEREAS, Many of the autonomous state chapters maintain active organizations that are connected to the national organization but are best able to actively and effectively represent their members’ interests and issues at the state level; and

WHEREAS, Many of the state chapters have their own policy efforts with their own state legislative agendas, connections, and relationships, including collaborative efforts with their own state medical associations; and

WHEREAS, There is remote history where ACEP, and/or its elected leaders, have interfered, given conflicting messages, and/or contradicted state legislative efforts resulting in great disruption and confusion in state policy and legislative efforts; and

WHEREAS, It is not appropriate for ACEP to supersede state level policy and legislative efforts or overrule state policy agendas; therefore be it

RESOLVED, That ACEP develop policy that addresses ACEP involvement in state level regulatory and legislative agendas, including direct lobbying efforts, without expressed formal request to ACEP by the state chapter and without formal established explicit ACEP policy conflict; and be it further

RESOLVED, That ACEP present a policy that addresses ACEP involvement in state level regulatory and legislative activities for consideration and comment at the 2018 Council meeting.

Background

This resolution calls for ACEP to develop a policy addressing ACEP’s involvement in state regulatory and legislative activities when not requested to do so by the state chapter and when there is no formal and explicit ACEP policy
conflict. The resolution also directs ACEP to present the policy for consideration and comment at the 2018 Council meeting.

There are 53 ACEP chapters with varying resource levels, staffing models, and engagement in state advocacy efforts. Approximately half of the state chapters contract with lobbyists. ACEP members and chapters work frequently with state medical society lobbyists or related interest groups to address legislative and regulatory issues impacting emergency medicine. ACEP leaders and staff provide a variety of resources to state chapters, including materials related to ACEP policies and interests, legislative information, political intelligence, state public policy grants, public relations resources, assistance with letters and talking points for use with policymakers, and policy expertise to assist chapters with their advocacy efforts. ACEP also works collaboratively with a variety of national interests to facilitate collaboration on both the national and state level. National ACEP does not contract with registered state level lobbyists in any state.

While ACEP offers assistance and support for chapter advocacy efforts, the scope and direction of state legislative and regulatory activity is at the direction of the chapter. In the vast majority of cases, all parties agree on the position that should be taken on legislation impacting emergency medicine. Occasionally, differences of opinion arise over how complex legislation may impact emergency medicine practice. State chapters will sometimes experience internal debate on how or whether to approach particular legislation, or on very rare occasions, differences of majority opinion may arise between state and national ACEP leadership. In 2017, the Texas College of Emergency Physicians (TCEP) determined to monitor legislation related to maintenance of certification (MOC) without taking a formal, public position. National ACEP leadership was urged by other national organizations to act on its own and formally take a position on the state legislation. Ultimately, after consulting with TCEP leaders, ACEP decided not to engage in efforts regarding the legislation.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
   Objective A - Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
   Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
   Objective E – Achieve meaningful liability reform at the state and federal levels.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

May 2017, the Executive Committee discussed a request from the American Board of Emergency Medicine to intervene in the pending Texas legislation on maintenance of certification and send email messages to legislators to block the bill from a vote. There was consensus that ACEP should not act to lobby against the Texas legislation. The Board ratified the actions of the Executive Committee at their June 2017 meeting.

April 2017, discussed the Senate bill in Texas regarding MOC.

Background Information Prepared by: Harry J. Monroe, Jr.
   Director, Chapter & State Relations

Reviewed by: James Cusick, MD, FACEP, Speaker
   John McManus, MD, FACEP, Vice Speaker
   Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 40(17)

SUBMITTED BY: Indiana Chapter

SUBJECT: Reimbursement for Emergency Services

PURPOSE: 1) Continue to uphold federal prudent layperson laws; 2) advocate for patients to prevent negative clinical or financial impact caused by lack of reimbursement; 3) partner with affected states and the AMA; and 4) work with Anthem and other third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources. Additional travel expenses of approximately $5,000 to meet in person with Anthem. Additional unknown expenses if legal action is initiated.

WHEREAS, Emergency Medicine is recognized by the American Board of Medical Specialties as an independent specialty with a recognized unique knowledge base and procedural skill set that is certifiable by board examination; and

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires Emergency Departments to provide a medical screening examination including stabilization and treatment regardless of ability to pay to all patients who present themselves to the Emergency Department requesting medical care; and

WHEREAS, ACEP supports the “prudent layperson” definition of an emergency medical condition as one in which a person who possess an average knowledge of health and medicine and might anticipate serious impairment to their health; and

WHEREAS, The range of emergency medical conditions experienced by patients seen in emergency departments is extremely variable and difficult to recognize by patients; and

WHEREAS, Anthem has announced intention to deny reimbursement for Emergency Medical services when Anthem defines the condition as non-emergent and has requested that providers direct patients to care sites with lower levels of service; and

WHEREAS, The value of emergency medical services cannot be defined as a presenting symptomatic complaint or final diagnosis; and

WHEREAS, The Indiana chapter of ACEP supports ACEP in endeavors to ensure access to care for all patients; therefore be it

RESOLVED, That the policy of many third party payers including Anthem of denying payment for Emergency Medical Services is in opposition to the prudent layperson definition of an emergency and federal EMTALA laws; and be it further

RESOLVED, That ACEP work with Anthem and other third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care; and be it further

RESOLVED, That ACEP, in order to promote public health and patient safety, continue to uphold federal
Resolution 40(17) Reimbursement for Emergency Services
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EMTALA laws by providing a medical screening examination and appropriate medical care to all patients who request emergency services and ACEP will advocate for subsequent reimbursement for such services; and be it further

RESOLVED, That ACEP continue to advocate for our patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services; and be it further

RESOLVED, That ACEP partner with affected states and the American Medical Association to oppose this harmful policy and the denial of payment for emergency services.

Background

This resolution directs ACEP to continue to uphold federal prudent layperson laws (PLP), advocate for patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services, and partner with affected states and the AMA on these issues. It also calls on ACEP to work with Anthem and other third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

History of Prudent Layperson Federal and State Laws

The first PLP law was enacted in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC) drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included the PLP standard. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from the PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of a PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. As of July 1, 2017, 47 states and the District of Columbia have adopted a PLP law covering access to emergency medical care.

Federally, the Balanced Budget Act of 1997 originally implemented the PLP for Medicaid Managed Care and Medicare recipients and was the prequel to the ACA language standard subsequently adopted as the model for all health plans. However, this remains a source of legislative and regulatory controversy across many states. As previously mentioned, the 2010 ACA Bill of Rights adopted PLP language, however individual insurers have continued to try to reduce payments for emergency care they deem to be non-emergent.

Challenging the Anthem Policy on Retrospective Denials and Down Coding

Anthem has rolled out a policy in Georgia, Indiana, Kentucky, and Missouri, that retrospectively denies coverage for ED services providing care for conditions they deem not to be actual emergencies and that could have been effectively treated in a lower acuity setting. Since May 2017, ACEP has been actively monitoring and challenging the policy and has been protesting an extensive list of diagnoses that Anthem deems to be non-emergent. For ED use, Anthem recommends the following: “You should always go to the ER if you believe your life or health is in danger. However, for less severe injuries or illnesses, the ER can be expensive and wait times can average over 4 hours”; although, the policy lists conditions that may require immediate screening for more serious diagnoses.

ACEP sent a letter to Anthem’s President and CEO Joseph Swedish in August 2017 asking him to immediately cease their policy, citing PLP violations. In that letter, ACEP provided data from a study that showed of nearly 35,000 unique ED visits, 6.3% of visits were determined to have primary care–treatable conditions based on discharge diagnosis, yet the chief presenting complaints reported for these ED visits were the same chief complaints reported for 88.7% of all ED visits. Of these visits, 11.1% were serious enough to be identified at ED triage as needing immediate emergency care, and 12.5% required hospital admission. The letter also challenged the nature of the cases Anthem exempted from the policy; patients 13 years of age or younger, patients directed to the ED by a physician, patients not
within 15 miles of an urgent care center, and/or the visit occurs on a Sunday or major holiday, as being arbitrary or unclear. It closes by expressing concern about patients with true emergencies that could delay needed care because of fear that they would be stuck with large bills.

As of the writing of this background material, ACEP’s Washington, DC Office staff initiated a public relations campaign to push back on Anthem’s policy in the media and proposed to the ACEP Board a comprehensive plan to involve third party stakeholders, while simultaneously seeking relief from congressional and state legislature leaders. On the regulatory front, ACEP is considering a meeting with the Department of Health & Human Services (DHHS) and the Center for Consumer Information & Insurance Oversight (CCIIO) at the national level and encouraging chapters to involve their state insurance commissioners in the fight. CCIIO is charged with helping implement many reforms of the ACA and oversees the implementation of the provisions related to private health insurance.

ACEP will also develop a toolkit to reach out to third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts to halt implementation of the policy. For example, Congressional pressure on the Anthem plan in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to DHHS or CCIIO to encourage their action, and a Hill briefing (panel of emergency physicians, consumer representative, impacted patient). In the states, ACEP is working with chapters to identify champions in the state legislatures and/or governors’ offices who might have influence with the insurance commissioner, develop op-eds in key markets to influence state lawmakers, and work with chapters to encourage impacted constituents to write to their legislators.

To support all of this work, efforts are being made to track and collect payment denials by Anthem in states where the policy has taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the prudent layperson standard. The ACEP DC office launched a website to collect patient stories of denials, and is beginning to publicize it more broadly. Finally, ACEP will continue to explore legal options to prevent Anthem from enforcing this policy, including possible injunctions.

Current AMA Policy on Prudent Layperson

The AMA House of Delegates adopted the following resolution at the June 2017 annual meeting:

RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (Directive to Take Action)

The AMA sent a letter on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee, staff, and consultant resources. Additional travel expenses of approximately $5,000 to meet in person with Anthem. Additional unknown expenses if legal action is initiated
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**Prior Council Action**

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 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, a payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted. Directed ACEP to collaborate with other organizations to lobby the federal government to fund EMTALA-mandated services not covered by current funding mechanisms.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed that ACEP solicit member input to formulate and submit recommendations to CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among 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. This resolution called for the College to work with appropriate organizations and agencies to improve EMTALA for emergency departments; and that the Board of Directors report back to the membership regarding progress on these endeavors at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board. The resolution called on the College to support a requirement that when a patient calls their HMO with questions regarding medical care, that decisions are made by an appropriate licensed professional according to sound triage protocols developed by qualified individuals.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted. The resolution called for the College to investigate and report back on the establishment of an ACEP office of EMTALA usage and compliance for the development of continuing programs for comprehensive regulatory monitoring, member and public education and the coordination of legal and regulatory advocacy for an environment which is conducive to appropriate emergency practice.

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 state that have the definition in law.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. This resolution called on the College to continue its current efforts with appropriate government agencies and other interested parties regarding the following EMTALA issues: (1) the role that health care insurance entities have played in denying access to emergency care to their beneficiaries, and ensure that those entities come under the jurisdiction of the statute; (2) the distorted interpretation and misuse of the original intent of the statute; and (3) seeking relief from the onerous implications of the law in light of managed care; and report back to the Council at the 1997 meeting.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors, due to ongoing efforts in support of United States House of Representatives bill H.R. 2011. This resolution called for the College to urge managed care organizations to adopt a “prudent layperson” definition to ensure access to timely emergency care for all subscribers.

Substitute Resolution 39(90) Amendments to COBRA adopted. This resolution called for the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.
Resolution 40(17) Reimbursement for Emergency Services

Page 5

Substitute Resolution 49(86) Patient Transfer adopted. This resolution called for the College to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

**Prior Board Action**

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.


April 2016, approved the revised policy statement “Fair Payment for Emergency Department Services;” originally approved April 2009.

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.


Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Resolution 31(01) Possible Violation of the Constitutional Rights of Emergency Physicians not adopted. Called for ACEP to obtain a legal opinion on whether EMTALA violates the constitutional rights of emergency physicians.

Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.
Background Information Prepared by:  David A. McKenzie, CAE, Reimbursement Director
                        Adam Krushinskicke, MPA, Reimbursement Manager

Reviewed by:  James Cusick, MD, FACEP, Speaker
               John McManus, MD, FACEP, Vice Speaker
               Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 41(17)
SUBMITTED BY: Illinois College of Emergency Physicians
SUBJECT: Reimbursement for Hepatitis C Virus Testing Performed in the ED

PURPOSE: Encourage adoption of state laws that expand reimbursement for HCV testing to additional settings, including the emergency department.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, An estimated 3.2 million people in the United States are currently living with chronic Hepatitis C Virus (HCV) infection, 50% of whom may not even be aware of their condition and remain undiagnosed; and

WHEREAS, Patients with chronic HCV infection are at risk of developing cirrhosis, hepatocellular carcinoma, and extra-hepatic complications leading to significant costs to the healthcare system and patient; and

WHEREAS, Patients born during 1945-1965 comprise about 75% of the current HCV cases in the United States and a significant number of these patients have comorbid conditions including intravenous drug use; and

WHEREAS, The Emergency Department oftentimes functions as a safety net for those patients who otherwise may not have access to healthcare; and

WHEREAS, There is effective treatment to cure HCV infection, especially those diagnosed at early stages of fibrosis; and

WHEREAS, The evidence is adequate to conclude that screening for HCV is considered a grade “B” recommendation by the U.S. Preventive Services Task Force (USPSTF) and CMS will cover screening for HCV when ordered within the context of a primary care setting for adults at high risk for HCV infection and for those who were born from 1945 through 1965; and

WHEREAS, For the purposes of national coverage determination (NCD), Emergency Departments, as well as inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are explicitly not considered primary care settings appropriate for testing; and

WHEREAS, HIV testing previously faced similar scrutiny, and it is currently accepted that Emergency Departments are an ideal location for routine and/or non-risk based testing for patients; and

WHEREAS, Not all states currently allow for reimbursement for laboratory testing for certain conditions, including HCV testing, outside of the primary care setting; therefore be it

RESOLVED, That ACEP encourage the adoption of state laws that allow for reimbursement for HCV testing in settings beyond the primary care setting including the Emergency Department.

References
Background

This resolution calls for ACEP to encourage the adoption of state laws that expand reimbursement for Hepatitis C Virus (HCV) testing to additional settings, including the emergency department.

Current Reimbursement Policies

Reimbursement for HCV testing has been determined by CMS and the U.S. Preventative Services Task Force (USPSTF) to cover only primary care physicians who can assess the patient’s history as part of the annual wellness visit in a patient’s comprehensive prevention plan. Acceptance of HCV as a reimbursable screening test for preventative care by CMS and the USPSTF is strictly limited to the primary care setting. For professional billing requirements to be met, HCPCS code G0472 (HCV screening) must be submitted by one of the following provider specialties: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatric Medicine, Geriatric Medicine, Certified Nurse Midwife, Nurse Practitioner, Certified Clinical Nurse Specialist, or Physician Assistant – Emergency Medicine is not included.

The USPSTF recommends offering one-time screening for HCV infection in adults born between 1945 and 1965. Since this population comprises 75% of all current HCV cases, coverage for testing has been provided mainly by government programs such as Medicaid and Medicare.

Medicare, which provides health care insurance for much of the covered population group already 65 and older, will only cover HCV screening tests without coinsurance or deductibles if they are ordered by a primary care physician or practitioner. In June 2014, CMS issued a National Coverage Determination based on the USPSTF recommendation for HCV testing that covers one-time testing for those covered by traditional Medicare. Medicare Advantage plans are also required to offer screening and cannot charge deductibles, copays or coinsurance; however, they are limited to primary care visits.

Medicaid coverage of screening is highly dependent on HCV testing being medically necessary and whether a state has elected to cover preventive services such as screenings without cost-sharing being applicable. The Social Security Act requires state Medicaid programs (including managed care programs) to cover medically necessary lab services with the option to cover screening on a regular basis. Medicaid expansion plans under the ACA, beginning in 2014, cover screening without cost-sharing. Two types of state reimbursement policies for Medicaid apply, with some states covering routine HCV screening by primary care providers, while others cover only screening based on medical necessity, with only reimbursement for lab services covered in full.

For those not covered by Medicare or Medicaid, private insurance offers periodic screening for those “at risk” and one-time testing for those born between 1945-1965. The ACA required most individual and group market plans to cover screening; however, this only applies to plans enacted after June 25, 2014. Many grandfathered plans do not offer screening coverage.

Current State Laws and Regulations

Although no states currently allow for or enforce provisions in their statutes or regulations for reimbursement of HCV screening, six states have statutes requiring or recommending offering a screening test. Actions in other states have largely been symbolic, with signed resolutions and proclamations to create awareness of HCV testing in “baby boomers” and other at-risk populations.

California, Connecticut, Massachusetts, and Washington require primary care physicians to offer HCV screening to anyone born between 1945-1965. New York goes a step further and requires offering testing in in-patient facilities, outpatient facilities, and in the emergency department.

Colorado recommends health care providers offer HCV screenings to patients born between 1945-1965, but does not require reimbursement by payers. The statute only applies to services rendered by a primary care physician and is limited to patients not previously screened, not currently being treated for a life-threatening illness, and not lacking capacity to consent to a screening test.
ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

None

Prior Board Action

June 2017, approved the revised policy statement “Bloodborne Pathogens in Emergency Medicine” (which includes HCV); revised and approved April 2011, April 2004, and October 2000 with the revised title, “Bloodborne Infections in Emergency Medicine;” originally approved September 1996 with the title “HIV and Bloodborne Infections in Emergency Medicine.”

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
2017 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 42-55

John H. Proctor, MD, MBA, FACEP (TN), Chair
Enrique R. Enguidanos, MD, FACEP (WA)
Heather A. Heaton, MD, FACEP (MN Alt)
Marianna Karounos, DO, FACEP (NJ Alt)
Michael D. Smith, MD, MBA, CPE, FACEP (LA Alt)
James M. Williams, DO, MS, FACEP (TX)

Margaret Montgomery, RN, MSN
Loren Rives, MNA
RESOLUTION: 42(17)

SUBMITTED BY: Arizona College of Emergency Physicians

SUBJECT: ACEP Policy Related to Cannabis

PURPOSE: Directs that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, “Cannabis use remains a critical issue in the United States”\(^1\); and

WHEREAS, Although some may argue the untoward consequences of broadened availability of medical cannabis (such as accidental ingestion by children and others) is increasing, that could be said of any medication and fortunately most medical cannabis formulations have relatively low toxicity; and

WHEREAS, There are no legitimate medically recognized uses of marijuana, cannabis, synthetic cannabinoids, and similar substances in emergency care; and

WHEREAS, There is now sufficient evidence regarding the untoward negative medical, social, societal and economic impact of non-medical (e.g. recreational) use of cannabis and related compounds\(^1,2,3,4,5,6\); and

WHEREAS, The legalization, decriminalization, and efforts to promote the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances has resulted in broader availability leading to untoward long-term effects (such as transition to more serious illicit substance abuse) and increased toxicity due to various enhanced production techniques\(^1,2,3,4,5,6\); therefore be it

RESOLVED, That ACEP has no position on the medical use of marijuana, cannabis, synthetic cannabinoids and similar substances, in light of the fact there is no legitimate medically recognized use of such substances in emergency care; and be it further

RESOLVED, That ACEP does not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

References
6. “It is fair to say this is more than tricky. This is about the hardest, most complicated thing in public life that I’ve ever had to work on. I urge caution. My recommendation has been that they should go slowly and probably wait a couple of years. And let’s make sure that we get some good vertical studies to make sure that there isn’t a dramatic increase in teenage usage, that there isn’t a significant increase in abuse like while driving. We don’t see it yet but the data is not perfect. And we don’t have
Resolution 42(17) ACEP Policy Related to Cannabis
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enough data yet to make that decision.” John Hickenlooper, Governor, Colorado - 60 Minutes – Sunday, October 30, 2016
http://www.cbsnews.com/news/60-minutes-five-states-to-vote-on-recreational-pot/

Background

This resolution calls for the College to not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and to not support the non-medical use of marijuana, cannabis, synthetic cannabinoids, and similar substances.

The American Academy of Pain Medicine in their 2013 policy, “Position on Research into the Use of Cannabinoids for Medical Purposes,” states: “The lack of rigorous scientific and clinical research leave both physicians and patients alike at a disadvantage when considering the potential risks and benefits of cannabinoids as medicine….” The AAPM does not have a policy on participation in a pain management program and concurrent use of cannabinoids.

The AMA policy, “Cannabis for Medicinal Use H-95.952,” …calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. “…the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods … should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.”

The AMA policy, “Cannabis - Expanded AMA Advocacy D-95.976,” supports education of the media and legislators on the health effect of cannabis, urges legislatures to delay initiating full legalization of marijuana use until there is further research “on the public health, medical, economic and social consequences of use of cannabis.” The policy further calls for warning labels “… on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.”

From 2009 to 2016 the College has received eleven Council resolutions related to advocacy, treatment, legalization, regulation, and decriminalization of marijuana. Nine of these resolutions were not adopted by the Council and two were referred to the Board. Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use was assigned to the Emergency Medicine Practice Committee, the Ethics Committee, the Medical Legal Committee, and the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding any further action on the resolution. While many supported the decriminalization of possession of small amounts of marijuana, the majority did not support ACEP addressing this issue. In June 2017, The Board approved the recommendation from these three committees to take no further action on the referred resolution.

Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED was also assigned to the Emergency Medicine Practice Committee (EMPC) to review and provide a recommendation to the Board. This resolution called for ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication. In June 2017, the Board approved the committee’s recommendation to take no further action on Resolveds 1, 2, and 4 and approve their recommendations for Resolved 3 (assign to the Toxicology Section or other body for additional work to address intentional intoxications and accidental exposure) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness.) Once data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication.

Two other resolutions related to marijuana have been submitted to the 2017 Council:
Resolution 42(17) ACEP Policy Related to Cannabis
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- 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders
- 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board. This resolution called for ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. This resolution called for adoption and support of a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.
Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

**Prior Board Action**

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

June 2017, approved the Emergency Medicine Practice Committee’s recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolveds 3 and 5.

**Background Information Prepared by:** Margaret Montgomery, RN, MSN
Practice Management Manager

**Reviewed by:**
- James Cusick, MD, FACEP, Speaker
- John McManus, MD, FACEP, Vice Speaker
- Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 43(17)

SUBMITTED BY: AAWEP Section  
Larry Bedard, MD, FACEP  
Nicole Berwald, MD, FACEP  
Leila Getto, MD, FACEP  
Susan Haney, MD, FACEP  
Bernard Lopez, MD, FACEP  
Tracy Sanson, MD, FACEP  
Vicken Totten, MD, FACEP  
Evengeline Sokol, MD, FACEP  
Mary Westergaard, MD, FACEP

SUBJECT: Expanding ACEP Policy on Workforce Diversity in Health Care Settings

PURPOSE: Expand the policy statement “Workforce Diversity in Health Care Settings” to more clearly identify the diverse groups and promote inclusion of qualified individuals with additional diverse characteristics.

FISCAL IMPACT: Budgeted committee and staff resources:

WHEREAS, Attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal; and

WHEREAS, ACEP has a longstanding commitment to workforce diversity in health care settings; and

WHEREAS, ACEP currently has a Diversity & Inclusion Task Force, examining how ACEP can promote diversity and inclusion within emergency medicine by engaging colleagues, identifying and breaking down barriers, and highlighting the effects of diversity and inclusion on patient outcomes as a path to improving these outcomes;¹ and

WHEREAS, The inclusion of diversity and inclusion is an important part of ACEP's strategic plan;² and

ACEP’s Board of Directors is now working “to promote and facilitate diversity, inclusion, and cultural sensitivity” as an integral part of the ACEP strategic plan; and

WHEREAS, Current ACEP policy confines its description of workforce diversity to include qualified individuals who reflect only the ethnic and racial diversity in our nation;³ and

WHEREAS, The ACEP Diversity & Inclusion Task Force has identified numerous additional minority groups that contribute to the diversity, resilience, well-being, and quality of patient care in emergency medicine; and

WHEREAS, The Task Force has identified five initial focus groups (age, gender, race/ethnicity, sexual orientation, and religion) but plans to pursue other groups in the future and recognizes that there are other forms of diversity that extend far beyond the obvious visual distinctions;⁴ and

WHEREAS, ACEP’s existing policy statement “Workforce Diversity in Health Care Settings” provides a highly visible and concise platform to both engage our membership and declare ACEP’s ongoing commitment to recognizing and understanding the importance of diversity and inclusion in all of emergency medicine (including both academic and clinical); therefore be it
RESOLVED, That ACEP expand its policy statement “Workforce Diversity in Health Care Settings” to help identify and promote inclusion of qualified individuals with additional diverse characteristics (including racial and ethnic diversity, as per existing policy) and amend it to read:

The American College of Emergency Physicians believes that:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals who reflect the ethnic and racial diversity in our nation of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care; and
- Attaining diversity with well qualified physicians in emergency medicine residencies and faculties that reflects our multicultural society is a desirable goal.

References

Background

This resolution calls for the College to expand its policy statement “Workforce Diversity in Health Care Settings” to more clearly identify the diverse groups and promote inclusion of qualified individuals with additional diverse characteristics. The draft language to amend the current policy is provided.

The College approved its first policy on workforce diversity in the health care setting in 2001. Since that time, the policy has been reaffirmed twice, and most recently in June 2013.

The Board of Directors, the Council Nominating Committee, and the Council officers, have long acknowledged the need – and their desire – for diversity and inclusion within ACEP at all levels of leadership within national ACEP and its chapters. In 2011, the Leadership Development Group (LDAG) was created to identify and mentor potential leaders within ACEP. Their role is also to serve as a resource to members and component bodies in their development of future leaders. The LDAG and the Nominating Committee are deeply committed to increasing diversity in leadership.

A Diversity Summit was convened by ACEP in April 2016 to discuss diversity and inclusion and a task force was appointed in June 2016 with the following objectives:

1. Engage the specialty of emergency medicine on diversity and inclusion.
2. Identify obstacles to advancing within the profession of emergency medicine related to diversity and inclusion and ways to overcome the obstacles.
3. Highlight the effects of diversity and inclusion on patient outcomes and identify ways to improve these outcomes.

The Diversity & Inclusion Task Force has conducted a survey of the membership to better understand the diversity within ACEP’s membership and the degree to which members’ backgrounds influence their interactions with ACEP and their practice of emergency medicine. They are also performing a survey to look at the diversity within current
leadership positions in the field. These will become baseline data and will be compared to data in the future as ACEP continues diversity and inclusion initiatives.

Additionally, in response to Amended Resolution 7(16) Diversity in Emergency Medicine Leadership, a Leadership Diversity Task Force was appointed with the following objectives:

1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices.
2. Survey current pipeline programs within the Council’s component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership.
3. Identify barriers to becoming a councillor, Council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type.

The task force plans to present their recommendations to the Board of Directors in April 2018.

In the 2016-17 committee year, 14 of ACEP’s 27 committees were assigned objectives addressing diversity and inclusion. Many of these objectives are specific to workplace diversity and inclusion. The Diversity & Inclusion Task Force has served as a resource to all committees as they have worked on their assigned objectives.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
   Objective F – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to develop strategies to increase diversity within the ACEP Council and its leadership and provide a report to the Council on effective means of implementation.

Resolution 32(05) Code of Ethics for Emergency Physicians adopted. Called for the College to expand its policy statement “Code of Ethics for Emergency Physicians” to include additional language stating that “emergency medical treatment should not be based on gender, age, race, socioeconomic status, sexual orientation, real or perceived gender identity, or cultural background.”

Prior Board Action


Resolution 43(17) Expanding ACEP Policy on Workforce Diversity in Health Care Settings

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**Background Information Prepared by:** Margaret Montgomery, RN, MSN
Practice Management Manager

Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice & Academics

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 44(17)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Guidelines for Opioid Prescribing in the Emergency Department

PURPOSE: Encourage electronic medical record providers to incorporate easy-to-use prescription monitoring programs into their electronic medical record products; discourage mandates for screening all emergency department patients for opioid use; and promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Fatal drug overdose has increased more than six-fold in the past three decades and now claims the lives of over 47,000 Americans every year and opioids, both prescription and illicit, are responsible for the majority of these deaths; and

WHEREAS, The death rate from prescription opioid-associated overdose nearly quadrupled from 1999 to 2013; and

WHEREAS, Emergency physicians should consider non-opioid and other alternative therapies; and

WHEREAS, Emergency physicians should limit the amount prescribed to less than seven days; and

WHEREAS, Emergency physicians should not prescribe long-acting opioids such as extended-release morphine or methadone unless coordinated with an outpatient provider; and

WHEREAS, Emergency physicians should not fill prescriptions for lost or missed doses of opioids; and

WHEREAS, Emergency physicians should be strongly urged to consult state-based prescription monitoring programs (PMPs); therefore be it

RESOLVED, That ACEP encourage electronic medical record providers to incorporate easy-to-use Prescription Monitoring Programs functionality into their products; and be it further

RESOLVED, That ACEP strongly discourage mandates for screening all emergency department patients for opioid use; and be it further

RESOLVED, That ACEP promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

Background

This resolution calls for the College to: encourage electronic medical record providers to incorporate easy-to-use prescription monitoring programs (PMPs) into their electronic medical record products; strongly discourage mandates for screening all emergency department patients for opioid use; and promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.
ACEP continues to address the issues of pain management, diversion of controlled substances for non-medical purposes, and the increasing number of prescription drug overdose deaths. ACEP offers resource information for members and chapters and serves as the central repository for sharing information, such as state activities related to opioid prescribing.

The ACEP policy statement “Health Information Technology” supports emergency physician involvement in the evaluation, selection, configuration, and implementation of health information technology and emergency department information systems.

The ACEP policy statement “Electronic Prescription Drug Monitoring Programs” supports the use of electronic prescription drug monitoring programs (PDMP) that facilitate seamless data flow from the PDMP into the electronic health record, minimize burdensome requirements, and provide liability protection for the provider.

The ACEP policy statement “Optimizing the Treatment of Acute Pain in the Emergency Department” supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association.

Numerous ACEP chapters have worked to address the opioid prescribing issue in their states. For example, the Washington and Oregon chapters, working with other organizations within their states, have developed statewide ED opioid prescribing guidelines. The Florida College of Emergency Physicians has developed guidelines about chronic nonmalignant pain management in the ED that have been adopted at numerous hospitals in Florida. The Ohio chapter provided input into the Opioids and Other Controlled Substances Prescribing Guidelines for Ohio and endorsed the guidelines. The Kentucky chapter developed an informational guidance document on narcotics and sedatives usage in the ED for use in Kentucky.

The 2012 ACEP Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department addresses four critical questions: (1) the utility of state prescription drug monitoring programs in identifying patients at high risk for opioid abuse; (2) use of opioids for acute low back pain; (3) effectiveness of short-acting schedule II versus short-acting schedule III opioids for treatment of new-onset acute pain; and (4) the benefits and harms of prescribing opioids on discharge from the ED for acute exacerbation of noncancer chronic pain. This guideline acknowledges the increase in opioid deaths, recognizes the difficulties emergency physicians face in treating pain appropriately while avoiding adverse events, identifies the literature (and lack of literature) related to the four critical questions, and offers some guidance on prescribing opioids at ED discharge for acute pain and acute exacerbation of noncancer chronic pain. At the same time, it recognizes the importance of the individual physician’s judgment, and provides information for individuals and groups such as state chapters to work within their states and institutions to develop opioid guidelines appropriate for their locations. This clinical policy was funded by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury.

This clinical policy, which is available on the ACEP Web site at http://www.acep.org/clinicalpolicies/, was highlighted in several communications to the membership, and was published in Annals of Emergency Medicine in October 2012. The guideline identifies some of the state and chapter activities that have already occurred related to opioid prescribing in the ED. The guideline was also distributed to all ACEP chapters and to The Joint Commission for their information.

The Emergency Medicine Practice Committee was assigned an objective for the 2016-17 committee year to “Work with the Pain Management Section to compile and develop resources for opiate free emergency departments.” They have developed a template for compiling resources on a variety of alternatives to opioids for the treatment of pain in the ED. Drafts have been developed for nitrous oxide, ketamine for acute and chronic pain, trigger point injections, femoral nerve blocks, sphenopalantine ganglion blocks for migraine and buprenorphine in the ED. The plan is to format the resources into an app for easy access by members in the clinical setting. These resources will also be
Resolution 44(17) Guidelines for Opioid Prescribing in the ED
Page 3

available on the ACEP website. Additional resource development is planned with a focus on alternatives to opioids for the treatment of pain for patients in the ED.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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 18(13) Creation and Federal Funding of a National Prescription Monitoring Program adopted. Directed ACEP to work with the federal government and stakeholders to create a best practice, federally funded, nationally accessible Prescription Drug Monitoring Program.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. This resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Amended Resolution 29(10) Prescription Electronic Monitoring adopted. Directed ACEP to create a policy supporting the use of web-based prescription monitoring programs in every state and support the authorization of federal funding for NASPER and intra-state linkages of databases.

Prior Board Action

April 2017, revised and approved “Optimizing the Treatment of Acute Pain in the Emergency Department” policy statement originally approved June 2009.

January 2017, revised and approved “Electronic Prescription Drug Monitoring Programs” policy statement originally approved October 2011.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.


Amended Resolution 18(13) Creation and Federal Funding of a National Prescription Monitoring Program adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.


Background Information Prepared by:  Travis Schulz, MLS, AHIP
                                    Clinical Practice Manager

Reviewed by:  James Cusick, MD, FACEP, Speaker
              John McManus, MD, FACEP, Vice Speaker
              Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 45(17)
SUBMITTED BY: New York Chapter
SUBJECT: Group Contract Negotiation to End-of-Term Timeframes

PURPOSE: 1) Establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage. 2) Oppose sudden, abrupt changes in contract groups without time for adequate transition and training.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Outsourcing clinical services is increasing in United States Hospitals; and
WHEREAS, Emergency medicine is one of the top five most outsourced patient care services; and
WHEREAS, Sudden abrupt changes in clinical staff and leadership are a patient safety concern; and
WHEREAS, Sudden changes in staffing can affect the education and training of staff; therefore be it
RESOLVED, That ACEP establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage; and be it further
RESOLVED, That ACEP oppose sudden, abrupt changes in contract groups without time for adequate transition and training.

Background

This resolution calls for ACEP to establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage and to oppose sudden, abrupt changes in contract groups without time for adequate transition and training.

The disruptive contract transition for ED physicians at Summa Health in Akron, Ohio caused the emergency medicine community to re-evaluate the contract transition process. While such situations are relatively rare, they are nothing new. However, this particular event involved multiple EDs, including the main hospital with an emergency medicine residency program, placing patient care and the residency program in jeopardy.

In reviewing the situation and steps to prevent similar occurrences, an ACEP task force was appointed with an objective to produce an information paper outlining best practices in contract transitions as a guide to members and interested parties and to include information on realistic timelines for RFPs and preservation of the residency program with no adverse impact on the residents. The task force includes representatives from key constituencies such as: Emergency Medicine Practice Committee, Academic Affairs Committee, Democratic Group Practice Section, Council of Emergency Medicine Residency Directors, Emergency Medicine Residents’ Association, an emergency physician with hospital administration experience, and a few at-large members with contract expertise. The resulting information paper will include best practices for timeframes for initiation of contract renewal discussions and will be accompanied by targeted messages for ACEP members, medical directors and group owners, and the American Hospital Association and hospital administrators.
The Board reviewed the draft information paper “ED Physician Group Staffing Contract Transition,” in June 2017. The paper is being finalized based on comments provided by the Board and another draft will be distributed to the Board for review. The final information paper will be provided to the Council and will be available on the ACEP Website.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
  Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

*The Council has discussed and adopted many resolutions regarding ED contracts. The following resolutions are germane to the situation that occurred at Summa Health.*

Amended Resolution 20(00) “Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups” adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 49(94) “Information on Contract Issues” adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action

June 2017, reviewed the draft information paper “ED Physician Group Staffing Contract Transition.”

January 27, 2017, issued a statement on rapid transitions of ED contracts.

January 2017, discussed concerns regarding the residency program at Summa Health.

Amended Resolution 20(00) “Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups” adopted.

Amended Resolution 49(94) “Information on Contract Issues” adopted.

Background Information Prepared by:  David A. McKenzie, CAE  Reimbursement Director

Reviewed by:  James Cusick, MD, FACEP, Speaker  John McManus, MD, FACEP, Vice Speaker  Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 46(17)

SUBMITTED BY: California Chapter
Washington Chapter
Wilderness Medicine Section

SUBJECT: Impact of Climate Change on Patient Health and Implications for Emergency Medicine

PURPOSE: Research and develop a policy to address impact of climate change on the patient health and well-being. Utilize the policy to guide future research, training, advocacy, preparedness, migration practices, and patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, There is scientific consensus that the world’s climate is changing, with 2016 being the warmest year in history, and future projections indicating further acceleration in these changes; and

WHEREAS, Climate change will likely affect human health in a number of indirect and direct ways, including extreme weather events, shifting vector-borne epidemics, rising sea levels, resource scarcity, population displacement, and contaminants in air, water, and soil; and

WHEREAS, Such change has been shown to increase the incidence of many conditions seen in the ED, including exacerbations of respiratory, cardiovascular, and renal disease; mental health emergencies; shifting infectious disease burden; injuries from extreme weather; and trauma from interpersonal violence; and

WHEREAS, The patients who rely disproportionately on the ED – those at the extremes of age, the socially marginalized, and patients with multiple comorbidities – are most vulnerable to the evolving effects of climate change; and

WHEREAS, Emergency Medicine providers, by virtue of our craft, and the fact that we are highly represented among those who manage the nation’s emergency care infrastructure – from prehospital systems, to disaster response activities, to health system coordination – will be serving at the front lines of catastrophic extreme weather events, newly emerging and/or spreading infectious diseases, and population displacement associated with a changing climate; and

WHEREAS, Several other prominent medical organizations including, but not limited to, the World Health Organization, the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American Lung Association, and the American Public Health Association have put forward policy statements regarding the impacts of climate change on human health, safety, and security; therefore be it

RESOLVED, That ACEP research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy statement to guide future research, training, advocacy preparedness, mitigation practices, and patient care.

Background

This resolution calls for the College to research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy to guide future research, training, advocacy, preparedness, migration practices, and patient care.
Climate change can be a controversial topic. However, both domestic and global organizations are currently addressing the effect of climate change on public health, disaster response, disease prevalence and clinical implications. This involves research and response to direct and indirect medical impact related to climate change.

The World Association for Disaster and Emergency Medicine (WADEM) released the WADEM Climate Change Position Statement on April 24, 2017. It states; “Climate change is affecting disaster risk and disaster impact. WADEM recognizes climate change as an issue of global concern. It is WADEM’s responsibility to support the capacity of emergency management, humanitarian and health professionals to address the disaster impacts of climate change.” The statement also supports “cooperation among and between multidisciplinary professionals involved in research, education, management and practice in pre-hospital, emergency, public health and disaster care.” The final recommendations include:

- Recognizing the importance of climate change due to its influence on frequency and severity of natural hazards, and on disasters of natural, public health related, and conflict causes;
- -Recognizes all disaster and emergency professionals and organizations adopt a risk-based approach to emergency planning that prepares for and enhances resilience to climate change effects…”

The U.S. Global Change Research Program established by Presidential Initiative in 1989 and mandated by Congress in 1990 to “assist the Nation and the world to understand, assess, predict and respond to human-induced and natural process of global change.” Their 2016 report, The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment, examines climate change on human health in the US including temperature-related death and illness; air quality impacts; vector-borne diseases; water-related illness; food safety, nutrition and distribution; mental health and well-being and populations of concern.

The American Medical Association (AMA) 2014 policy, Global Climate Change and Human Health H-135.938, “supports the findings for the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change …..These climate changes will create conditions that affect public health, with disproportional impact on vulnerable populations…” Further the 2016 AMA policy, AMA Advocacy for Environmental Sustainability and Climate H-135.923, calls for the AMA to support efforts “to promote environmental sustainability and other efforts to halt global climate change.” The AMA also reaffirmed their policy, Stewardship of the Environment H-135.973, that “…encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; …encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.”

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None
RESOLUTION: 47(17)

SUBMITTED BY: Jack Handley, MD, FACEP
Charles Pilcher MD FACEP

SUBJECT: Improving Patient Safety Through Transparency in Medical Malpractice Settlements

PURPOSE: 1) Develop a policy to reduce medical errors and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members and others as appropriate. 2) Support elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits. 3) Report progress to the 2018 Council.

FISCAL IMPACT: Budgeted staff resources and approximately $4,000 for analysis of the NPDB data (if the data is available).

WHEREAS, Improving patient safety requires the elimination of mistakes; and
WHEREAS, Our most egregious mistakes become medical malpractice lawsuits; and
WHEREAS, Our least defensible lawsuits are settled before trial, almost always with a non-disclosure or confidentiality clause; and
WHEREAS, A confidentiality clause generally prohibits only the disclosure of the parties involved and the amount of the settlement yet is interpreted as a “gag order” that inhibits the disclosure of all elements of a case; and
WHEREAS, “Mistakes are meant for learning, not repeating,” and medical malpractice lawsuits – won or lost – are a valuable resource for physician education and improvements in patient safety; and
WHEREAS, Patients report medical errors and pursue lawsuits “so that this won’t happen to someone else” as often as they do seeking compensation for their loss; and
WHEREAS, Confidential pre-trial settlements of such lawsuits suppress both the learnings available from these events and the injured patient’s goal to improve safety for other patients; and
WHEREAS, To improve safety, other industries have taken a position of transparency and active disclosure of defects or errors that, if not disclosed, would lead to subsequent harm to others, e.g., the automotive industry (via the NHTSA), the aviation industry (via the NTSB), and product manufacturers (via the CPSC); and
WHEREAS, Allowing physicians to learn from pre-trial settlements will 1) improve patient safety by reducing the number of mistakes and 2) reduce the cost and stress of malpractice lawsuits by preventing error in the first place; therefore be it

RESOLVED, That ACEP develop a policy to reduce medical error and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate; actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits; and report progress on this objective at the ACEP annual meeting in 2018.
Background

This resolution directs ACEP to develop a policy to reduce medical errors and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate. It further asks that ACEP actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits. It asks for ACEP to report progress on this objective at the ACEP annual meeting in 2018.

The primary question is whether the appropriate data is available.

The National Practitioner Data Bank (NPDB) requires reporting of any “payment for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for medical malpractice against that practitioner.” Individuals who pay their settlements out of personal funds do not need to report.

The data is available through a public use data file. This free file contains 1,317,232 cases, which represents reported cases since September 1, 1990. The data file is updated quarterly. Each file has up to 54 variables that include year of the report, state, age of practitioner, specific malpractice allegation, severity of alleged malpractice injury, payment amount, adverse action classification, basis for action, etc. NPDB also codes for specialties (among them emergency medicine) but does not provide that information in the public use data file. This information may be available through a request for specific data. Because of the size of the file, it requires SPSS or other statistical software. However, the information available is unlikely to provide the details of the case necessary to provide the information needed to improve care.

The majority of settlements involve a non-disclosure agreement which limits access to the case details. Access to this data is limited to insurance companies, some of whom have analyzed their individual databases.

A private company, MedPro Group produces a free annual report Malpractice Claims Data and Risk Analysis. Its 2016 report analyzes the aggregated data from emergency medicine claims opened between 2005 and 2014, in cases where an emergency physician was the primary provider responsible for the service. The report provides information around claim type (diagnosis related, medication related, treatment related, other), and specific diagnosis (infection, cardiac, etc.). It provides information on key risk factors such as poor patient assessment, failure to reevaluate prior to discharge and poor tracking systems that prevent post-discharge tests from reaching the patient or physician. The report provides detailed information on each of these factors along with risk mitigation strategies.

Another company, CRICO Strategies, provides similar reports broken down by the type of error. Its report for emergency medicine analyzes 1300 medical malpractice cases and provides information about the errors made and strategies for mitigating risk. Similar reports are available from Physician Insurers Association of America, which includes demographic data, and The Doctor’s Company. In 2013, the Medical-Legal Committee compared data from CRICO, The Doctor’s Company, and Physician Insurers Association of America. The data was often quite general and did not permit a granular analysis. The report provided some information about the patient condition (chest pain, abdominal pain, etc.), the allegation (missed/delayed diagnosis, medication related, etc.), and claim (history and physical exam, ongoing monitoring of clinical status, etc.).

If ACEP can obtain permission to receive a report from NPDB specific for emergency medicine, the report would likely need to be outsourced for analysis on a quarterly basis.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Emergency Care
  Objective E – Achieve meaningful liability reform at the state and federal levels.

Goal 2 – Enhance Membership Value and Member Engagement
  Objective C – Promote member well-being and improve resiliency.
Fiscal Impact

Budgeted staff resources and approximately $4,000 for analysis of the NPDB data (if the information is available).

Prior Council Action

None

Prior Board Action

October 2013, reviewed the information paper, *Summary of Malpractice Claim Data & Trends from Three Sources*.

**Background Information Prepared by:** Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 48(17)

SUBMITTED BY: Forensic Medicine Section
William Green, MD, FACEP
Michael L. Weaver, MD, FACEP
Ralph Riviello, MD, FACEP
Heather Rozzi, MD, FACEP
William Smock, MD

SUBJECT: Non-Fatal Strangulation

PURPOSE: Work with other organizations to develop educational resources and programs related to evaluation and management of non-fatal strangulation, develop a policy statement on its seriousness, and develop a clinical practice guideline.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Intimate partner violence (IPV) and sexual assault (SA) are serious public health problems; and
WHEREAS, Many IPV and SA victims seek treatment in the emergency department; and
WHEREAS, Non-fatal strangulation is a form of asphyxia characterized by external pressure on the neck, closing the blood vessels or airway; and
WHEREAS, Studies indicate that 23-68% of female domestic violence victims and up to 35% of sexual assault victims will experience strangulation; and
WHEREAS, Strangulation is an indicator of the escalation of violence and associated with increased risk of serious injury and even death in cases of IPV; and
WHEREAS, Strangulation has been identified as one of the most lethal forms of IPV and SA; and is used to exert power over a victim by taking from them control of their own body; and
WHEREAS, When strangled, unconsciousness and anoxic brain injury may occur within seconds and death within minutes; and
WHEREAS, Oftentimes, even in fatal cases, there is no external evidence of injury from strangulation, yet because of underlying brain damage due to hypoxia during the strangulation assault, victims may have serious internal injuries or consequences, including death, even days, or weeks later; and
WHEREAS, Many emergency medicine providers lack specialized training and knowledge to identify the signs and symptoms of strangulation, often only focusing on visible or airway injuries, and to properly evaluate and manage the non-fatal strangulation patient. This lack of training has led to the minimization of this type of violence, exposing victims to potential serious, short- and long-term health consequences, permanent brain damage, and increased likelihood of death; and
WHEREAS, There are no specific guidelines or recommendations regarding the emergency department management of the non-fatal strangulation victim including, history taking, physical examination, radiographic imaging, treatment, disposition, and documentation; therefore be it;
Resolution 48(17) Non-Fatal Strangulation
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RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders, to provide educational and clinical resources as well as in person and enduring educational programs for emergency providers on the evaluation, radiographic investigation, and management of non-fatal strangulation; and be it further

RESOLVED, That ACEP create a policy statement on the seriousness of non-fatal strangulation and develop a clinical practice guideline for the emergency department evaluation, treatment, and management of non-fatal strangulation.

Background

This resolution calls for ACEP to work with other pertinent organizations to develop educational resources and programs for evaluation and management of non-fatal strangulation, and for ACEP to develop a policy statement on the seriousness of non-fatal strangulation and a clinical practice guideline for the evaluation and treatment of non-fatal strangulation in the emergency department.

The “2016 Model of the Clinical Practice of Emergency Medicine,” developed by seven emergency medicine organizations, lists core patient conditions that present to emergency departments: https://www.acep.org/Search.aspx?filter=acep&searchtext=Model%20of%20the%20Clinical%20Practice%20of%20Emergency%20Medicine&folderpath=ACEP/Clinical%20and%20Practice%20Management/policy%20statements/. Item 18.1.9.4 Neck trauma, strangulation is listed as a disorder for which patient acuity could be critical, emergent, or lower acuity. Patient acuity level is fundamental to determining the priority and sequence of tasks to manage the patient.

Clinical signs and symptoms of non-fatal strangulation vary from patient to patient and may not appear for 24-36 hours, while the absence of external neck injuries does not exclude strangulation, all of which can make it difficult to identify this injury.

As an adjunct to the ACEP policy statement, “Management of the Patient with the Complaint of Sexual Assault,” ACEP’s Forensic Medicine Section prepared the handbook, “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” that is available on the ACEP Web site, https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/. Chapter 16 of the handbook is titled “Strangulation.” This chapter addresses the challenges, physiology, mechanisms, definitions, pathophysiology, clinical symptoms and caveats, clinical findings, clinical evaluation, management, and documentation related to strangulation. There are also examples of a documentation chart for non-fatal strangulation cases, medical release form and questions to ask the victim.

The International Association of Forensic Nurses has developed a position statement on non-fatal strangulation and a documentation toolkit; both available on their Web site: http://www.forensicnurses.org/page/STOverview. The Emergency Nurses Association has a Topic Brief, “An Overview of Strangulation Injuries and Nursing Implications.”

There is a paucity of research evidence related to the evaluation and treatment of non-fatal strangulation in the emergency department. A review of PubMed revealed two useful studies (one a cross-sectional study and the other a case-control study) related to the etiology of non-fatal strangulation. Further research is needed to provide evidence for the development of an evidence-based clinical practice guideline on this topic.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective B – Provide robust communications and educational offerings, including novel delivery methods.
Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Rhonda Whitson, RHIA  
Clinical Practice Manager

Reviewed by:  James Cusick, MD, FACEP, Speaker  
                John McManus, MD, FACEP, Vice Speaker  
                Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 49(17)

SUBMITTED BY: Alaska Chapter
Government Services Chapter
New Mexico Chapter
Ohio Chapter
Oregon Chapter
South Carolina College of Emergency Physicians
Washington Chapter

SUBJECT: Participation in ED Information Exchange and Prescription Drug Monitoring Systems

PURPOSE: Collaborate with Veterans Health Affairs, the Department of Defense, and Indian Health Services and potentially legislatures regarding participation in state PDMPs and real-time electronic exchange of patient information.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients of the Veterans Health Affairs (VHA), Department of Defense (DoD), and Indian Health Services (IHS) deserve the constant, quality care where ever they access emergency care; and

WHEREAS, The VHA and DoD provide care for nearly 20 million beneficiaries and IHS an additional 2.2 million beneficiaries; and

WHEREAS, Prescription Drug Monitoring Programs (PDMPs) have become prevalent throughout much of the country; and

WHEREAS, Both health and financial benefits have been realized with real time Emergency Department information sharing systems that push data (such as care plans, safely concerns, ED utilizations, and in some state PDMP information) to emergency departments; and

WHEREAS, Real time information sharing of care plans and ED utilization is becoming increasingly prevalent and is now legislated or required in numerous states including Washington, Oregon, Alaska, and New Mexico; and

WHEREAS, DoD, VHA, and IHS emergency departments do not currently all consistently participate in PDMPs or ED information exchange programs even where it is state-mandated; and

WHEREAS, DoD, VHA, and IHS have spent significant time and money to combat the opioid crisis and create care plans for their beneficiaries that are not available outside their systems; and

WHEREAS, Beneficiaries of DoD, VHA, and IHS still may go to any emergency department and these hospital systems are key players in the emergency care environment; therefore be it

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate their participation in state prescription drug monitoring programs; and be it further

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures, to encourage and
facilitate their participation, to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits and hospital care plans for frequent users of emergency departments.

Background

The resolution calls upon the College to collaborate with the Department of Veterans Affairs, the Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate participation in state Prescription Drug Monitoring Programs (PDMPs) and, as consistent with federal law, real-time electronic exchange of patient information.

Currently, 49 states (Missouri being the exception) have prescription drug monitoring programs. Because state governments do not have jurisdiction over the above referenced federal entities, state laws related to PDMPs and electronic health records do not apply to those entities. This has created information gaps relative to patients receiving care through those entities.

Collective Medical Technologies (CMT) entered into a corporate sponsor agreement and exclusive partnership with ACEP in April 2016 to aid in the promotion and support of the CMT’s Emergency Department Information Exchange (EDIE) program. EDIE, also called PreManage ED, collects data from all EDs visited by a patient, packages that data into actionable insights, and then delivers the information to emergency physicians via real-time notifications during the patient visit. EDIE is currently available in 13 states and CMT continues to pursue participation in other states.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
  Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians work with stakeholders to mitigate patients’ risk of self-directed or interpersonal harm; and investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

Amended Resolution 29(13) Support of Health Information Exchanges adopted. Directed ACEP to investigate and support health information exchanges, work with stakeholders to promote the development, implementation, and utilization of a national HIE, and develop an information paper exploring a national HIE.

Amended Resolution 18(13) Creation and Federal Funding of a National Prescription Monitoring Program. Directed ACEP to work with other stakeholders to create a best practice-based, federally funded, nationally accessible PDMP and oppose mandatory query of PDMP data for ED patients.

Amended Resolution 29(10) Prescription Electronic Monitoring adopted. Directed ACEP to create a policy supporting the use of web-based prescription monitoring programs in every state and support the authorization of federal funding for NASPER and intra-state linkages of databases.
Resolution 49(17) Participation in ED Information Exchange and Prescription Drug Monitoring Systems
Page 3

Prior Board Action

January 2017, approved the revised policy statement “Electronic Prescription Drug Monitoring Programs” originally approved October 2011.

April 2016, approved a corporate sponsor agreement and exclusive partnership with CMT for promotion of the implementation of a nationwide Emergency Department Information Exchange Program.

October 2014, reviewed the information paper “Health Information Exchange in Emergency Medicine” and it was published in Annals of Emergency Medicine.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter & State Relations

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 50(17)

SUBMITTED BY: Hawaii Chapter

SUBJECT: Promoting Clinical Effectiveness in Emergency Medicine

PURPOSE: Create a Clinical Effectiveness Committee responsible for identifying, assessing, and promoting evidence-based cost-effective emergency medicine practice.

FISCAL IMPACT: 50% FTE staff, in-person meeting at Scientific Assembly. $100,000 recurrent annual expense.

WHEREAS, The American College of Emergency Physicians (ACEP) is a leader amongst medical specialties and an advocate for our patients and cost-effective health care; and

WHEREAS, The Organization for Economic Cooperation and Development (OECD) reports that in 2016 the United States expenditure on health, as a percent of gross domestic product, was 17.2% (OECD, 2017); and

WHEREAS, ACEP has previously investigated and commented on value based care as per the Value Based Emergency Care (VBEC) Task Force (2009) (ACEP, 2009); and

WHEREAS, ACEP partnered with Choosing Wisely in 2013 to create a list of tests and procedures that may not be cost effective (ACEP, 2013); and

WHEREAS, Other medical organizations maintain recommendations that impact emergency physicians such as the “ Appropriateness Criteria” published by the American College of Radiology (ACR, 2017); and

WHEREAS, ACEP has 27 committees, none of which are focused on cost effective quality care (ACEP, 2016); therefore be it

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

References

Background
This resolution calls for ACEP to create a new Clinical Effectiveness Committee responsible for identifying, assessing, and promoting evidence-based cost-effective emergency medicine practice.
Cost effectiveness analysis weighs the benefits of a treatment or testing modality for a population. This rigorous analysis includes factors such as the cost and outcome of screening (identification of false positives and false negatives), treatment and mortality. It is a very effective tool, when done with precision, to guide clinicians and determine best practices for a population. Such cost effective analysis has led to recommendations by the U.S. Preventive Services Task Force for prostate cancer screening.

The American College of Radiology has embarked on a high profile cost effectiveness analysis for imaging with their Appropriateness Criteria. Using large panels of radiologists and representatives from stakeholder organizations, ACR has developed cost effective approaches to many common conditions. ACEP has participated in several of these panels. The results of those analyses have formed the basis of ACR Select, which is now required in some hospitals for ordering images.

ACEP’s clinical policies have long been one of the more popular products of the College, and among the most frequently downloaded documents. These policies are created by an expert panel who review and grade the literature and answer specific question regarding preferred practice guidelines. These reviews may cover effectiveness, but rarely consider cost as a variable.

Though not a formal cost effectiveness program, the Emergency Quality Network (E-QUAL) offers analysis and recommendations for cost effective treatment. The Network offers learning collaboratives in three main areas: sepsis, reducing avoidable imaging (low back pain, minor head injury, pulmonary embolism, and renal colic) and low risk chest pain. The network offers a toolkit with best practices and sample guidelines, as well as access to benchmarking data. It provides free CME and meets the CMS Improvement Activity requirements of the new CMS Quality Payment Program (MIPS). Any ACEP member may join the network for free. The network is financed through a CMMI grant. Additional modules may be added. The E-QUAL Network may be a reasonable alternative to a cost effectiveness committee.

Cost effective analysis may provide a basis to control cost while improving outcomes. However, the analysis is based on what is best for a population, not necessarily what is best for the individual. For example, the recommendations from the US Preventive Services Task Force regarding prostate cancer screening will reduce the number of unnecessary biopsies and the morbidity and even occasional mortality associated with false positive screenings. However, the individual whose cancer was detected in situ may view this recommendation differently. It is said that every test (or treatment) has a ‘U curve’ of effectiveness. On the right side of the U are the individuals who benefit from the test. In the middle are those who neither benefit nor are harmed. On the left side of the U are the individuals who are harmed, either by the test/procedure itself, or by unnecessary follow-up testing. Cost effectiveness analysis attempts to analyze this U curve.

ACEP has made some recommendations to reduce cost through its Choosing Wisely recommendations. Though not based primarily on true cost-effectiveness criteria, these are recommendations to reduce testing. While the literature was thoroughly reviewed by the expert panel, final selection was based on consensus.

A cost effectiveness program would require effort by ACEP similar to what is expended on clinical policies. Currently, the clinical policies process requires two FTE ACEP staff with an eventual output of 6-8 clinical policies per year.

**ACEP Strategic Plan Reference**

**Goal 1 – Reform and Improve the Delivery System for Acute Care**  
**Objective A –** Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

**Fiscal Impact**

50% FTE staff member and in-person meeting at Scientific Assembly. Approximately $100,000 recurrent annual cost.
Prior Council Action

Resolution 15(12) Choosing Wisely Campaign not adopted. Called for the College to formally join the Choosing Wisely Campaign.

Prior Board Action

June 2014, approved the second list of ACEP Choosing Wisely recommendations (6-10)

June 2013, approved ACEP Choosing Wisely recommendations (1-5)

June 2012, approved the recommendation from the review panel to not join the Choosing Wisely campaign.

October 2011, approved the action taken to decline the invitation to join the Choosing Wisely campaign.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 51(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Retirement or Interruption of Clinical Emergency Medicine Practice

PURPOSE: 1) Study and evaluate mechanisms to support practicing emergency physicians to recognize potential physical and emotional limitations to clinical practice, educate members about alternatives and opportunities for temporary interruption of active clinical practice including mechanisms for reintegration back into clinical practice, and support members considering career transitions including retirement. 2) Develop resources and communicate career transition opportunities, including support for members who believe they are being restricted from practice for discriminatory reasons as regulated by established federal equal employment opportunity discrimination laws.

FISCAL IMPACT: Budgeted staff resources and $20,000 for in-person task force meeting.

WHEREAS, Emergency Medicine is a highly regarded and vitally important clinical specialty and the practice of Emergency Medicine requires physical stamina, a broad range of clinical knowledge and the cognitive ability to immediately provide essential procedural skills in a busy, sometimes chaotic, workplace; and

WHEREAS, The physical and intellectual demands on Emergency Physicians require that individual practitioners know their limits and recognize when, for physical, cognitive, emotional or other reasons, they may no longer be prepared to handle, whether for short term or extended term, the demands required of a clinical shift; and

WHEREAS, The Emergency Medicine workforce has a bimodal distribution with a more experienced, longer serving, peak of physicians nearing the traditional retirement age, which may raise questions regarding this group’s physical stamina and cognitive veracity; and

WHEREAS, Discrimination based purely upon physical characteristics which cannot be controlled by the individual, including race, ethnicity and age, is not acceptable in the American workplace in general and thereby extends to the Emergency Medicine workforce; and

WHEREAS, There are a variety of reasons individuals may temporarily suspend their clinical practice or choose to permanently retire from clinical practice; therefore be it

RESOLVED, ACEP study and evaluate mechanisms to support practicing Emergency Physicians to help recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement; and be it further

RESOLVED, That ACEP actively engage in developing resources and communication of career transition opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

Background

This resolution asks ACEP to study and evaluate mechanisms to support practicing emergency physicians to recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and
opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement. In addition, it asks ACEP to actively engage in developing resources and communication of career transition opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

Emergency medicine developed as a specialty in the 60s and 70s, a time when medical school enrollment increased, the Baby Boomers were in college and graduate school, and resident education was interrupted by the doctor draft during the Vietnam War. At that same time, emergency departments went from being staffed by moonlighting residents – or with nurses who called in physicians from home as needed – to full-time professional staff, some of whom had actually completed EM residencies. When the specialty was recognized in 1979, there was a bolus of physicians who grandfathered into the specialty. That bolus of individuals is now at or approaching traditional retirement age. Like other physicians of their era, they continue to work, and will continue for a longer period of time with support from their specialty and colleagues.

ACEP has developed several resources for the aging physician. Early resolutions recognized that some physicians would be impaired or disabled for a period of their career, and that the College should support these individuals and their return to work. A reduced cost retirement membership category was created in 2008 in the hopes of retaining those individuals as members of the College.

In 1990 (reaffirmed in 1994, 1999, 2006, 2013), the College issued a policy statement on physician impairment. In that policy, ACEP promotes early intervention and treatment for the impaired physician. It also supports assistance in returning the physician to practice once recovered and licensed.

In 2009, and reaffirmed in 2015, the College developed a policy on the needs of physicians in pre-retirement years. The policy recognized that these physicians could continue to contribute, but could make a greater contribution with some considerations to the practice environment such as reducing circadian stress, reducing night shifts, additional recovery time after night shifts, shorter shift length, and shift to administrative/teaching duties.

In 2006, the Well-Being Committee formed the Aging Physician Task Force with the dual aims of enhancing the careers of emergency physicians in the latter stages of their professional lives and facilitating the transition of emergency physicians from active practice to semi- or full retirement. In 2010, ACEP published “A Primer for Emergency Physicians in Pre-retirement Years” which is still available on the website. This primer contains sections on transitioning to retirement, dealing with partnership concerns, managing shift work/stress/burnout, health screening/diet/exercise, as well as opportunities for volunteer work, travel and education. There is a checklist at the end of the document that allows the user to outline their personal journey to retirement.

In 2006-07, ACEP funded a section grant to survey 1,000 ACEP members over the age of 55. The response rate was 80%. The study found a significant decrease in the ability of respondents to manage the stress of practice (recovery from night shifts, less ability to manage heavy patient loads, emotional exhaustion at the end of shift, etc.). Additionally, about half of the respondents expressed concerns about financial preparedness and loss of identity after retirement. Despite the perceived toll of clinical shifts, the vast majority of respondents believed they were as competent (or even more competent) in handling complicated clinical problems, performing common procedures, and empathizing with patients as they were in the past. (Goldberg R, Thomas H, Penner L. Issues of concern to emergency physicians in pre-retirement years: a survey. J Emerg Med. 2011;40:706-713)

This survey led to the development of the ACEP policy statement, “Considerations for Emergency Physicians in Pre-Retirement Years” (approved in 2009 and reaffirmed in 2015). This policy outlined accommodations that may be appropriate for emergency physicians in the pre-retirement years of their career.

ACEP recently partnered with the Society for Academic Emergency Medicine (SAEM) and the American Board of Emergency Medicine (ABEM) to conduct a focused survey of emergency physicians who are nearing or at retirement age, or who have already transitioned from clinical practice. This survey, conducted by Gloria Kuhn, DO, FACEP,
assessed respondents’ emotional and financial preparedness for retirement as well as explored their post-retirement activities. The study has been published in the *American Journal of Emergency Medicine*.

Resolution 46(15) Transitioning Out of Medical Practice was assigned to the Well-being Committee (WBC). The WBC reviewed the Emergency Medicine Practice Committee’s paper on careers outside of the emergency department and additional information on opportunities in education, subspecialties, and event medicine. The revised information paper, “*Hospital Employment and Careers Outside the ED*” is available on the ACEP Website.

The new Wellness Book has an excellent chapter on retirement. The Well-being Committee also has a list of resources for physicians throughout various stages of their career and life.

In response to Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians, another Aging Physician Task Force was created, in collaboration with the American Board of Emergency Medicine, to assess resources and provide recommendations to aid in the assessment of competency and improve practice for older physicians. A report from the task force is expected by October 2017 and will be made available to the Council.

Nearly half of all physicians in the U.S. are over the age of 50. As a result of an aging workforce, some employers have begun to assess the competency of older physicians. Several programs are available, though few are evidence based. Mandatory assessments based solely on age raise questions of age discrimination.

In 2015, the American Medical Association (AMA) began a process to develop guidelines and screening modalities to assess the ability of older physicians to continue to practice. Their Council on Medical Education has produced research that demonstrates that physicians beyond the age of 60 can demonstrate some ‘differences in performance’. In addition, the report suggests that older physicians have a harder time incorporating new knowledge into practice. Clearly physicians are affected by aging to different degrees and show cognitive decline at different ages. Therefore, the AMA suggests that some type of cognitive and physical screening begin between the ages of 65 and 70.

Age is not the only factor that can affect performance. Prolonged absences from practice, or transitioning to a new practice setting (complex pediatric patients, low resource rural practice), may require education and procedural practice. ACEP provides several courses for physicians re-entering the workforce, or who need additional procedural practices. Among these are the Emergency Medicine Academy, cadaver and other skill labs at Scientific Assembly, and the Advanced Pediatric Assembly.

**ACEP Strategic Plan Reference**

Goal 2 – Enhance Membership Value and Member Engagement
   Objective A – Increase total membership and membership retention.
   Objective C. Promote member well-being and improve resiliency.

**Fiscal Impact:**

Budgeted staff resources and $20,000 for in-person task force meeting.

**Prior Council Action**

Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians adopted. Called for ACEP to create a task force to study issues specific to senior/late career emergency physicians.

Resolution 46(15) Transitioning Out of Medical Practice adopted. It directed ACEP to develop and provide resources for members transitioning out of the clinical practice of emergency medicine.
Resolution 51(17) Retirement or Interruption of Clinical Emergency Medicine Practice
Page 4

Prior Board Action

Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians adopted.

June 2016 and November 2015, reviewed the information paper, “Hospital Employment and Careers Outside the Emergency Department.”

Resolution 46(15) Transitioning Out of Medical Practice adopted.


October 2013 approved the policy statement, “Physician Impairment.” Previously approved October 2006; Reaffirmed September 1999; Approved April 1994, Originally approved September 1990.

March 2010, reviewed the information paper, “A Primer for Emergency Physicians in Pre-retirement Years.”

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 52(17)

SUBMITTED BY: Donald Stader, MD, FACEP
Erik Verzemnieks, MD

SUBJECT: Support for Harm Reduction and Syringe Services Programs

PURPOSE: Endorse syringe services programs, promote access to these programs for people who inject drugs, educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

FISCAL IMPACT: Budgeted committee and staff resources. Other costs are dependent on the extent of the promotional and educational activities.

WHEREAS, The opioid epidemic has become a major cause of preventable death in America, with 33,000 Americans dying of opioid overdose in 2015 and overdose from all drugs now becoming the number one killer of Americans under the age of 50; and

WHEREAS, Heroin use and IV drug use has grown exponentially with the opioid epidemic causing increasing mortality from IV opioid use (12,000 deaths in 2015) and dramatic increases in morbidity (Hepatitis C, HIV, Soft Tissue Infections, Endocarditis, Epidural abscess, etc.) from poor injection technique and sharing injection materials; and

WHEREAS, According to the Centers for Disease Control and Prevention (CDC) injection drug use accounts for one in ten new HIV diagnosis and is the leading cause of new Hepatitis C virus (HCV) diagnosis which, according to the CDC, have increased 300% in the last seven years; and

WHEREAS, Of people who inject drugs, an estimated 40% share syringes and injection materials; and

WHEREAS, Every case of HIV, Hepatitis C, soft tissue infection and overdose death is nearly 100% preventable with good injection technique and practices among people who inject drugs (PWID); and

WHEREAS, Emergency Departments and clinicians are on the front lines of the opioid and IV drug use epidemic, caring for most patients who overdose or experience complications of IV drug use; and

WHEREAS, Most emergency clinicians have never learned harm reduction practices and are not closely partnered with Syringe Services Programs (SSPs) in their communities; and

WHEREAS, SSPs provide sterile needles, syringes, and other drug preparation equipment and disposal services, along with risk reduction counselling, HIV and viral hepatitis screening and treatment referral, substance use disorder counseling and treatment referral, and recovery support services; and

WHEREAS, SSPs have not been found to increase drug use; and

WHEREAS, SSPs are supported by the CDC, World Health Organization, American Civil Liberties Union, and the American Medical Association and are identified by the Surgeon General of the United States as an effective manner to combat disease transmission and drug abuse; therefore be it

RESOLVED, That ACEP endorse Syringe Services Programs for those who use injection drugs; and be it
RESOLVED, That ACEP promote the access of Syringe Services Programs to people who inject drugs; and be it further

RESOLVED, That ACEP invest in educating its members on harm reduction techniques and the importance of Emergency Departments to partner with local Syringe Services Programs to advance the care of people who inject drugs.

Background

This resolution calls for the College to endorse syringe services programs, promote access to these programs for people who inject drugs and to educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

On its HIV and Injection Drug Use web page, the CDC states that HIV diagnosis among persons who inject drugs (PWID) declined 48% from 2008 to 2014, but injection drug use (IDU) in nonurban areas has created prevention challenges and new populations are at-risk. In 2015, 6% of the 39,513 diagnoses of HIV in the US were attributed to IDU. The number of new cases of hepatitis C increased from 16,500 in 2011 to 30,500 in 2014. Most of the new cases are attributed to IDU.

According to the CDC, syringe services programs (SSP) are community-based programs that provide comprehensive harm-reduction services which can include sterile needles, syringes, and other injection equipment; safe disposal containers for needles and syringes; HIV testing and linkage to treatment; education about overdose prevention and safer injection practices; referral for substance use disorder treatment; referral to medical, mental health and social services and tools to prevent HIV, STDs and viral hepatitis. The CDC website noted that persons who inject drugs can access sterile needles and syringes through SSPs and through pharmacies without a prescription. Laws vary by state concerning over-the-counter sales of syringes but barriers exist even in states where such sales are legal. A study published in the Journal of the American Pharmacist Association in January 2015 found that only 21% of 248 attempts to purchase syringes at community pharmacies in two California counties were successful, despite the fact that the law allows anyone 18 years or older to purchase syringes from a community pharmacy without a prescription. One of the study authors noted that there appeared to be “a widely held belief among pharmacists and staff that selling syringes to people who inject drugs promotes drug use.”

In February 2011, the Health and Human Services Department determined that there is scientific evidence supporting the important public health benefits of SSPs, and that a demonstration needles exchange program would be effective in reducing drug abuse and the risk of HIV infection among injection drug users. Federal funding for states and local communities is available under limited circumstances to support certain components of SSPs.

The Council and the Board adopted Resolution 21(16) Best Practices for Harm Reduction Strategies. It 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 to provide educational resources to ED providers for improving direct referral of substance use disorder patients to treatment. This resolution was assigned to the Emergency Medicine Practice Committee to work with the Public Health and Injury Prevention Committee to “Develop an information paper on the transition of care for patients seen in the ED with substance abuse issues (eg, “warm handoffs,” sobering centers, prescribing Suboxone etc.).” The information paper will be submitted to the Board for review in October. The focus of this paper is on screening for opioid use disorders, ED management of withdrawal, and transitioning patients out of the ED, including medication assisted therapy and linkages to treatment.
Resolution 52(17) Support for Harm Reduction and Syringe Service Programs
Page 3

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee and staff resources. Other costs are dependent on the extent of the promotional and educational activities.

Prior Council Action

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Prior Board Action


Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 53(17)

SUBMITTED BY: Georgia College of Emergency Physicians

SUBJECT: Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders

PURPOSE: Directs ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Cannabidiol (CBD), one of the active cannabinoids found in cannabis sativa (marijuana), which unlike tetrahydrocannabinol (THC), is believed not to have intoxicating or psychotropic effects due to its low affinity for central nervous system cannabinoid type I (CB1) receptors; and

WHEREAS, CBD appears to inhibit glutamate release resulting in downregulation at glutamatergic synapses which may contribute to lowering seizure thresholds; and

WHEREAS, Antidotal reports and limited studies of children with a history of intractable seizures, such as those due to Dravet syndrome and Lennox-Gastaut syndrome, which are unresponsive to currently available anti-elliptic medications have had significant improvement following use of CBD; and

WHEREAS, There has been little formal research meeting current scientific standards because of previous federal restrictions allowing for studies as to the potential risks and benefits of CBD in children for seizure control; and

WHEREAS, The National Institutes of Health have approved scientifically valid studies, and the Food and Drug Administration Center for Drug Evaluation and Research (CDER) has approved Investigation New Drug (IND) applications for phase 2/3 clinical trials for CBD for children with certain intractable seizure disorders; therefore be it

RESOLVED, That ACEP go on record supporting scientific research to evaluate the risks and benefits of Cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

References
Resolution 53(17) Supporting Research in the Use of Cannabidiol in Intractable Pediatric Seizure Disorders
Page 2


Current Clinical Trials (www.clinicaltrials.gov)
A. Cannabidiol (CBD) and Pediatric Epilepsy (NCT02447198), University of Colorado, Denver.
B. Epidiolex and Drug Resistant Epilepsy in Children (CBD) (NCT02397863), Augusta University
C. Study of Cannabidiol for Drug-Resistant Epilepsies (NCT03014440), Children's Hospital of Pittsburgh, Geisinger Clinic
D. Treatment of Drug Resistant Epilepsy (Cannabidiol) (NCT02461706), University of Florida

Background

This resolution calls for ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to currently available anti-elliptic medications.

Most states have passed laws approving the use of medical marijuana. Only four states, Idaho, South Dakota, Nebraska, and Kansas, do not have laws enacted on medical marijuana. Some states have tightly controlled medical marijuana statutes and have CBD-specific laws that allow for the use of cannabis extracts that are high in CBD and low in THC.

Legal Medical Marijuana States – CBD Specific

<table>
<thead>
<tr>
<th>States with CBD Specific laws</th>
<th>Signed</th>
<th>Qualifying Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>2014</td>
<td>Debilitating epileptic conditions</td>
</tr>
<tr>
<td>Florida</td>
<td>2014</td>
<td>Cancer, muscle spasms, seizures, terminal illness (&gt;12 mo.)</td>
</tr>
<tr>
<td>Georgia</td>
<td>2015</td>
<td>AIDS, Alzheimer’s, amyotrophic lateral sclerosis, autism, cancer, Crohn’s, hospice care patients, mitochondrial disease, multiple sclerosis, Parkinson’s, sever or end state peripheral neuropathy, seizure disorder, sickle cell disease, Tourette’s</td>
</tr>
<tr>
<td>Indiana</td>
<td>2017</td>
<td>Treatment resistant epileptic conditions, including Dravet syndrome and Lennox-Gastaut syndrome</td>
</tr>
<tr>
<td>Iowa</td>
<td>2014</td>
<td>AIDS/HIV, amyotrophic lateral sclerosis, cancer, cancer-related chronic pain, Crohn’s disease, multiple sclerosis, Parkinson’s, intractable epilepsy, terminal illness, untreatable pain</td>
</tr>
<tr>
<td>Kentucky</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Mississippi</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Missouri</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>2015</td>
<td>Pediatric epilepsy</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2014</td>
<td>Dravet syndrome, Lennox-Gastaut syndrome, refractory epilepsy</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Texas</td>
<td>2015</td>
<td>Intractable epilepsy*</td>
</tr>
<tr>
<td>Utah</td>
<td>2014</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Virginia</td>
<td>2015</td>
<td>Intractable epilepsy</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>2014 - expanded</td>
<td>Any “medical condition” for which a physician recommends it</td>
</tr>
<tr>
<td>Wyoming</td>
<td>2015</td>
<td>Intractable epilepsy (defined as epilepsy that “does not respond to other treatment options”)</td>
</tr>
</tbody>
</table>
This level of legislative activity on the part of most of the nation’s states appears to challenge the Drug Enforcement Agency’s position of listing marijuana as a Schedule I drug with “no currently accepted medical use and a high potential for abuse.”

- In July of 2017, the Senate Appropriates Committee passed an amendment to add a clause to the 2018 Commerce, Justice, Science and Related Agencies budget that would block the Department of Justice (DOJ) from using federal funds to prosecute state-legal medical marijuana operations. This is in line with the current protections under the Rohrabacher-Farr amendment (H.R. 2578), voted on annually, which has similar protections for the use of state-legal medical marijuana.
- In May 2017, President Trump signed H. R. 244 into law. This contained a provision (Division B, section 537) that the DOJ would not use funds to prevent implementation of medical marijuana laws by states and territories. However, there are mixed messages from the Administration on its stance of enforcing laws regarding illegal drugs and conflicts between state and federal law.
- The National Academies of Sciences, Engineering and Medicine conducted a comprehensive study on the health effects of therapeutic and recreational cannabis use, looking at research publications since 1999. One of the recommendations in their report, published in January 2017, called for developing a comprehensive evidence base on the effects of cannabis use including prioritized research streams for unstudied and understudied health endpoints, such as epilepsy in pediatric populations.
- On July 19, 2016, the Drug Enforcement Administration (DEA) denied a petition to initiate rulemaking proceedings to reschedule marijuana from Schedule I of the CSA to any other schedule.
- In fiscal year 2015, the NIH supported 281 projects totaling over $111 million on cannabinoid research. Within this investment, 49 projects ($21 million) examined therapeutic properties of cannabinoids, and 15 projects ($9 million) focused on CBD (Cannabidiol). Cannabinoid research is supported broadly across NIH Institutes and Centers (ICs), with each IC supporting research specifically focused on the impact of cannabinoids on health effects within their scientific mission.
- In 2015, the American Academy of Pediatrics reaffirmed their policy statement opposing legalization of marijuana for recreational or medical use. In their statement, the AAP opposed medical marijuana outside of the usual FDA approval process of pharmaceutical products, but supported the further study of pharmaceutical cannabinoids.
- The AMA policy remains against marijuana legalization, but in 2013, they reaffirmed their policy *Cannabis for Medicinal Use H-95.952* which calls for further and well-controlled studies of marijuana and cannabinoids in patients with serious conditions for its medical utility. The AMA also supports reducing criminal penalties and urges Congress and the DEA to review the status of marijuana as a Schedule I controlled substance, noting it would support rescheduling if doing so would facilitate research. According to its 2014 advocacy statement on cannabis, the AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic, and social consequences of use of cannabis and, instead, support the expansion of such research. The AMA will also increase its efforts to educate the press, legislators, and the public regarding its policy position that stresses a “public health,” as contrasted with a “criminal,” approach to cannabis.
- President Obama did not legalize marijuana at the national level, but in 2009 a Department of Justice memo from the Attorney General to the nation’s U.S. Attorneys advised them not to expend federal resources to prosecute individuals in states that have legalized medical marijuana.
- The Institute of Medicine’s 1999 study concluded that THC, the active ingredient in marijuana, may have medicinal potential and should be subjected for further research.

**ACEP Strategic Plan Reference**

None.

**Fiscal Impact**

Budgeted committee and staff resources.
Resolution 53(17) Supporting Research in the Use of Cannabidiol in Intractable Pediatric Seizure Disorders

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Prior Council Action

Since 2009, there have been 16 resolutions submitted to the Council regarding the use of marijuana. None of these resolutions have pertained to research in the use of cannabidiol in the treatment of pediatric seizure disorders.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19 (14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

None.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 54(17)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Use of Cannabis as an Exit Drug for Opioid Dependency

PURPOSE: Adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The United States is in the midst of a historic, opioid dependency epidemic, resulting in opioid overdose deaths of tens of thousands of people annually; and

WHEREAS, 75% of opioid dependent patients began their dependency with the use of prescription opioids such as Oxycontin, Percodan and Vicodin; and

WHEREAS, On January 12, 2017, the National Academies of Science, Engineering, and Medicine released the publication “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research;” and

WHEREAS, This publication, which reviewed over 10,700 abstracts and article published between 1999 and 2015 on cannabis, found conclusive/substantial evidence for cannabis as an effective treatment for chronic pain and spasticity symptoms in multiple sclerosis and moderate evidence for treatment of fibromyalgia; and

WHEREAS, Research at the University of San Diego found cannabis to be effective in treating neuropathic pain; and

WHEREAS; States that have legalized medicinal cannabis saw a 24.8 % reduction of opioid overdose deaths; and

WHEREAS, Additional research found that many patients who use medical cannabis for pain decrease or eliminate their use of opioids; and

WHEREAS, In states where medical cannabis is legal, many pain management programs automatically eliminate patients solely because they test positive for cannabis on random drug tests, even when recommended by their personal physician; therefore be it

RESOLVED: That ACEP adopt a policy that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis recommended by their physician.

Background

This resolution directs the College to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis recommended by their physician.

The American Academy of Pain Medicine, in their 2013 policy, “Position on Research into the Use of Cannabinoids..."
Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency

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for Medical Purposes,” states: “The lack of rigorous scientific and clinical research leave both physicians and patients alike at a disadvantage when considering the potential risks and benefits of cannabinoids as medicine.” The AAPM does not have a policy on participation in a pain management program and concurrent use of cannabinoids.

The AMA policy, “Cannabis for Medicinal Use H-95.952,” “…calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.” “…the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods.” “…should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.”

The AMA policy, “Cannabis - Expanded AMA Advocacy D-95.976,” supports education of the media and legislators as to the health effect of cannabis, urges legislatures to delay initiating full legalization of marijuana use until there is further research “on the public health, medical, economic and social consequences of use of cannabis.” The policy further calls for warning labels “…on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.”

ACEP has several policy statements regarding pain/pain management, but none specific to the use of marijuana.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Since 2009, there have been 16 resolutions submitted to the Council regarding the use of marijuana/cannabis. None of these resolutions have pertained to chronic pain patients in a pain management program being eliminated from the program solely because they use cannabis recommended by their physician. Several resolutions have been submitted regarding decriminalization of marijuana for personal and medical use.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. This resolution called for adoption and support of a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.
Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

**Prior Board Action**

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

April 2017, approved policy statement “Optimizing the Treatment of Acute Pain the Emergency Department.”


**Background Information Prepared by:** Margaret Montgomery, RN, MSN
Practice Management Manager

**Reviewed by:** James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
RESOLUTION: 55(17)

SUBMITTED BY: Howard Mell, MD, FACEP
Missouri College of Emergency Physicians

SUBJECT: Workplace Violence

PURPOSE: Develop actionable guidelines and measures to ensure safety in the ED; work with local, state and federal bodies for protections and endorsement of violations of guidelines to protect patients and staff from violence in the workplace; and create model legislative and regulatory language that can be shared with state chapters.

FISCAL IMPACT: Budgeted staff time and resources

WHEREAS, Recent news of multiple events against Emergency Department personal have continued to show evolving safety issues for Emergency Department patients and staff; and

WHEREAS, ACEP has the “Protection from Violence in the Emergency Department” policy statement approved by the ACEP Board of Directors January 1993 and most recently revised and approved April 2016, has published an Emergency Department Violence Fact Sheet, has published a case study for legislative lobbying use, and includes the topic in its Emergency Department Directors Academy; and

WHEREAS, In the several states, laws are being enacted specifically to address Emergency Department workplace violence and establish penalties for these acts (e.g., GA); and

WHEREAS, The Joint Commission, via a Sentinel Event Alert and via its Resource page at Joint Commission Resources, advocates for Emergency Department personnel safety measures; and

WHEREAS, Other governmental efforts, including the Centers for Disease Control and Prevention National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration have recognized the current dangers of violence in the Emergency Department as a health and safety issue; therefore be it

RESOLVED, That ACEP move past policy creation and simple awareness campaigns with state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling provided), to ensure safety in the Emergency Department for patients and staff; and be it further

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters addressing workplace violence.

Background

This resolution calls for the College to develop actionable guidelines and measures to ensure safety in the ED; work with local, state and federal bodies for protections and endorsement of violations of guidelines to protect patients and staff from violence in the workplace; and create model legislative and regulatory language that can be shared with
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state chapters.

The Government Accountability Office published in March 2016 a report on Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. The GAO identified three areas of improvement for the Department of Labor’s Occupational Safety and Health Administration (OSHA). Among the issues identified was an acknowledgement that there are no OSHA standards that require employers to implement workplace violence prevention programs. Voluntary guidelines have been issued. OSHA can issue warnings to employers, but they are not required to take corrective action. While inspections have increased since 2010, only 86 were conducted in 2014. OSHA has not assessed the results of its efforts to address workplace violence in health care settings.

The GAO report identifies nine states (CA, CT, IL, MA, MD, NJ, NY, OR, WA) that have enacted laws that require health care employers to have a workplace violence prevention program. The OSHA Voluntary Guidelines outline components of an effective workplace violence prevention program. Seven of the nine states that have enacted these laws meet all the components as outlined by OSHA.

The Joint Commission notes in the rationale for the Environment of Care Standard (EC.01.01) that workplace violence is an example of a security risk. Hospitals are required to implement a process to identify safety and security risks that could affect patients, staff and others coming to the hospital (EC.02.01.01 EP.1) and are required to take action to minimize or eliminate the risks.

A significant majority of states have statutes creating enhanced penalties for persons guilty of assault against health care personnel generally or against emergency health care personnel, in particular. However, many of these laws referencing emergency care are specific to emergency services technicians and personnel and do not apply to physicians.

The American Medical Association has model legislation, “Concerning Assault of Emergency Health Care Workers” that includes physicians in its definition of “emergency health care workers.”

ACEP has a long history of developing policies and resources for members addressing workplace violence prevention and enforcement of protections for emergency care providers and the patients they care for. The current ACEP policy statement “Protection from Violence in the Emergency Department” outlines specific hospital responsibilities, including ED security systems based on institution-specific risk assessment, ongoing assessment of security systems, coordination with local law enforcement, written protocols with employee input, education for staff, mandatory reporting, and zero tolerance policies, in addition to post-event support and pursuit of enforcement and prosecution. The first ACEP policy on workforce safety was adopted in 1993.

In 2016, the ACEP Public Health & Injury Prevention Committee (PHIPC) developed an information paper “ED Violence: An Overview and Compilation of Resources.” This paper defines workplace violence, the magnitude of the problem, risk factors, prevention strategies, approaches to dealing with potentially violent individuals, in addition to available resources. In 2015, the PHIPC developed an information paper on the “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED.” This information paper was developed in response to Substitute Resolution 21(14) “ED Mental Health Information Exchange” and reviews tools for assessing patient violence risk. In 2014, the PHIPC developed an information paper “Hospital-based Violence Intervention Programs” to promote awareness of evidence-based solutions for violence reduction and resources for these programs. A compilation of educational programs and resources titled “Violence in the Emergency Department: Resources for a Safer Workplace” is also available on the ACEP Website. This page is a compilation of CME lectures, podcasts, Annals articles, and policies.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective D – Develop and implement solutions for workforce issues that promote and sustain quality and
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patient safety.

Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Promote member well-being and improve resiliency.

**Fiscal Impact**

Budgeted staff time and resources.

**Prior Council Action**

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.

Substitute Resolution 21(14) Emergency Department Mental Health Information Exchange adopted. This resolution called for ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence and devise strategies to help emergency care providers with stakeholders to mitigate patients’ risk of self-directed for interpersonal harm and investigate the feasibility and functionality of sharing patient information under HIPAA.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital’s emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention, among others, to make financial support available for research into this area.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 11(93) Violence-Free Society adopted. It directed ACEP to develop a policy statement that its members support the concept of a violence free society and to make every effort to educate its members about the preventable nature of violence and the important role physicians can play in violence prevention.

Amended Resolution 44(91) Health Care Worker Safety adopted. It directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

**Prior Board Action**

May 2016, reviewed the information paper, “Emergency Department Violence: An Overview and Compilation of Resources.”

April 2016, approved the revised policy statement “Protection from Violence in the Emergency Department;” previously revised June 2011 and April 2008 titled “Protection from Physical Violence in the Emergency Department Environment;” reaffirmed October 2001 and October 1997; originally approved January 1993 as “Protection from Physical Violence in the Emergency Department.”

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.”

June 2013, reaffirmed the policy statement “Violence-Free Society;” previously revised and approved January 2007; reaffirmed October 2000; and originally approved January 1996.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

Substitute Resolution 21 (14) Emergency Department Mental Health Information Exchange 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 11(93) Violence-Free Society adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Harry J. Monroe, Jr.
Director, Chapter & State Relations

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director
Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 26, 2017

Subj: Amended Resolution 13(16) ED Boarding and Overcrowding is a Public Health Emergency

The 2016 Council and the Board of Directors adopted Amended Resolution 13(16):

RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further

RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council’s next scheduled meeting; and be it further

RESOLVED, That ACEP publicly promote the following as sustainable solutions to hospital crowding which have the highest impact on patient safety, hospital capacity, ICU availability, and costs:

1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge strategies (e.g., 11:00 am discharges, scheduled discharges, staggered discharges) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital.

ACEP continues to work with HHS and the appropriate committees of jurisdiction to identify emergency department boarding solutions, which include a variety of options. This issue was addressed specifically in comment letters responding to the 2018 proposed Medicare Physician Fee Schedule and the 2018 proposed Outpatient Prospective Payment System rules. ACEP has continued efforts to work with The Joint Commission, most recently at a meeting in June 2017, and with other stakeholders to address and eliminate boarding in the ED.
Regarding the second resolved, in June 2016, the Board reviewed the updated information paper, *Emergency Department Crowding High-Impact Solutions*. The Emergency Medicine Practice Committee and representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians collaborated on the revisions. ACEP has in the past and will continue to hold meetings with TJC and other organizations about boarding.

The Public Relations Committee updated ACEP’s crowding and boarding messaging to include the solutions proposed in the resolution. Boarding solutions were promoted to news media organizations, including WLOS-TV in Asheville, NC, which received ACEP’s journalism award, an Emmy, and an Edward R. Murrow award.

ACEP sponsored the Hospital Flow Conference in Boston, MA in May 2017. The conference focused on improving hospital efficiency, capacity, and flow and provided participants with the knowledge and tools needed to eliminate ED boarding, improve hospital capacity, enhance patient safety, shorten length of stay, and improve patient and staff satisfaction. The processes discussed do not add cost or staff, are associated with significant and sometimes dramatic savings to the institution, and focus on a small number of practically proven key processes that can dramatically improve overall hospital capacity. The conference provided an introduction to these processes, followed by workshops to discuss the practical details, both procedural and political, in implementing institutional change. The faculty included individuals who have had firsthand experience in implementing these processes at their own institutions. There were 233 attendees. Resources are available on ACEP’s and cosponsor’s Websites.
Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 26, 2017

Subj: Amended Resolution 19(16) Health Care Financing Task Force

The 2016 Council and the Board of Directors adopted Amended Resolution 19(16):

RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

The task force name was changed to “Single-Payer Task Force” to differentiate it from the previously appointed Health Care Financing Task Force that has focused on alternate payment models.

ACEP reached out to many leaders to request their service as chair of the task force. The task force was officially appointed in June 2017 and the first meeting will be held during ACEP17.

Members who were invited to serve on the task force include the primary author of the resolution, members who have expressed viewpoints in favor of and opposed to single-payer, some who have neutral viewpoints, and others whose viewpoint is unknown on this issue.
This item will be provided as soon as it is available.
This item will be provided as soon as it is available.
Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 26, 2017

Subj: Action on 2016 Resolutions

The attached report summarizes the actions taken by the Board of Directors on the 25 resolutions (24 non-Bylaws, and one Bylaws) adopted by the 2016 Council. Five resolutions were referred to the Board of Directors.

The actions on resolutions are also included on the ACEP Website.
Action on 2016 Council Resolutions

Resolution 1  Commendation for Michael J. Gerardi, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Michael J. Gerardi, MD, FACEP, for his exemplary service, leadership, and commitment to the College, the specialty of emergency medicine, and to the patients we serve.

Action: A framed resolution was presented to Dr. Gerardi.

Resolution 2  In Memory of Kenneth L. DeHart, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, MD, FACEP, as one of the leaders in Emergency Medicine and the greater medical community; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family of Kenneth L. DeHart, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of South Carolina and the United States.

Action: A framed resolution was prepared for Dr. DeHart’s family.

Resolution 4  Legacy Fellows – Housekeeping Change – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be amended to read:

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

Action: The Bylaws were updated.

Resolution 6  Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians (as amended)
RESOLVED, That the ACEP Board of Directors create a task force to study issues specific to Senior/Late Career Emergency Physicians. The task force shall make recommendations regarding identified issues to the Board, which shall deliver an update on this matter to the 2017 ACEP Council.

Action: The American Board of Emergency Medicine is undergoing a substantial review of cognitive skill and physician age and has data from their ConCert exam. Additionally, the AMA and the American College of Surgeons are reviewing this issue. A task force was appointed and another meeting is scheduled during ACEP17.

Resolution 7  Diversity in Emergency Medicine Leadership (as amended)
RESOLVED, That the ACEP Board of Directors work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation.

Action: The resolution is being addressed through the work of the Diversity & Inclusion Task Force, the Leadership Development Advisory Group, the Leadership Diversity Task Force, and the National/Chapter Relations Committee. The majority of ACEP’s 26 committees were assigned objectives in the 2016-17 committee year to address diversity and inclusion.

Resolution 9  Accreditation Standards for Freestanding Emergency Centers
RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further
RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

Action: A task force was appointed with representation from the Freestanding Emergency Centers Section. Their work is underway and a meeting will be held during ACEP17.

Resolution 11 CMS Recognition of Independently Licensed Freestanding Emergency Centers
RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further
RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

Action: Assigned the first resolved to Public Affairs staff to include in advocacy and regulatory initiatives. Assigned the second resolved to the AMA Section Council on Emergency Medicine. The Board will discuss the Section Council’s recommendation at their October 2017 meeting.

Resolution 13 ED Boarding and Overcrowding is a Public Health Emergency (as amended)
RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further
RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department boarding with a report back to the ACEP Council at the Council’s next scheduled meeting; and be it further
RESOLVED, That ACEP publicly promote the following as sustainable solutions to hospital crowding which have the highest impact on patient safety, hospital capacity, ICU availability, and costs:
1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge strategies (e.g., 11:00 am discharges, scheduled discharges, staggered discharges) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital.

Action: Assigned first resolved to Public Affairs staff to include in advocacy initiatives and the third resolved to the Public Relations Committee to develop messaging.

Regarding the second resolved, in June 2016, the Board reviewed the updated information paper, “Emergency Department Crowding High-Impact Solutions” The Emergency Medicine Practice Committee and representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians collaborated on the revisions. ACEP has in the past and will continue to hold meetings with TJC and other organizations about boarding.

The Public Relations Committee updated ACEP’s crowding and boarding messaging to include the solutions proposed in the resolution. Boarding solutions were promoted to news media organizations, including WLOS-TV in Asheville, NC, which received ACEP’s journalism award, an Emmy, and an Edward R. Murrow award.

ACEP sponsored the Hospital Flow Conference in Boston, MA in May 2017. The conference focused on improving hospital efficiency, capacity, and flow and provided participants with the knowledge and tools needed to eliminate ED boarding, improve hospital capacity, enhance patient safety, shorten length of stay, and improve patient and staff satisfaction. The processes discussed do not add cost or staff, are associated with significant and sometimes dramatic savings to the institution, and focus on a small number of practically proven key processes that can dramatically improve overall hospital capacity. The conference provided an introduction to these processes, followed by workshops to discuss the practical details, both procedural and political, in implementing institutional change. The faculty included individuals who have had firsthand experience in implementing these processes at their own institutions. There were 223 attendees. Resources are available on ACEP’s and cosponsor’s Websites.

ACEP has continued efforts to work with The Joint Commission, most recently at a meeting in June 2017, and other stakeholders to address and eliminate boarding in the ED.
Resolution 14  Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs (as amended)

RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients in EDs; and be it further
RESOLVED, That ACEP endorse integration of a dashboard for reporting and tracking of behavioral health patients boarding in EDs in electronic health record systems as a means for linking to broader priority systems, for communicating the impact of boarded behavioral health patients, and to further collaborate with all appropriate health care and government stakeholders.

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee’s recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently 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. The Quality Improvement & Patient Safety (QIPS) Section is currently working on an ACEP-funded grant titled “Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper.” The paper will address issues pertinent to the length of stay of behavioral health patients in the ED and describe best practices to reduce length of stay. The section will apply for another section grant in the next cycle to develop the toolkit.

Resolution 15  Enactment of Narrow Networks Requirements (as amended)

RESOLVED, That ACEP shall create a study of the impact of narrow networks laws and potential solutions that address balance billing issues without increasing the burden on the patient; and be it further
RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks protects fair payment for emergency medical care.

Action: Assigned to Public Affairs staff to discuss with ACEP’s health policy consultants and to Chapter & State Relations staff for recommendations.

The Public Relations Committee developed a “Fair Coverage” campaign about out-of-network issues, which counters health insurance industry statements about “surprise billing.” The campaign focuses on coverage for emergency patients, not payment for physicians. Committee members also participated in a letters to the editor campaign promoting ACEP’s key fair coverage messages and participated as cast members of ACEP’s parody Cigna video. The video served as a means to promote ACEP’s fair coverage campaign messages and generated more than 300,000 views on Facebook and YouTube, and resulted in a meeting with Cigna. The messaging was tested with focus groups consisting of policymaker audiences. Network adequacy and fair payment for out of network services was a constant emphasis of state advocacy in 2016-17. State legislation related to network adequacy was included in the legislative tracking reports provided to chapters. Staff also participated in meetings and communications with other hospital based specialties about proposals regarding network adequacy and the sufficiency of efforts by regulators to enforce existing laws.

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

RESOLVED, That ACEP develop a report or information paper analyzing the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where Emergency Departments in Critical Access and Rural Hospitals that have closed, or are in the process of closing.

Action: ACEP has supported legislation to allow critical access and rural hospitals to become freestanding EDs. Assigned to Public Affairs staff to investigate status of the legislation.

ACEP met with Senator Grassley’s health legislative assistant and current health policy fellow on January 10, 2017, to discuss ACEP’s positions heading into ACA reform and the REACH Act (converting community access hospitals into rural emergency hospitals; loan forgiveness for emergency physicians who work at these institutions; and allowing rural rotations for emergency medicine residents). Senator Grassley intends to reintroduce the REACH Act and asked for ACEP’s help in finding a lead Democrat for the legislation. Information is pending on the current status of the REACH Act.

Resolution 18  Opposition to CMS Mandating Treatment Expectations (as amended)

RESOLVED, That ACEP work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence based care of individual patients; and be it further
RESOLVED, That ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

*Action:* Assigned first resolved to Public Affairs staff to include in advocacy initiatives. Assigned second resolved to the Public Relations Committee to develop messaging.

A similar resolution was submitted to the AMA, from ACEP members, and it was referred to the Board of Trustees:

**Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927**

1. Our AMA will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

**Resolution 19  Health Care Financing Task Force (as amended)**

RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

*Action:* A task force was appointed in June 2017 and the first meeting will be held during ACEP17. The name was changed to “Single-Payer Task Force” to differentiate it from the previously appointed Health Care Financing Task Force that has focused on alternate payment models.

**Resolution 20  Support & Advocacy for 24/7 Hyperbaric Medicine Availability**

RESOLVED, That the American College of Emergency Physicians work with the Undersea & Hyperbaric Medical Society (UHMS) and the Divers Alert Network (DAN) to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide timely and appropriate treatment to patients in need.

*Action:* Assigned to Public Affairs staff to include in advocacy initiatives, in collaboration with UHMS and DAN.

**Resolution 21  Best Practices for Harm Reduction Strategies**

RESOLVED, That ACEP develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and be it further

RESOLVED, That ACEP provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

*Action:* Assigned to the Emergency Medicine Practice Committee and the Public Health Committee.

There are resources on the ACEP Website that address alcohol screening and brief intervention in the ED. Other resources include the Sobering Centers and “Alcohol Screening in the ED” information papers. The alcohol screening information paper was submitted to *Annals of Emergency Medicine* for publication consideration. It was not accepted and then was submitted to the *Western Journal of Emergency Medicine* and accepted. A publication date has not been determined. It will be available on ACEP’s Website after publication.

There are currently three ACEP policy statements that address alcohol misuse: “Addressing the Public Safety Dangers Associated with Impaired or Distracted Driving,” “Alcohol Screening in the Emergency Department” and “Alcohol Taxation.”

The Public Health & Injury Prevention Committee has prepared a draft information paper on Medication Assisted Therapy. It will be shared with the Emergency Medicine Practice Committee and the Pain Management Section for comments prior to submission to the Board.

The intent of this resolution is being met through objectives assigned to multiple committees. The policy statement *Optimizing the Treatment of Acute Pain in the Emergency Department* was approved by the Board in April 2017. Additional resources are available on the ACEP Website. The Emergency Medicine Practice Committee was assigned an objective in 2016-17 objective to “Work with the Pain Management Section to compile and develop resources for opiate free emergency departments.” The plan is to provide a brief overview for each modality
indications, contraindications, dosing, charting tips, special considerations and references for each. Topics to include: nerve blocks, nitrous, buprenorphine, trigger point injections, ketamine, etc. The Public Health & Injury Prevention Committee was assigned an objective in 2016-17 to “Develop an information paper on the transition of care for patients seen in the ED with substance abuse issues (e.g., “warm handoffs,” sobering centers, prescribing Suboxone, etc.). The committee is drafting an information paper focused on transitions of care for patients with opioid abuse issues. The information paper is in development and will address screening for opiate abuse, symptomatic relief for withdrawal, prescribing Naloxone, and referral to treatment centers. The Pain Management Section will continue to develop resources for members on pain management and addiction medicine. Discussions were initiated on the development of the ACEP website to feature resources for providers on pain management in the ED and development of a “DART” type app for members.

**Resolution 22  Court Ordered Forensic Evidence Collection in the ED**
RESOLVED, That ACEP study the moral and ethical responsibilities of emergency physicians within the context of court-ordered forensic collection of evidence in the context of patient refusal of consent, and if appropriate, develop policy to support emergency physicians’ professional responsibilities when in conflict with court-ordered forensic collection of evidence and or medical treatment.

*Action:* Assigned to the Ethics Committee and the Medical-Legal Committee. The committees collaborated to revise the policy statement “Law Enforcement Information Gathering in the ED” and it was approved by the Board in June 2017.

**Resolution 23  Medication Assisted Therapy for Patients with Substance Use Disorders in the ED (as amended)**
RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further
RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction programs from the Emergency Department.

*Action:* Assigned to the Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committee. The Public Health & Injury Prevention Committee has prepared a draft information paper on Medication Assisted Therapy. It will be shared with the Emergency Medicine Practice Committee and the Pain Management Section for comments prior to submission to the Board for review.

**Resolution 24  Mental Health Boarding Solutions (as amended)**
RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, the National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further
RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further
RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and other appropriate stakeholders to develop community and hospital based benchmark performance metrics for ED mental health flow and psychiatric facilities acceptance of patients.

*Action:* This resolution is being addressed primarily by the Coalition on Psychiatric Emergencies. The Coalition stemmed from a psychiatric emergency summit held in December 2014 comprised of multiple stakeholder groups from emergency medicine, emergency psychiatry, and patient advocacy to improve the treatment of psychiatric emergencies for patients and providers. The overarching goals of the Coalition are to bring awareness and recognition to the national challenges surrounding psychiatric emergencies and work collaboratively to address these problems and create change. There are four working groups (Education, Research, Operations/Boarding, Advocacy) each with their own objectives and tasks. A repository of resources is available on the Emergency Medicine Foundation Website.

The Coalition sponsored a research consensus conference on December 7, 2016, with experts from around the country, on the evidence that rapid treatment of patients with acute mental health disorders leads to better patient outcomes. The goal of the conference was to address underlying questions related to time to treatment, and if early intervention can affect patient outcomes. Breakout sessions included: acute psychosis, depression and suicidality, substance use disorder and agitation in the elderly. Manuscripts are being developed that will be sent to peer reviewed publications.
The Coalition worked with ACEP’s Emergency Medicine Practice Committee to develop the information paper, Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department, on best practices for boarding patients with mental health disorders. A podcast is in development and will be available on the ACEP website.

The Clinical Policies Committee revised the Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department and it was approved by the Board in January 2017. In 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 Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently 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 admission to ED departure time for psychiatric and mental health patients. The Quality Improvement & Patient Safety (QIPS) Section is currently working on an ACEP-funded grant titled “Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper.” The paper will address issues pertinent to the length of stay of behavioral health patients in the ED and describe best practices to reduce length of stay. The section will apply for another section grant in the next cycle to develop the toolkit.

Resolution 25 Military Medics Integration into Civilian EMS (as amended)
RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training to allow transition of current military pre-hospital personnel to the civilian sector and which recognize the current level of training and experience of military medical specialist providers in our nation’s service.

Action: Assigned to the EMS Committee to develop a policy statement and to Public Affairs and State Legislative staff to include in federal and state advocacy initiatives.

The EMS Committee worked with several members with past military experience as well as representatives from the Government Services Chapter to develop a draft policy statement. The committee also reviewed current projects underway that are supported by the National Association of State EMS Officials (NAEMSO), the National Association of EMS Educators (NAEMSE), the National Association of EMTs (NAEMT) and the National Registry of EMT’s (NREMT) on military to civilian EMS transition to ensure ACEP’s policy is consistent with these initiatives. The Board approved the policy statement “Support for Transition of Military Medics into Civilian EMS Careers” in June 2017.

Resolution 26 Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians (as amended)
RESOLVED, That ACEP supports users of emergency ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of emergency ultrasound by non-radiology specialists and the billing for such services; and be it further
RESOLVED, That ACEP continue to support emergency physicians working to develop and implement emergency ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

Action: Assigned to the Emergency Medicine Practice Committee and the Emergency Ultrasound Section to develop a policy statement. The Board approved the policy statement “Advocacy for Emergency Department Ultrasound Privilege and Practice” in June 2017.

Resolution 27 Pediatric Surgery Centers
RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further
RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

Action: Assigned to the Pediatric Emergency Medicine Committee. The committee was assigned objective in 2016-17 to work with the Pediatric Surgery Society to revise the guidelines. ACEP discussed concerns with the leadership of the Pediatric Surgical Society and the American College of Surgeons (ACS) in March 2017. ACEP met with leaders of the American Academy of Pediatrics (AAP) during the 2017 ACEP Advanced Pediatric Emergency Medicine Assembly. AAP indicated they were not aware of the concerns prior to this meeting and agreed to review their processes on endorsement of documents and involve ACEP in future revisions of the Pediatric Surgery Center Guidelines. The ACEP Board had further discussions on this issue at their
June 2017 meeting and a letter was sent to ACS on August 28, 2017. ACS responded on September 25, 2017, providing additional background about development of the Guidelines and agreed to include representation from ACEP in future revisions.

**Resolution 28 Reimbursement for Opioid Counseling**
RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further
RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

**Action:** Assigned first resolved to the Coding & Nomenclature Committee. Assigned second resolved to the Emergency Medicine Practice Committee.

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents. The resources will be reviewed by the Board in October 2017.

**Resolution 29 The Opioid Epidemic – A Leadership Role for ACEP (as amended)**
RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further
RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further
RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

**Action:** Assigned to the Emergency Medicine Practice Committee (EMPC) to review current policies and resources and determine if revisions or additional resources are needed. The following resources and activities were identified:

- 2012 *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department*. The Clinical Policies Committee has started work on a revision to this policy that will be completed in 2018. The critical questions have been finalized and literature searches completed. The literature is being obtained and grading will begin in the fall 2017.
- 2014 PREP Equipment for Ground Ambulances. Naloxone is listed under required equipment for advanced life support (ALS) emergency ground ambulances.
- *ACEP Website Resources*: In September 2014, the Emergency Medicine Practice Committee compiled resources on opioid prescribing in the ED, including information on the scope of the problem, resources on pain management in the ED, state initiatives, regulatory information, prescribing guidelines, prescription drug monitoring programs, and patient education materials and treatment resources.
- Emergency Medicine Practice Committee 2016-17 objective to “Work with the Pain Management Section to compile and develop resources for opiate free emergency departments.” The plan is to provide a brief overview for each modality indications, contraindications, dosing, charting tips, special considerations and references for each. Topics to include: nerve blocks, nitrous, buprenorphine, trigger point injections, ketamine, etc.
- Public Health & Injury Prevention Committee 2016-17 objective to “Develop an information paper on the transition of care for patients seen in the ED with substance abuse issues (e.g., “warm handoffs,” sobering centers, prescribing Suboxone, etc.). The committee is drafting an information paper focused on transitions of care for patients with opioid abuse issues. The information paper is in development and will address screening for opiate abuse, symptomatic relief for withdrawal, prescribing Naloxone, and referral to treatment centers.
- Public Health & Injury Prevention Committee has prepared a draft information paper on Medication Assisted Therapy. It will be shared with the Emergency Medicine Practice Committee and the Pain Management Section for comments prior to submission to the Board.
- The Pain Management Section will continue to develop resources for members on pain management and addiction medicine. Discussions were initiated on the development of the ACEP website to feature resources for providers on pain management in the ED and development of a “DART” type app for members.
- State Legislative/Regulatory Committee 2016-17 objective expanding and updating previous work to “research and report on successful approaches to opioid prescribing legislation impacting EDs, with a focus on state mandates related to PDMP’s, the use of clinical guidelines, programs with state agencies (e.g., “warm hand off” programs and expansion of local treatment programs) and the availability of naloxone.” A panel discussion was
held at the 2017 Leadership & Advocacy Conference that featured creative responses led by ACEP members to the opioid crisis in Paterson, NJ and northwestern NM. The committee is developing a tool kit of legislative resources that will be made available on ACEP’s website.

- State legislative staff tracks legislation related to opioid prescribing, PDMP’s, and the availability of naloxone, and provides that information to state chapters.

  In April 2017, the Board approved the committee’s recommendation to take no further action and concurred that the intent of the resolution had been addressed.

**Resolution 31 Opposing the Development of Sublingual Sufentanil (as amended)**

RESOLVED, That ACEP actively oppose the FDA approval of sublingual formulations of synthetic fentanyl analogs, including sufentanil, via direct testimony or other means that the Board may find suitable.

**Action:** Assigned to the EMS Committee to obtain more information and provide a recommendation to the Board. The resolution was initiated as a result of the pharmaceutical company contacting EMS providers and indicating that EMS was supportive of the development. A letter was sent to the FDA in January 2017 opposing the use of sublingual fentanyl by EMS and in civilian emergency departments. ACEP leaders have had multiple discussions with the pharmaceutical company that developed the drug to inform them of ACEP’s concerns.

### Referred Resolutions

**Resolution 8 Opposition to Required High Stakes Secured Examination for Maintenance of Certification**

RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

**Action:** The officers of ACEP and ABEM met several times since the 2016 Council meeting to discuss these issues. ACEP has relayed the growing discontent among some ACEP members with the Maintenance of Certification (MOC) process and particularly the high-stakes ConCert exam. ABEM has been active in exploring alternative approaches to physician assessment. This exploration includes detailed analyses of every pilot project in which other specialty boards are involved. ABEM informs ACEP that it is participating in direct discussions and research consortia with other American Board of Medical Specialties (ABMS) specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited. ABEM has assembled panels of senior ABEM leaders to explore modification and options to the ConCert examination. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination. ABEM will hold a national ConCert Summit October 2-3, 2017, that will include representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is also looking to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates. Additionally, ACEP, along with dozens of other specialty societies and state medical societies will meet with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

**Resolution 10 Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use**

RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

**Action:** Assigned to the Ethics Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the resolution.

The Ethics Committee was initially assigned as the lead committee to work on the resolution, but opined that this was not an ethical issue and the work should be led by the Public Health & Injury Prevention Committee. The resolution was subsequently assigned to the Emergency Medicine Practice Committee as this committee was also assigned Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED. After extensive discussion, there was not a consensus on a recommendation to the Board. A two-question survey was developed and shared with the four committees identified to review this resolution. The questions asked were: 1) Should ACEP adopt a policy supporting decriminalization of marijuana? and 2) Should ACEP submit a resolution to the AMA in support of decriminalization? While approximately 67% of the respondents were opposed to ACEP adopting a policy in favor of decriminalization of marijuana, all but one of the comments were in opposition. Others commented they are in favor
of decriminalization of position of small amounts of marijuana, but did not believe this is an issue for ACEP to address. After review of the survey results and consideration of the comments, the Emergency Medicine Practice Committee recommended that no further action be taken on the resolution. The Board approved the committee’s recommendation in June 2017.

Resolution 12  Collaboration with Non-Medical Entities on Quality and Standards (as amended)
RESOLVED, That the American College of Emergency Physicians reach out and build coalitions with non-medical organizations involved in developing non-clinical quality standards that include an evaluation of the cost of providing the highest level quality of care.

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee’s recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Resolution 17  Insurance Collection of Beneficiary Deductibles (as amended)
RESOLVED, That ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patients’ deductibles for EMTALA-related care after the insurance company pays the physician; and be it further
RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates that advocates for a national law requiring health care insurance companies to collect patient’s deductibles after the insurance company pays the physician for EMTALA related care.

Action: Assigned to the Federal Government Affairs Committee to review and provide a recommendation to the Board regarding further action on the resolution. The committee did not support adding this issue to the legislative and regulatory priorities given the scope of work on initiatives related to the repeal and/or replacement of the Affordable Care Act. The committee’s recommendation will be discussed by the Board at their October 2017 meeting.

The AMA adopted a similar resolution in November 2016. The AMA Board of Trustees was directed to make a decision and provide a report at the June 2017 AMA Annual meeting. At their April 2017 meeting, the AMA Board of Trustees determined:

Health Insurance Companies Should Collect Deductible From Patients After Full Payment to Physicians – The Board received a report in response to Resolution 805-I-16 which was referred for decision at the 2016 Interim Meeting of the House of Delegates. Resolution 805, sponsored by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont delegations, asks our AMA to “seek federal and state legislation that requires health insurers to reimburse physicians the full negotiated payment rate for services to enrollees in high deductible plans and that the health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient.”

Those in support of Resolution 805-I-16 argued that such legislative action was necessary to address the potential increase in bad debt as a result of patient collections becoming more challenging due to the growth in high-deductible health plans. Conversely, others expressed concern over the unintended consequences to physician practices and the larger political challenges of successfully enacting such legislation.

In lieu of Resolution 805-I-16, the Board voted to approve that the AMA: 1. Reaffirm Policies H-165.849, “Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans,” and D-190.974, “Administrative Simplification in the Physician Practice;” 2. Engage in a dialogue with health plan representatives (e.g., America’s Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

Resolution 30  Treatment of Marijuana Intoxication in the ED
RESOLVED, That ACEP investigate the scope of treatment of marijuana intoxication in the ED that has legal implications; and be it further
RESOLVED, That ACEP determines if there are state or federal laws that provide guidance to emergency physicians in the treatment of marijuana intoxication in the ED; and be it further
RESOLVED, That the Board of Directors assign an appropriate committee or task force to answer clinically relevant questions that address the need to care for ED patients with possible marijuana (or other drug) intoxication; and be it further

RESOLVED, That ACEP investigate how other medical specialties address the treatment of marijuana intoxication in other clinical settings; and be it further

RESOLVED, That ACEP provide the resources necessary to coordinate the treatment of marijuana intoxication in the ED.

Action: Assigned to the Emergency Medicine Practice Committee, the Public Health Committee, and the State Legislative/Regulatory Committee to review and provide a recommendation to the Board regarding further action on the resolution. A thorough analysis was conducted and in June 2017, the Board approved the committee’s recommendation to take no further action on the first, second, and fourth resolveds; assign the third resolved to the Toxicology Section or other body for additional work; and for the fifth resolved, educate ED providers to document diagnosis of marijuana intoxication and make subsequent efforts to correlate the diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then focus on determining the resources needed to coordinate treatment of marijuana intoxication.
Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 23, 2017

Subj: Action on 2015 Resolutions

The attached report summarizes the actions taken by the Board of Directors on the 37 resolutions (34 non-Bylaws, 2 Bylaws, and one Council Standing Rules) adopted by the 2015 Council. Six resolutions were referred to the Board of Directors.

The actions on resolutions are also included on the ACEP Website.
Action on 2015 Council Resolutions

Resolution 1  Commendation for Marsha D. Ford, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Marsha D. Ford, MD, FACEP, for her service as an emergency physician, scholar, and patient advocate and for her lifelong dedication to the advancement of the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. Ford.

Resolution 2  Commendation for Kevin M. Klauer, DO, EJD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Kevin M. Klauer, DO, EJD, FACEP, for his service as Council Speaker and Council Vice Speaker and for his commitment and dedication to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Klauer.

Resolution 3  Commendation for Alexander M. Rosenau, DO, CPE, FACEP
RESOLVED, That the American College of Emergency Physicians commends Alexander M. Rosenau, DO, CPE, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

Action: A framed resolution was presented to Dr. Rosenau.

Resolution 4  In Memory of Stanley M. Zydlo, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Stanley M. Zydlo, Jr., MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of EMS; and be it further RESOLVED, That national ACEP and the Illinois College of Emergency Physicians extends to his wife, Joyce Reid, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialties of Emergency Medicine and Emergency Medical Services.

Action: A framed resolution was prepared and sent to the family of Dr. Zydlo.

Resolution 5  EMRA Councillor Allocation – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph three, be amended to read: EMRA shall be entitled to four eight councillors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA

Action: The Bylaws were updated.

Resolution 6  Fellowship Criteria – Bylaws Amendment
RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility, be amended by deletion of criterion number four:
Fellows of the College shall meet the following criteria:
1. Be regular or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application:
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
B. Satisfaction of at least three of the following individual criteria during their professional career:

1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
4. active involvement in emergency medicine administration or departmental affairs;
5. active involvement in an emergency medical services system;
6. research in emergency medicine;
7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

4. Provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.

Action: The Bylaws were updated.

Resolution 11 Ethical Violations by Non-ACEP Members (as amended)

RESOLVED, That ACEP shall extend the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” to include non-ACEP members whose actions involve ACEP members; and be it further

RESOLVED, That ACEP’s current “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” shall be modified to reflect that any disciplinary actions taken by ACEP and involving non-ACEP members will be reported to the expert’s own professional society and may be reported to the expert’s state licensing board for further action; and be it further

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

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

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

Action: Assigned to the Ethics Committee (lead committee) and the Medical-Legal Committee. Note: this resolution cannot be implemented until the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” are amended, which will require a College Manual resolution.

The Ethics Committee and the Medical-Legal Committee had differing viewpoints about the resolution and presented their recommendations to the Board in June 2016. The Board assigned a workgroup of Board members and members of both committees to develop recommendations for implementation of the resolution. A conference call was held and preliminary work completed. The task force will continue in 2017-18.

Resolution 12 Searchable Council Resolution Database (as amended)

RESOLVED, That ACEP improve the existing database of all prior Council resolutions submitted for discussion, designed for use by the ACEP membership, to include the relevant background material, adopted amendments, final disposition of each resolution, and any references to subsequent ACEP action such as a result of the resolution, to improve search functionality, and to publicize this tool to future councillors.

Action: Assigned to Technology Services staff to explore options and provide a recommendation for implementation. Development was completed and staff are uploading all resolutions since 1972. It is expected to be available to members and staff by spring 2018.
RESOLVED, That ACEP evaluate the expanding role and cost for pharmaceuticals affecting the practice of emergency medicine and identify and collaborate, where appropriate, with interested parties/stakeholders, including pharmaceutical manufacturers and others to best assure an appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and report back to the ACEP Council in 2016.

Action: Assigned to Public Affairs staff and to utilize consultants as needed.

ACEP helped secure in the last reauthorization of the Prescription Drug User Fee Act (PDUFA) in 2012, the “Food and Drug Administration Safety and Innovation Act” (FDASIA), that substantially amended the Food, Drug & Cosmetic Act's (FDCA) drug shortage provisions. FDASIA eliminated the requirement that a company be the sole manufacturer of a drug to be subject to the drug shortage requirements. Additionally, FDASIA explicitly made drugs used in emergency medical care or during surgery subject to the drug shortage notice requirements. FDASIA established an annual report to Congress by the FDA on drug shortage statistics, communication within FDA on addressing shortages and actions taken by FDA to prevent or mitigate shortages. Additionally, this legislation called for regular Government Accountability Office (GAO) reports to Congress on the cause of drug shortages and on recommendations on how to prevent or alleviate shortages. The most recent report was published in July 2016. PDUFA was reauthorized in August 2017, though few substantial changes were made to specifically address drug shortages. ACEP’s Public Affairs staff and the Federal Government Affairs Committee will continue to review potential policy recommendations.

ACEP is also a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC also has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is developing bi-partisan, market-based solutions to lower drug prices in the United States.

In late August 2016, several ACEP members briefed House Judiciary Committee staff on the price history and availability of naloxone and buprenorphine and how these changes have subsequently affected availability of these drugs for emergency patients. This discussion led directly to the invitation by the committee for an ACEP witness to testify at an upcoming hearing conducted by the House Judiciary Regulatory Reform Subcommittee on September 22, 2016, to discuss rising drug prices.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the Board of Trustees appointed a 13-member Task Force on Pharmaceutical Costs consisting of representatives of AMA councils, state medical associations, and national medical specialty societies, to provide guidance on AMA advocacy and grassroots efforts aimed at addressing pharmaceutical costs. Between January and May 2016, the task force held four meetings/conference calls and reached agreement that the first phase of the AMA grassroots campaign should focus on increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. Board of Trustees Report 10-I-16 summarizes the work of the Task Force and describes the first phase of the grassroots campaign. An online petition calling on Congress to demand that pharmaceutical companies, pharmacy benefit managers, and health plans introduce greater transparency in the processes for determining prescription drug prices was promoted in late summer 2016 on the AMA’s Patients’ Action Network (PAN) and other cause-oriented websites (e.g., standunited.org and care2.org). More than 62,000 individuals have signed the petition. On November 1, 2016, consistent with the recommendations of the task force, the AMA launched TruthInRx.org, which seeks to highlight the lack of transparency and inherent unfairness involved in prescription drug pricing. The interactive microsite allows supporters to take action, from sending a message to Congress to sharing content with their own social networks. Notably:

- The overall design of the microsite uses pharmaceutical, scientific and technical industries as inspiration for creative design, and vibrant, energetic colors help emphasize important points throughout the site, such as facts, figures and callouts
- The homepage immediately takes the user through an interactive experience after he/she lands on the site, scrolling through the labels of a drug box to learn about the lack of transparency in drug pricing.
- The interior pages include a campaign page that opens with a striking visual related to understanding the issue; a “your stories” page that engages the audience to share content with their social networks, including a meme generator, prepopulated tweets/Facebook posts and a traditional submit your own story option for users; a “get involved” page that houses the traditional take action features, allowing users the ability to contact Congress via email, phone and social media; and a “get informed” page that houses a variety of resources for the user to explore to gain more knowledge on the issue.
An AMA press statement announcing TruthInRx.org was also released. ACEP promoted the link to the microsite via the PAN and the Physicians’ Grassroots Network, and used other online and social media promotion to aid in the launch. The microsite was also featured at the AMA grassroots booth at the AMA Interim Meeting in November 2016 and related materials were distributed to the AMA House of Delegates.

**Resolution 17  Electronic Nicotine Delivery Systems**

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

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

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

**Action:** Assigned first resolved to Chapter & State Relations staff and Public Affairs staff to include in state and federal advocacy initiatives. Assigned second and third resolved to the Public Health & Injury Prevention Committee.

This issue was included in the state advocacy reports provided to the chapters.

The Public Health & Injury Prevention Committee developed the revised policy statement “Tobacco and Nicotine Products – Public Policy Measures” and recommended: 1) incorporating updates on the rapidly growing body of research on tobacco cessation and electronic nicotine delivery systems into the curriculum at ACEP Scientific Assembly and similar academic and professional forums; and 2) partnering with other medical professional organizations committed to tobacco control, such as the American College of Preventive Medicine, focused on primary prevention to increase reach, improve messaging coherence, and provide a template for future collaboration on prevention-based issues. The Board approved the policy statement and the committee’s recommendations in October 2016.

**Resolution 19  Graduate Medical Education Funding (as amended)**

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

**Action:** Assigned to the Academic Affairs Committee and to consult with Public Affairs staff as needed regarding legislative and regulatory issues related to GME funding.

The Academic Affairs Committee worked in collaboration with the ACEP-SAEM GME Work Group to address this resolution.

The 2014 Institute of Medicine (IOM) report called for additional transparency and accountability in GME payments. The committee reviewed and discussed these issues at length, consulted with ACEP’s Federal Government Affairs Committee and State Legislative/Regulatory Committee, institutional finance officials, graduate medical education officials, as well as other stakeholders to address this matter and to explore rules governing funding utilization and reporting by institutions receiving funding from the CMS. Additionally, the committee consulted with the ACEP-SAEM GME Work Group that has been working on this important issue for some time. The Academic Affairs Committee agrees with the ACEP-SAEM GME Work Group’s opinion that until more information and data become available, the resolution to create measures to ensure maintenance of publicly available records of GME funding is premature. While all agree the resolution has merit and greater transparency on how the funds are used is needed, it may have the unintended consequence of reducing funding, particularly indirect medical expenses (IME), at this time. Per a request for proposal (RFP), the ACEP-SAEM GME Work Group will be collecting additional research to further define the potential benefits AND risks of transparency. There is at least one state (Michigan) whose Medicaid department is attempting to institute a “boilerplate” set of expectations for institutional reporting of GME funding use, including IME. According to specialists in GME financing and institutional finance managers, this is nearly impossible to do. Whether other states will follow this lead is unclear. Health Policy Alternatives, Inc., ACEP’s health policy consultant, provided opinions on Michigan’s Boilerplate document for the ACEP-SAEM Work Group when or if a response is called for and appears to agree that additional information is required. At present, CMS has no reporting requirements on spending and does not appear to have any available annual reports on GME expenses, utilization, etc. The agency’s focus is to ensure no duplicative or excessive payments are made to the institutions. The Inspector General has made GME and IME a priority this year, and will be specifically investigating the Intern/Resident Information System (IRIS) reporting processes, hospital IME, whether IME payments are calculated correctly, and whether they are in accordance with federal regulations. It is unclear what CMS’s response would be to the suggestion by an organization such as ACEP to require hospital reporting measures to ensure transparency. It is
our recommendation that ACEP not engage CMS at this time until the issue of transparency and accountability is further defined and researched, and potential consequences are studied.

In June 2016, the Board approved delaying engaging in discussions with CMS regarding GME funding transparency and accountability until reporting requirements are further defined and researched and potential consequences are studied. The GME Work Group is drafting an RFP to address the value of emergency medicine residency programs to institutions and hospitals. The ACEP-SAEM Working Group continues to collect data to address this issue.

Resolution 20  Group Purchasing Effects on Patient Care (as amended)
RESOLVED, That ACEP study the effects on patient care from the lack of availability of appropriate medications and medical equipment due to group purchasing practices, medication shortages, and orphan product restrictions; and be it further
RESOLVED, That ACEP work with stakeholders such as the American Medical Association to develop model legislation that protects physicians from liability as a result of the inability to provide optimal care due to lack of appropriate medical devices or pharmaceuticals to diagnose and treat emergency patients.

Action: Assigned first resolved to the Emergency Medicine Practice Committee and second resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee developed survey questions on the lack of availability of appropriate medication and medical equipment due to medication shortages that were included in an Emergency Medicine Practice Research Network (EMPRN) survey distributed in early July. Results from the survey were compiled, reviewed by the Board in October 2016, and communicated to ACEP members. Information on group purchasing and the potential effects on medication shortages will be posted on the ACEP website.

The AMA Section Council on Emergency Medicine conferred with AMA staff who indicated they were unaware of any action that would likely impact a physician for failure to administer a medication or use a device if it was not available to the physician. Further, they believed joint and severable liability reforms that exist in several states would sufficiently protect physicians should any such action like this surface. ACEP and the AMA already support joint and severable liability reform. ACEP’s Medical-Legal Committee concurred with the AMA’s position and responded affirmatively that no separate action was warranted.

See additional information about medication shortages and the AMA’s actions in the report for Resolution 13.

Resolution 21  Healthcare Information Exchanges (as amended)
RESOLVED, That ACEP identify a recommended standard for ED information summary contained in Healthcare Information Exchanges; and be it further
RESOLVED, That ACEP work with relevant stakeholders to identify and promote the standard that allows for notification (in the ED electronic health record) of the existence of applicable Healthcare Information Exchange data; and be it further
RESOLVED, That ACEP promote the standardized requirements to the Healthcare Information Exchanges currently in the process of development.

Action: Assigned to the task force appointed to address Amended Resolution 20(14). The 2014 resolution directed ACEP to investigate and support health information exchanges, work with stakeholders to promote the development, implementation, and utilization of a national HIE, and develop an information paper exploring a national HIE. Their work is ongoing.

Collective Medical Technologies (CMT) entered into a corporate sponsor agreement and exclusive partnership with ACEP in April 2016 to aid in the promotion and support of the CMT’s Emergency Department Information Exchange (EDIE) program. EDIE, also called PreManage ED, collects data from all EDs visited by a patient, packages that data into actionable insights, and then delivers the information to emergency physicians via real-time notifications during the patient visit. EDIE is currently available in 13 states and CMT continues to pursue participation in other states.

Resolution 22  Increasing Use of Advance Directives by Designation on Drivers Licenses (as amended)
RESOLVED, That ACEP support efforts to encourage adults of all ages and states of health to talk with family, friends, spiritual advisors, health professionals, and physicians about advance directives and to record and keep these wishes updated.

Action: Assigned to the Public Relations Committee to develop public media campaign materials for distribution.

The committee developed and distributed a press release on advance directives and posted an article on ACEP’s public website EmergencyCareforYou.org.
**Resolution 23** Integrating Emergency Care Into the Greater Healthcare System

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

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

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

**Action:** Assigned first two resolveds to the Alternate Payment Models (APM) Task Force. Assigned third resolved to ED Information System Safety Issue Recognition and Management Task Force that was assigned to address Amended Resolution 20(14) and Amended Resolution 21(15). Additionally, ACEP’s partnership agreement with CMT (see comments on Resolution 21) addresses the third resolved.

The Board reviewed a status report from the APM Task Force in October 2016. This is a complicated issue and the task force continued its work in 2016-17. Several payment models have been developed and are now undergoing analysis, which may require use of Medicare and emergency medicine group data. Once the models have been analyzed and are considered potentially viable, the next step is to use the results to address the questions put forth by MACR’s Physician Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will provide technical assistance to applicants in bringing their proposals to a level for final review and submission to CMS.

The work of the ED Information System Safety Issue Recognition and Management Task Force was delayed because of various changes in ACEP staffing. Their work is now underway and a meeting will be held at ACEP17.

**Resolution 27** Reimbursement for Ultrasound Performed by Emergency Physicians (as amended)

RESOLVED, That ACEP develop a statement declaring that insurance companies and other payers reimburse emergency physicians for ultrasound studies and services that they perform and interpret as separate and identifiable procedures while providing patient care services in the Emergency Department; and be it further

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

**Action:** Assigned to the Reimbursement Committee in consultation with the Emergency Ultrasound Section. The Reimbursement Committee developed the policy statement, “Payment for Ultrasound Services in the Emergency Department,” that was approved by the Board in June 2016.

**Resolution 29** Support for Drug “Take-Back” Programs (as amended)

RESOLVED, That ACEP supports the development of drug “take-back” programs at no cost to patients; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine consider submitting a resolution to the American Medical Association to support drug “take-back” programs.

**Action:** The first resolved is a policy statement. Assigned to the Public Health & Injury Prevention Committee to review and determine if any additional information is needed to develop a policy statement. Assigned to the AMA Section Council on Emergency Medicine to discuss submitting a resolution to the AMA.

The Public Health & Injury Prevention Committee developed the policy statement, “Drug Take Back Programs,” that was approved by the Board in June 2016. The AMA Section Council on Emergency Medicine determined that the AMA already has policy in support of drug take-back programs:

> “Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
> 1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.”

**Resolution 31** American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure (as amended)

RESOLVED, That ACEP communicate its appreciation to ABEM for its efforts to be sensitive to the practicing emergency physician in interpreting the American Board of Medical Specialties (ABMS) mandates; and be
RESOLVED, That ACEP develop policy supporting the American Board of Medical Specialties Maintenance of Certification as appropriate support for state medical license Maintenance of Licensure, but actively oppose mandates that require or link Maintenance of Certification as the only pathway for ongoing Maintenance of Licensure; and be it further

RESOLVED, That ACEP develop policy that specifically opposes efforts of specialty boards to become the independent sole source and for profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy for emergency physicians.

Action: Assigned to the Academic Affairs Committee.

In October 2016, the Board approved the committee’s recommendations to 1) communicates 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. ACEP continues to work with ABEM on maintenance of certification/maintenance of licensure (MOC/MOL) issues as well as Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification that was referred to the Board by the 2016 Council. During this time, ACEP has relayed the growing discontent among some ACEP members with the MOC process and particularly the high-stakes ConCert exam. ABEM has been active in exploring alternative approaches to physician assessment. This exploration includes detailed analyses of every pilot project in which other specialty boards are involved. ABEM informs ACEP that it is participating in direct discussions and research consortia with other ABMS specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited. ABEM has assembled panels of senior ABEM leaders to explore modification and options to the ConCert examination. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination. ABEM will hold a national ConCert Summit October 2-3, 2017, that will include representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is also looking to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates. Additionally, ACEP, along with dozens of other specialty societies and state medical societies will meet with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

A similar resolution on Maintenance of Certification was submitted to the 2017 Council.

Resolution 32 Critical Communications for ED Radiology Findings (as amended)

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

Action: Assigned to the Emergency Medicine Practice Committee and include representation from the American College of Radiology in development of the policy statement.

The Emergency Medicine Practice Committee developed “Guiding Principles for Critical Communication for Emergency Department Radiology Findings.” The principles were reviewed by the Board in April 2016. ACR leaders met with leaders of the American College of Radiology (ACR) in June 2016. ACR expressed interest in a joint writing task force to address communication between radiology and emergency physicians. The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to incorporate the “Guiding Principles” into existing policy. ACR communicated its support to work with ACEP to revise the policy statement, “Ininterpretation of Imaging Diagnostic Studies.” A draft revision was completed and sent to ACR in September 2017 for review. It will be submitted to the ACEP Board following review by ACR.

Resolution 33 Defining and Transparency in Urgent Care Centers (as amended)

RESOLVED, That ACEP create a policy statement defining an urgent care center in order to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and value to make informed decisions when seeking care; and be it further

RESOLVED, That ACEP work with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.
Action: Assigned first resolved to the Emergency Medicine Practice in consultation with the Freestanding Emergency Centers Section. Assigned second resolved to the State Legislative/Regulatory Committee for state advocacy initiatives and Public Affairs staff for federal advocacy initiatives. The Emergency Medicine Practice developed the policy statement “Urgent Care Centers” with input from the Freestanding Emergency Care Section. It was approved by the Board in October 2016.

This issue was included in the weekly legislative tracking reports provided to state chapters. The issue was also addressed with AMA staff and other relevant stakeholders.

Resolution 34 Enabling Access to Epinephrine for Anaphylaxis (as amended)
RESOLVED, That ACEP, in conjunction with other interested organizations, evaluate state efforts to provide timely access to epinephrine for anaphylaxis, including current state legislation that includes liability protection for appropriate use, public education, awareness and timely access, including cost effective mechanisms for availability of devices that may be used for bystander or self-administration, and report back to the Council in 2016.

Action: Assigned to the State Legislative/Regulatory Committee. The committee provided a report to the Board in October 2016. At the federal level, in 2013, President Obama signed into law the School Access to Emergency Epinephrine Act, which encourages schools to stock epinephrine (epi) for severe asthma attacks and allergic reactions. The law also made changes to the Children's Asthma and Treatment Grants Program so that HHS will give preferential funding to a state’s asthma treatment grants if: 1) the state maintains an emergency supply of epi; 2) permit trained personnel at the school to administer the epi; and 3) develop a plan for ensuring trained personnel are available to administer epi during all hours of the school day. All states currently have legislation in place addressing epi in schools. However, the legislation varies by state. In most states, except West Virginia and Alabama, students are allowed to carry their own epi device. Most states require the student to have physician authorization, but there is no physician authorization mandate in Idaho, Iowa, and West Virginia. Most states have a student competency requirement, except Arizona, Colorado, Florida, Idaho, Illinois, Iowa, Michigan, New Jersey, Rhode Island, West Virginia, and Wisconsin. In most states, the school nurse and/or a staff administrator can give the epi; however, in Minnesota, only the nurse can give the epi. In Idaho, Maine, and North Dakota neither the nurse nor a staff administrator can give the epi and only the student can self-administer. Approximately 50% of states allow and/or require stockpiling of epi at schools. Most states have a release from liability, except for Delaware, Idaho, Indiana, Maine, Massachusetts, Pennsylvania, and Texas. This information was compiled from The Network for Public Health Law (the Network) and Food, Allergy, Research and Education (FARE). Both are non-profit organizations that maintain current information on state school laws. There is also legislation in many states to allow other places such as restaurants, children’s camps, adventure parks, and other “entities” to have access to epi. The Network provides a brief review of all legislation on “entities” as well as the state-by-state legislation. Currently, 27 states have entity stocking epi laws and six states have pending legislation. Seventeen states do not have laws or pending legislation on entities stocking epi. All 27 states that allow entity stocking have training requirements and liability exemptions for the entity administering the program, the employees that give the epi, and the healthcare professional that prescribed and dispensed the drug. ACEP has information on the website with the 2016 proposed legislation in the states and it includes information about the adopted 2016 Epi Pen legislation. There is no legislation that addresses how to pay for epi. Currently, one company (Mylan, the makers of EpiPen) holds 90% of the US market on epi. The cost of an EpiPen has increased 400% since 2008. Senator Amy Klobuchar (D-MN) has called for a Judiciary Committee inquiry into the pricing and an investigation by the Federal Trade Commission and the company has faced a barrage of media criticism and complaints from patient advocates based on its pricing practices. The American Academy of Allergy, Asthma and Immunology introduced the Airline Access to Emergency Epinephrine Act (S1972).

Resolution 35 Emergency Department Detox Guidelines (as amended)
RESOLVED, That ACEP create clinical practice guidelines for treatment of patients presenting to the emergency department in opioid or benzodiazepine withdrawal; and be it further
RESOLVED, That ACEP create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.

Action: Assigned to the Clinical Policies Committee. This issue is included in the revision of the 2012 opioid clinical policy currently in progress. The critical questions have been finalized and literature searches completed. The literature is being obtained and grading will begin in the fall 2017. The revised clinical policy is expected to be finalized by 2018.

Resolution 36 Establishing State and National POLST/EOL Registries (as amended)
RESOLVED, That ACEP support the use of and implementation of POLST (or equivalent) programs as a means of honoring our patients’ end of life wishes; and be it further
RESOLVED, That ACEP partner with organizations such as the American Medical Association, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, AARP, and all others it deems fit to advocate for and support the creation of state and/or a national POLST/EOL database(s) that can be accessed by emergency physicians and EMS responders in times of crisis and uncertainty around a patient’s end-of-life care; and be it further

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

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

Action: This resolution is being addressed in ACEP’s Strategic Plan: “Engage chapters and other medical organizations to promote Physician Orders for Life Sustaining Treatment (POLST) and other effective advance directive documents.” Assigned third resolved to the Palliative Medicine Section.

Articles on POLST have been published in ACEP Now as well as other palliative care principles in the emergency department. A plan was developed to distribute POLST CME materials to chapters, encourage their use, and encourage advocacy efforts in states without adequate POLST laws.

The Palliative Medicine Section worked with the State Legislative/Regulatory Committee to address the assigned third resolved. Over the past several years ACEP has been increasingly engaged on issues of palliative medicine, end-of-life (EOL) care and advanced directives as they relate to emergency medicine. Many of ACEP’s existing efforts were outlined in the background of the resolution. The collaborative work we sought to identify new opportunities for our organization to build on its educational efforts in the area of the POLST paradigm. The primary challenge in providing effective and targeted education for our membership is the significant state-to-state variability in the maturity of their POLST paradigm. Some states such as Oregon have a widely used POLST program that has been in place for many years while other states such as Arkansas do not have any sort of program in place. The National POLST Paradigm website provides a helpful map with some information about progress in each state (http://polst.org/programs-in-your-state/). However, even within categories on this map, there are major differences that would have a significant impact on providers. For example, both Indiana and Texas are categorized as “developing.” In Indiana, POLST forms are widely available and seen regularly by EPs on shift, at least on a regional basis. In Texas, most EPs have no familiarity with the program or associated forms. To provide practice-relevant education to ACEP members would require tailoring such education to each state. For this reason some outreach efforts initially considered were believed to be impractical. For example, providing an article for each chapter to publish in their chapter newsletter (if they so wished) regarding the POLST paradigm was considered. However, each article would need to be written by someone personally familiar with the program in that state; the workgroup did not include that depth of expertise. A similar challenge exists for any programming reaching a nationwide audience, including lectures at ACEP’s annual conference. To encourage physicians to learn about their own state programs, several articles have been published in ACEP Now about the POLST issue. In 2015, there were two articles about the complexities of the paradigm. Per our offer to provide additional materials for publication the editors may publish more information about this program in the future. EMRA’s publication, EM Resident, published an article in the June/July 2016 issue, “POLST: Guiding Providers in End of Life Care.” The article was co-authored by a member of the workgroup about the POLST paradigm, and was targeted at the new generation of emergency physicians. As an additional education outreach, information about the POLST paradigm was included in eCME course developed by ACEP. ACEP’s MOC/MOL Subcommittee was tasked with development of an ABEM approved MOC Part IV PI-CME activity on palliative care. A workgroup member served as the content expert assigned to integrate information about POLST into the final product. One exciting outreach effort occurred at the 2016 Council meeting. A table was located outside the Council meeting with information and content experts available to discuss and answer questions about POLST.

ACEP’s MOC/MOL Subcommittee will complete development of a new MOC Part IV activity on palliative care, which will also address POLST, in 2017-18.

The Ethics Committee worked with the Palliative Medicine Section to develop the “Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy.” The guidelines were approved by the Board in April 2017.

Resolution 37 Intravenous Ketamine for Pain Management in the ED (as amended)

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

Action: This resolution is being addressed in ACEP’s Strategic Plan: “Engage chapters and other medical organizations to promote Physician Orders for Life Sustaining Treatment (POLST) and other effective advance directive documents.” Assigned third resolved to the Palliative Medicine Section.

Articles on POLST have been published in ACEP Now as well as other palliative care principles in the emergency department. A plan was developed to distribute POLST CME materials to chapters, encourage their use, and encourage advocacy efforts in states without adequate POLST laws.

The Palliative Medicine Section worked with the State Legislative/Regulatory Committee to address the assigned third resolved. Over the past several years ACEP has been increasingly engaged on issues of palliative medicine, end-of-life (EOL) care and advanced directives as they relate to emergency medicine. Many of ACEP’s existing efforts were outlined in the background of the resolution. The collaborative work we sought to identify new opportunities for our organization to build on its educational efforts in the area of the POLST paradigm. The primary challenge in providing effective and targeted education for our membership is the significant state-to-state variability in the maturity of their POLST paradigm. Some states such as Oregon have a widely used POLST program that has been in place for many years while other states such as Arkansas do not have any sort of program in place. The National POLST Paradigm website provides a helpful map with some information about progress in each state (http://polst.org/programs-in-your-state/). However, even within categories on this map, there are major differences that would have a significant impact on providers. For example, both Indiana and Texas are categorized as “developing.” In Indiana, POLST forms are widely available and seen regularly by EPs on shift, at least on a regional basis. In Texas, most EPs have no familiarity with the program or associated forms. To provide practice-relevant education to ACEP members would require tailoring such education to each state. For this reason some outreach efforts initially considered were believed to be impractical. For example, providing an article for each chapter to publish in their chapter newsletter (if they so wished) regarding the POLST paradigm was considered. However, each article would need to be written by someone personally familiar with the program in that state; the workgroup did not include that depth of expertise. A similar challenge exists for any programming reaching a nationwide audience, including lectures at ACEP’s annual conference. To encourage physicians to learn about their own state programs, several articles have been published in ACEP Now about the POLST issue. In 2015, there were two articles about the complexities of the paradigm. Per our offer to provide additional materials for publication the editors may publish more information about this program in the future. EMRA’s publication, EM Resident, published an article in the June/July 2016 issue, “POLST: Guiding Providers in End of Life Care.” The article was co-authored by a member of the workgroup about the POLST paradigm, and was targeted at the new generation of emergency physicians. As an additional education outreach, information about the POLST paradigm was included in eCME course developed by ACEP. ACEP’s MOC/MOL Subcommittee was tasked with development of an ABEM approved MOC Part IV PI-CME activity on palliative care. A workgroup member served as the content expert assigned to integrate information about POLST into the final product. One exciting outreach effort occurred at the 2016 Council meeting. A table was located outside the Council meeting with information and content experts available to discuss and answer questions about POLST.

ACEP’s MOC/MOL Subcommittee will complete development of a new MOC Part IV activity on palliative care, which will also address POLST, in 2017-18.

The Ethics Committee worked with the Palliative Medicine Section to develop the “Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy.” The guidelines were approved by the Board in April 2017.
RESOLVED, That the position statement developed by ACEP and the other stakeholders on the use of sub-dissociative ketamine be distributed to all state nursing boards.

**Action:** Assigned to the Emergency Medicine Practice Committee and to include representatives from ENA, AAENP, SEMPA, and others as appropriate.

The committee considered addressing the use of sub-dissociative ketamine in the “Optimizing the Treatment of Acute Pain in the Emergency Department” policy statement, but determined that a separate policy is needed in addition to an information paper or PREP. The committee plans to complete the drafts for consideration by the Board in October 2017.

**Resolution 38 Patient Satisfaction Scores in Safe Prescribing (as amended)**

RESOLVED, That ACEP opposes any non-evidence based financial incentives predicated on patient satisfaction scores; and be it further
RESOLVED, That ACEP work with stakeholders to create a quality measure that is related to safe prescribing of controlled medications; and be it further
RESOLVED, That the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

**Action:** The first resolved is a policy statement. Assigned to the Emergency Medicine Practice Committee to review ACEP’s current policy statements regarding patient satisfaction surveys/scores and determine if any revisions are needed or whether an additional policy statement should be developed. Assigned second resolved to the Quality & Patient Safety Committee. Assigned third resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee revised the policy statement, “Patient Satisfaction Surveys” with the new title “Patient Experience of Care Surveys.” The policy was approved by the Board in June 2016.

The AMA Section Council on Emergency Medicine has supported and advocated ACEP’s position in discussions about ED-PEC and HCAHPS as patient satisfaction scores that need revision.

**Resolution 41 Procedural Credentialing Requirements (as amended)**

RESOLVED, That ACEP work within its several committees and sections charged with quality, emergency medicine practice, and rural emergency medicine to research and recommend such credentialing models to maintain the rural/underserved presence without undue hardship on ED physicians or result in a greater lack of board certified/board eligible emergency physicians in these areas; and be it further
RESOLVED, That ACEP develop a policy statement and information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas; and be it further
RESOLVED, That ACEP work with hospital accreditation bodies, the Centers for Medicare & Medicaid Services, the American Hospital Association, and related state hospital, regulatory, and certification organizations to recommend appropriate credentialing standards for ED physicians and facilities in rural/underserved areas.

**Action:** The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to explore development of a policy statement and other information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas and to work with the Rural Emergency Medicine Section and other committees as needed. The Board approved revisions to the policy statement, “Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine” in April 2017 and also reviewed the revised .

**Resolution 42 Prolonged Emergency Department Boarding (as amended)**

RESOLVED, That ACEP seek out and work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety; and be it further
RESOLVED, That ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

**Action:** Assigned to the Emergency Medicine Practice Committee to include in their current objective “Revise and update the 2008 paper “Emergency Department Crowding High-Impact Solutions” and explore new innovations to address boarding in the ED” and include participation and review by other organizations/stakeholders.

Representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians worked with the committee to revise the.
Resolution 43  Required CME Burden (as amended)
RESOLVED, That ACEP, in order to promote high quality, safe, and efficient emergency medicine care, address the fact that requiring a significant amount of concentrated continuing medical education in specific areas annually will lead to reduced ongoing education in other clinical areas important to the practice of emergency medicine (such as Pediatrics, Infectious Disease, Gastroenterology, Endocrinology, etc.), resulting in the unintended consequence of reducing physician readiness to care for the ED patients not included in the Time Critical Diagnosis initiative; and be it further
RESOLVED, That ACEP work with organizations such as the American Hospital Association, the American Heart Association, and related state hospital organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to be able to readily care for all emergency department patients without costly and redundant requirements, unless found to be necessary for individual physicians based on assessment and oversight by the ED medical director.

Action: Assigned to the Emergency Medicine Practice Committee. The policy statement, “CME Burden,” was approved by the Board in April 2016.

Resolution 45  Telemedicine Appropriate Support and Controls
RESOLVED, That ACEP investigate and evaluate the positive, negative, and potential unintended consequences of telemedicine; and be it further
RESOLVED, That ACEP develop appropriate policy that supports remote access to specialists that also assures the establishment of an appropriate doctor-patient relationship.

Action: Assigned to the Emergency Medicine Practice Committee to incorporate into their current work in developing a policy statement on telemedicine in conjunction with the Emergency Telemedicine Section. The Emergency Medicine Practice Committee developed the policy statement, “Emergency Medicine Telemedicine,” that was approved by the Board in January 2016. The Ethics Committee developed the policy statement, “Ethical Use of Telemedicine in Emergency Care,” that was approved by the Board in June 2016.

Resolution 46  Transitioning Out of Medical Practice
RESOLVED, That ACEP dedicate member resources towards the study and education of how best to transition out of the clinical practice of Emergency Medicine.

Action: Assigned to the Well-Being Committee. Review the Emergency Medicine Practice Committee’s recently completed paper on careers outside of the emergency department and determine if any additional information and resources should be developed.

The Well-Being Committee reviewed the Emergency Medicine Practice Committee’s information paper on this topic and added information on opportunities in education, subspecialties, and event medicine. The Board reviewed the revised information paper, “Hospital Employment and Careers Outside the ED,” in June 2016.

Resolution 47  In Memory of Marshall T. Morgan, MD
RESOLVED, That the American College of Emergency Physicians honors Marshall T. Morgan, MD, for his thoughtful, professional demeanor, his superb patient care skills, true compassion for all those he encountered, and his exemplary leadership in emergency medicine and the house of medicine.

Action: A framed resolution was prepared and sent to the family of Dr. Morgan.

Resolution 48  In Memory of Richard P. O’Brien, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted communicator and self-described “radio enthusiast,” Richard P. O’Brien, MD, FACEP, and extends condolences and gratitude to his family and friends for his service to the specialty of emergency medicine and to patient care.

Action: A framed resolution was prepared and sent to the family of Dr. O’Brien.
Resolution 49  In Memory of Leah Anne Davis, DO
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor the contributions made by Leah Anne Davis, DO, as one of the future leaders in Emergency Medicine; and be it further RESOLVED, That national ACEP and the Illinois Chapter extends to her family, friends, and colleagues our sympathy, great sense of sadness and loss, our gratitude for having been able to share a part of her life, and for her service to the specialty of Emergency Medicine

Action: A framed resolution was prepared and sent to the family of Dr. Davis.

Resolution 50 In Memory of Marvin Leibovich, MD, FACEP
RESOLVED, That the American College of Emergency Physicians fondly honors Marvin Leibovich, MD, FACEP, as one of the pioneers and leaders in the specialty of emergency medicine; and be it further RESOLVED, That national ACEP join with the Arkansas Chapter in extending our memorium and gratitude to Dr. Leibovich for a life well lived in the service of others.

Action: A framed resolution was prepared and sent to the family of Dr. Leibovich.

Resolution 51 In Memory of Michael G. Hughes, MD, FACEP
RESOLVED, That the American College of Emergency Physicians recognizes with gratitude and honor the contributions made by Michael G. Hughes, MD, FACEP, to the specialty of emergency medicine in Massachusetts and in his service to our country’s armed forces; and be it further RESOLVED, That ACEP extends to the family, friends, and colleagues of Dr. Hughes our sympathy, our great sense of sadness and loss, and our gratitude for having been able to share a part of his life

Action: A framed resolution was prepared and sent to the family of Dr. Hughes.

Resolution 52 Commendation for David Blunk
RESOLVED, That the American College of Emergency Physicians formally commends David Blunk for his dedicated efforts, leadership, and mentoring at both the state and local levels as the Executive Director of the Pennsylvania College of Emergency Physicians.

Action: A framed resolution was presented to Mr. Blunk.

Council Standing Rules Resolution

Resolution 9 Electronic Submission of Resolution Amendments
RESOLVED, That the “Resolutions” section of the Council Standing Rules, paragraph three, be amended to read:
All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Action: The Council Standing Rules were updated.

Referred Resolutions

Resolution 18 ER is for Emergencies
RESOLVED, That ACEP work with the American Medical Association and other interested parties to study the possibility of expanding the “ER is for Emergencies” program to a national scale.

Action: Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution and to consult with the AMA Section Council on Emergency Medicine as needed.

The committee sought advice from the Washington Chapter and members of the AMA Section Council on Emergency Medicine. Since October 2015, some internal changes have occurred within the Washington State Medical Association (WSMA) regarding the issue. By acquiescing to the WA-ACEP desire to bring this EM-specific issue to ACEP first and the resulting referral to the ACEP Board, the momentum was lost within the WSMA to bring the issue
before the AMA. The AMA Section Council on Emergency Medicine representatives also noted that this is a specialty-specific issue and is not the usual type of resolution brought before the AMA without specific requests or action items expected by the AMA. Additionally, it was discussed that other states (specifically, Oregon) have used the Washington experience to tailor initiatives to their state without specifically adopting the “ER is for Emergencies” program, but instead adapting components of the “Seven Best Practices” that were believed to be most effective in their particular climate. In October 2016, the Board approved the committee’s recommendation to take no further action at this time and continue to promote the spirit of the resolution by supporting state chapters with similar initiatives.

**Resolution 24 Interstate Medical Licensure Compact Legislation and Opposition to National Medical License**

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

**Action:** Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee identified resources and in October 2016 the Board approved the committee’s recommendation to distribute the information to members and chapters.

There have been ongoing discussions about how to improve the process of allowing physicians to practice in more than one state. In response to these discussions, the Interstate Medical Licensure Compact (IMLC) is a voluntary pathway that streamlines the ability for a physician to obtain a license in multiple states, while still allowing state medical boards to retain their regulatory oversight capacity. Currently, the process to obtain licensure in multiple states remains cumbersome. For initial licensure, basic standards remain uniform on a national level. However, states have implemented their own additional requirements for granting and renewing medical licenses for physicians. These include variable timetables for licensure renewal, CME requirements including formal course work, and potential face-to-face interviews with members of the state medical board. State agencies can then take many months to process their applications. In 2013, the Federation of State Medical Boards (FSMB) House of Delegates adopted a resolution to help improve the process of license portability. This initiative, known as the Interstate Medical Licensure Compact (IMLC), received support from the American Medical Association House of Delegates in 2014. Currently, 17 states have enacted legislation to enable the state to participate in the IMLC, and 10 additional states have introduced legislation to advance the measure. The IMLC is a voluntary option designed to streamline the current process and make it easier for physicians to obtain full, unrestricted licenses to practice in multiple states. The IMLC reduces the administrative and cost barriers previously faced by physicians providing in-person care in multiple states. The IMLC is also an important mechanism that will support physicians who are interested in using telemedicine technologies while ensuring that the state where the patient receives care is able to provide oversight and ensure accountability with state medical practice laws and standards of care. The Interstate Medical Licensure Compact Commission is the entity charged with administering the IMLC. The Commission held several public meetings from October 2015 to August 2016, published a rule open to comment, and developed the IMLC’s technical and data infrastructure. The interstate medical licensure compact was launched April 6, 2017.

**Resolution 28 Standards for Fair Payment of Emergency Physicians**

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

RESOLVED, That ACEP devote increased resources to monitor the state-by-state status and changes in law concerning the standards for fair payment of Emergency Physicians and establish a single point of contact at the national level as a resource for assisting all chapters; and be it further

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

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

RESOLVED, That ACEP work with the Emergency Medicine Foundation to research, publish, and disseminate the detrimental effects of legislation that limits the rights of emergency physicians to fairly bill and collect, and to develop effective educational materials explaining the facts concerning emergency physician billing and collection, for use at the national and local level in educating legislators, regulators, policy-makers, and the public; and be it further
RESOLVED, That ACEP and the Emergency Medicine Action Fund develop and support explore the development of a national “strike team” that can be deployed by ACEP leadership to help chapters in states where emergency physicians are facing an immediate legislative threat to the fair payment process.

Action: This resolution was addressed primarily through the work of the ACEP/EDPMA Task Force on Reimbursement Issues. It was also assigned to the Reimbursement Committee, State Legislative/Regulatory Committee, and Federal Government Affairs Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

In the summer of 2015, ACEP President Dr. Michael Gerardi appointed an ACEP/EDPMA Joint Task Force to study reimbursement issues. The subgroup working on balance billing issues considered concerns created by narrow networks with regard to those issues. The task force, working in conjunction with ACEP’s State Legislative/Regulatory Committee and Reimbursement Committee, produced a series of studies, “Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services” and “Situation Report: Balance Billing Legislation.” Those documents were approved by the Board in April 2016.

In December 2015, network adequacy and out of network reimbursement was an issue included on the agenda of a national call for state chapter leaders and lobbyists. In the 2015-16 fiscal year, the State Legislative/Regulatory Committee recommended, and the Board approved, Public Policy Grants for the Georgia and Florida chapters to address these issues and ACEP staff and member experts provided consultative services to assist numerous other chapters dealing with out of network payment legislation or regulation. Beginning in January 2016, ACEP leaders and staff began holding meetings with the American Society of Anesthesiologists about collaborating on network adequacy and balance billing issues at the state level. The collaboration subsequently expanded to include other hospital-based specialties and the AMA. Work toward building out this coalition is ongoing with plans to be operating collaboratively in 2017.

ACEP filed suit against the federal government in May 2016. 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. According to the lawsuit, insurance companies have failed to provide fair coverage for their insured patients. They have forced health care providers out of their health plans by offering reimbursement that barely covers the cost of care and constructed narrow networks that offer little coverage for emergency care in many parts of the country. The lawsuit is still pending. A motion for summary judgement was filed on November 18, 2016. The government filed its Cross Motion for Summary Judgement and Opposition to Summary Judgement on December 9, 2016. ACEP filed its response by January 20, 2016. The U.S. District Court for the District of Columbia partially granted ACEP’s Motion for Summary Judgment on August, 31, 2017, and denied the Government’s counter motion regarding its lawsuit against the federal government to contest a regulation that impedes emergency physicians from receiving accurate usual and customary payment for out-of-network services. The court remanded the matter back to the to the Centers for Medicare & Medicaid Services for further explanation of the regulation, saying that comments submitted to the federal departments (Departments of Health & Human Services, Labor, and Treasury) during its development expressed “concerns about the rule – for example, that the methods it used to set payments were not transparent and could be manipulated by insurers. Many of these commenters proposed using a transparent database to set payments instead. The Departments all but ignored these comments and proposals.” The ruling does not invalidate the regulation, but it is a clear step in the right direction and it forces the Government to respond to ACEP’s concerns in a substantive manner. The Parties (ACEP and the federal Departments) have been ordered to file a “joint status report” by October 30, 2017. This does not mean the Departments must respond by then, but that the Court will review and make a determination regarding its next steps from that point forward. The court has the right to move on to review the substantive issues raised by ACEP (i.e., that the entire rule is a violation of the Administrative Procedures Act and the Affordable Care Act) at that point. ACEP is now developing a strategy to emphasize our concerns with the new Administration pending a response from the agencies. The Departments will, at some point, file their response and may request additional comments or not. They may revise the regulation, or leave it as is.

ACEP provided funding to the Florida, Georgia, and Texas chapters in 2016 to support their efforts on out-of-network/balance billing legislation. The Emergency Medicine Action Fund has provided additional funding to the Georgia Chapter.

ACEP continues to hold strategy meetings on out-of-network/balance billing with multiple stakeholders. The AMA House of Delegates adopted the following resolution at the June 2017 annual meeting:

“RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.”

The AMA sent a letter on June 29, 2017, asking Anthem to rescind the policy citing federal patient
protections under prudent layperson, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

Another resolution adopted by the AMA in June, which originated from ACEP, brought together a large coalition of stakeholders from multiple states and specialties to protect out-of-network coverage for patients. The resolution calls for the AMA to join ACEP and the Physicians for Fair Coverage coalition to fight the surprise insurance gaps patients are experiencing while providing fair payment to emergency physicians.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

**Resolution 30 Use of Body Cameras Worn by Law Enforcement in the ED**

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

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

*Action*: Assigned to the Ethics Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee revised the policy statement, “Recording Devices in the Emergency Department” that was approved by the Board in January 2017.

**Resolution 39 Patient Satisfaction Scores in Emergency Medicine**

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

RESOLVED, That ACEP oppose reaffirm its opposition to the use of patient satisfaction surveys that have not been validated for physician credentialing or for emergency medicine practice financial incentives or disincentives, consistent with current ACEP policy.

*Action*: Assigned to the Emergency Medicine Practice Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

The committee revised the policy statement, “Patient Satisfaction Surveys” with the new title “Patient Experience of Care Surveys.” It was approved by the Board in June 2016.

**Resolution 44 State Medical Board Review of Emergency Medicine Practice**

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

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

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

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

*Action*: Assigned to the Medical-Legal Committee for review and to provide a recommendation to the Board regarding further action on this resolution. Their work continued in the 2016-17 committee year and a recommendation is expected for the October 2017 Board meeting.
Memorandum

To: 2017 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 23, 2017

Subj: Action on 2014 Resolutions

The attached report summarizes the actions taken by the Board of Directors on the 39 resolutions (35 non-Bylaws, 2 Bylaws, one College Manual, and one Council Standing Rules) adopted by the 2014 Council. Three resolutions were referred to the Board of Directors.

The actions on resolutions are also available on the ACEP Website.
Action on 2014 Council Resolutions

Resolution 1  Commendation for Marilyn Bromley, RN
RESOLVED, That the American College of Emergency Physicians commends Marilyn Bromley, RN, for her service as staff liaison to the Emergency Ultrasound Section and for her commitment, dedication, and contribution to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Ms. Bromley.

Resolution 2  Commendation for W. Calvin Chaney, JD, CAE
RESOLVED, That the American College of Emergency Physicians commends W. Calvin Chaney, JD, CAE, for his service as General Counsel and Associate Executive Director of the American College of Emergency Physicians.

Action: A framed resolution was presented to Mr. Chaney.

Resolution 3  Commendation for Andrew E. Sama, MD, FACEP
RESOLVED, That the American College of Emergency Physicians commends Andrew E. Sama, MD, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

Action: A framed resolution was presented to Dr. Sama.

Resolution 4  In Memory of Ben C. Corballis, MD, FACEP
RESOLVED, That the American College of Emergency Physicians remembers with honor the contributions made by Ben C. Corballis, MD, FACEP, to the state of Delaware and to the specialty of emergency medicine; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Dr. Corballis our deepest sympathy, our sense of sadness and loss, and our gratitude for his service to our specialty and our patient communities.

Action: A framed resolution was prepared and sent to Dr. Corballis’ family.

Resolution 7  Fellow Status – Housekeeping Changes
RESOLVED, That the ACEP Bylaws, Article V – Fellowship, be amended to read:

ARTICLE V — ACEP FELLOWSHIP
Section 1 — Fellow Status Eligibility

Fellows of the College shall meet one of the following two sets of criteria:
1. Be active, life, honorary, or international members for three continuous years immediately prior to election, and must have been
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. Maintenance of Fellow status requires continued membership in the College. [This sentence is moved to Section 2 below.]
3. In addition, Meet the following requirements demonstrating evidence of high professional standing must be met by candidates 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.

2. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:

A. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
B. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
   1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
   2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
   3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
   4. active involvement in emergency medicine administration or departmental affairs;
   5. active involvement in an emergency medical services system;
   6. research in emergency medicine;
   7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
   8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
   9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
   10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

4. In addition, the candidate must provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.

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

Section 2 – Fellow Status

Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. 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.

Section 2—Fellow Emeritus
Members in good standing who are either fellows or former fellows who are ineligible for another class of fellowship may be elected by the Board of Directors to Fellow Emeritus status. A Fellow Emeritus shall be authorized to use “FACEP (Emeritus)” in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellow Emeritus status shall be determined by the Board of Directors.

Action: The Bylaws were updated.

Resolution 9 Membership Restructuring (as amended)

RESOLVED, That the ACEP Bylaws Article IV – Membership, Article V – Fellowship, and Article VIII – Membership Restructuring (as amended)

ARTICLE IV – MEMBERSHIP

Section 2 — Classes of Membership

All members shall be assigned elected or appointed by the Board of Directors to one of the following classes of membership: (1) active; (2) inactive; (3) honorary; (4) life; (5) candidate; or (6) international. Additionally, a member may concurrently belong to the councillor class: (1) regular member; (2) candidate member; (3) honorary member; or (4) international member. The qualifications required of the respective classes, their rights and obligations, and the methods of their election or appointment shall be set forth in these Bylaws or as otherwise determined by the Board of Directors in the extraordinary case of an individual who does not satisfy all of the criteria of any particular class. Benefits for each class of membership shall be determined by the Board of Directors.

Section 2.1 — Active Regular Members

The active Regular members of the College shall be are physicians who devote a significant portion of their medical endeavors to emergency medicine. All active regular members must meet one of the following criteria: 1) Satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); 2) Satisfactory completion of an emergency medicine subspecialty training program accredited by ACGME; 3) Satisfactory completion of an emergency medicine residency training program accredited by the American Osteopathic Association (AOA); 4) Satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country; 5) Satisfactory completion of a subspecialty training program in pediatric emergency medicine accredited by the ACGME; 6) Primary board certification by an emergency medicine certifying body recognized by ACEP; or 7) Eligibility for Active or International membership in the College (as defined by the College Bylaws then in force) at any time prior to close of business December 31, 1999. Such physicians must be licensed in the state, province, territory or foreign country in which they practice, or be serving in a governmental medical assignment. They shall fulfill such postgraduate education requirements as may be prescribed by the Board of Directors.

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

Section 2.2 — Inactive Members

Regular members who are unable to engage in active medical practice may, upon application to the Board of Directors, be elected assigned to inactive membership status by the Board of Directors. Election to inactive membership The inactive status designation shall be for a period of one year. However, an inactive member may, upon application, be re-elected to this classification renewable annually upon re-application to the Board of Directors.

Regular members who have retired from medical practice for any reason shall be assigned to retired status.
Any regular member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

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

Section 2.32 — Honorary Members

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

Section 2.4 — Life Members

Any person who has: 1) held active, inactive, or international membership in the College for a minimum of 15 years and who has attained the age of 60; or 2) held active, inactive, or international membership in the College for a minimum of 10 years and who has attained the age of 70; or 3) held active, inactive, or international membership in the College for a minimum of 20 years and who is retired from medical practice; or 4) become permanently disabled, may on application to and approval by the Board of Directors be classified as a life member.

Section 2.53 — Candidate Members

Candidate members must meet one of the following criteria: 1) medical student or intern interested in emergency medicine; 2) physician participating in an emergency medicine residency shall be eligible for candidate membership. Individuals going directly from any residency into subspecialty fellowship training, the completion of which would qualify them for active membership, are eligible to be candidate members for the duration of their fellowship. Physicians in the uniformed services while serving as general medical officers shall be eligible for candidate membership for a maximum of four years.

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

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

Section 2.64 — International Members

Any physician interested in emergency medicine who is not a resident of the United States or a possession thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides and practices, shall be eligible for international membership. Other qualifications for international membership shall be determined from time to time by the Board of Directors. All international members will be assigned by the Board of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.
International members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

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

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

Section 2.7 — Councillor Members

Councillors shall be elected or appointed from active, honorary, life, or candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies. A councillor shall retain all rights and obligations of the class of membership from which the councillor was duly elected or appointed. A councillor may acquire the rights and obligations of a class of membership other than the one from which the councillor was duly elected or appointed, if the councillor satisfactorily documents qualifications for such new class of membership.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the College Bylaws, amendment or restatement or repeal of the College Articles of Incorporation, and election of the Council Officers, the President-Elect, and of members to the College Board of Directors are vested exclusively in the councillor class and are specifically denied to all other classes of membership. These rights are not applicable at the chapter level unless specifically permitted in a chapter’s bylaws.

Section 4 — Voting & Holding Office

Active and life members shall be entitled to vote and hold office, except as otherwise provided for herein. Inactive, honorary, and international members shall not be entitled to vote or hold office except as otherwise provided for herein. Candidate members may be entitled to vote and hold office at the chapter level according to chapter bylaws. At the national level, candidate members shall not be entitled to vote or hold office, except when designated as councillor or alternate councillor by their sponsoring bodies. Candidate members when appointed to national committees shall be entitled to vote on committee business. Rights for honorary members designated prior to 2006 shall be determined by the rights in their previous class of membership, if any, before being elected to honorary membership.

Section 5 — Disciplinary Action

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

Section 6 — Dues, Fees, and Assessments

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

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

Section 7 — Official Publications

Each member shall receive Annals of Emergency Medicine and ACEP News as official publications of the College as a benefit of membership.
ARTICLE V — FELLOWSHIP
Section 1 — Fellow Status

Fellows of the College shall meet one of the following two sets of criteria:

1. Be active, life, honorary, regular or international members for three continuous years immediately prior to election and must have been 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. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates 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.

[No changes proposed to the second set of criteria in this resolution. Another resolution has been submitted that deletes the second set of criteria if adopted.]

2. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
   A. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
   B. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, 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.

In addition, the candidate must provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.

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.

Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

ARTICLE VIII — COUNCIL

Section 1 — Composition of the Council

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

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

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

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

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

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

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

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

Each component body shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body's councillor at Council meetings at which such councillor is not available to participate. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.

Section 2 — Powers of the Council

The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions, including amendments to the College Manual, and other actions or appropriations enacted by the Council. Notwithstanding any other provision of these Bylaws, the Council shall have the right to amend the College Bylaws and College Manual, amend or restate or repeal the College Articles of Incorporation, and to elect the Council officers, the president-elect, and the members of the Board of Directors. The Board of Directors shall act on all resolutions adopted by the Council no later than the second Board meeting following the annual meeting and shall address all other matters referred to the Board within such time and manner as the Council may determine.
The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

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

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.

[The above deleted paragraphs moved to proposed Section 8 – Board of Directors Action on Resolutions.]

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

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

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

The speaker of the Council shall act as presiding officer of the Council.

[No change proposed to Section 3 – Meetings]

Section 4 — Quorum; Vote Required

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

[No changes proposed for Section 5 – Voting Rights, Section 6 – Resolutions, or Section 7 – Nominating Committee]

Section 8 – Board of Directors Action on Resolutions

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

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

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.
**Resolution 12  Affiliate Membership Feasibility Study (as amended)**
RESOLVED, That the ACEP Board of Directors commission a study and report on the feasibility of creating a non-voting, non-office holding membership category for individuals not currently eligible for full, active membership and that this report, including the financial and advocacy impact of membership expansion, be presented to the 2015 Council.

**Action:** Assigned to staff to develop a report for review by the Board in June 2015. The report was reviewed by the Board in June and distributed to the Council on July 9, 2015. The report provided a tremendous amount of data and perspectives. Additional input from key stakeholders was sought and a meeting was convened at ACEP on July 16, 2015. A report was developed and provided to the 2015 Council. Both reports were assigned to Reference Committee A for discussion. There was no testimony provided on the reports.

**Resolution 13  Medical Student Voice in ACEP Council (as amended)**
RESOLVED, That the ACEP Steering Committee be charged with the following tasks:
1. Evaluate the ACEP Council’s ability to address candidate students’ membership needs.
2. Explore ways in which candidate student members can contribute to the Council.
3. Report their findings and recommendations to the ACEP Board of Directors.

**Action:** Assigned to the Steering Committee to provide a report to the Board of Directors by June 2015. The Steering Committee discussed the resolution at their meeting on January 20, 2015. Haishim Zaidi, vice chair of the Emergency Medicine Residents’ Association (EMRA) Medical Student Council, participated in the discussion with the Steering Committee. It was noted that some medical students are more involved at the chapter level than with EMRA. The Steering Committee expressed strong support for welcoming medical student attendance at the Council meeting and addressing their needs to the extent possible within ACEP’s existing structure. It was suggested that ACEP consider creating a medical student section; however, it is unknown whether EMRA would have concerns or objections since they have an established and active Medical Student Section. Mr. Zaidi was asked to provide the Steering Committee with specific information on how ACEP can address the needs of medical students.

EMRA provided a letter with suggestions for immediate and near future consideration. The Steering Committee’s discussed these suggestions at their May 6, 2015, meeting and their comments regarding each suggestion are enumerated:

1. **Immediate:** Therefore, we ask that the Steering Committee recommend active promotion and encouragement for medical student membership and involvement in ACEP committees.”

   **Steering Committee Response:** This request is directed toward the Council, but it is not within the purview of the Council given the separation of powers between the Council and the Board. Although the Steering Committee can support the Board and the President’s decision to further include medical students in the committee structure, it would be inappropriate for the Steering Committee to take on this initiative or drive this agenda. Consideration and appointment of medical students on national committees is already part of the committee process. Medical student appointments are based on recommendations from EMRA.

2. **Near future:** Requested a change to the ACEP Bylaws Article IV – Membership, Section 2.3 – Candidate Members to allow medical students to serve as alternates as appointed by their state chapters.

   **Steering Committee Response:** Simply adding the word “candidate,” to this section of the Bylaws, as suggested in the letter, does not appropriately amend the Bylaws to address this request since the term “candidate member” includes medical students and residents. EMRA certainly has the right and opportunity to submit a Bylaws resolution to this effect.

It should be noted that the original resolution submitted to the 2014 Council proposed exploring the possibility of medical students being allowed to serve as alternate councillors. This language was deleted from the resolution because many disagreed with the concept of having medical students as councillors with full voting privileges. Alternate councillors have the same rights and responsibilities as councillors.
The Steering Committee supports continuing to look for ways to involve medical students in the Council meeting, but did not support developing or cosponsoring a resolution to allow medical students to serve as councillors or alternate councillors. The Council meeting is open to all members of ACEP, including medical students. Medical students can also attend and participate in the Reference Committee hearings. Suggestions from the Steering Committee for additional medical student participation included:

1. “Shadowing” a councillor or alternate councillor.
2. Attending the Reference Committee hearings and reporting on the discussions to their delegation members who may not be able to attend that Reference Committee hearing or during the discussion on a particular resolution.
3. Active participation in social media communications during the Council meeting.

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

**Resolution 18  Assistant Physician Designation (as amended)**

RESOLVED, That ACEP work with appropriate stakeholders to oppose special licensing pathways for physicians who are not currently enrolled in an Accredited Council for Graduate Medical Education or American Osteopathic Association training program, and have not completed at least one year of accredited post-graduate U.S. medical education; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to call on Governor Jay Nixon and the Missouri legislature to rescind the sections of 716 and 754 creating the “Assistant Physician” designations.

*Action:* Assigned first resolved to the Academic Affairs Committee and the second resolved to the Chapter & State Relations staff to work with stakeholders and prepare a letter from the ACEP president to the Missouri Governor and legislature.

The Academic Affairs Committee submitted a report to the State Legislative/Regulatory Committee that addressed reimbursement, medical legal, and supervision issues.

ACEP sent a letter to the Missouri Governor and legislature on October 6, 2015. The issue moved slowly in Missouri for a variety of political reasons. The State Board of Registration for the Healing Arts recently filed rules that were effective by the end of January 2017.

**Resolution 20  ED Information System Safety Issue Recognition and Management**

RESOLVED, That ACEP create a task force to evaluate a variety of potential means to better capture ED information system (EDIS) safety issues, including but not limited to the current reporting methods such as hospital-based issue logging, the Safety Button, and others; and be it further

RESOLVED, That the ED Information System Task Force harmonize efforts with those of the FDA, ONC, and the efforts associated with FDASIA to avoid duplication of efforts and synergize resources; and be it further

RESOLVED, That the ED Information Task Force include ACEP members and invited members of the EDIS vendor community; and be it further

RESOLVED, That the ED Information Task Force develop recommendations for a proposed ACEP policy on improved methods for capture and management of safety issues and supporting documentation shall include details regarding the potential benefits and risks of capture methods, feedback processes, and reporting paradigms.

*Action:* A task force was appointed. Their work was delayed because of various changes in ACEP staffing. Their work is now underway. A meeting will be held at ACEP17.

**Resolution 21  ED Mental Health Information Exchange (as substituted)**

RESOLVED, That ACEP research the feasibility of identifying and risk-stratifying patients at high risk for violence; and be it further

RESOLVED, That ACEP devise strategies to help emergency physicians work with stakeholders to mitigate patients’ risk of self-directed or interpersonal harm; and be it further

RESOLVED, That ACEP investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

*Action:* Assigned to the Public Health & Injury Prevention Committee. The information paper, “Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED,” was developed and reviewed by the Board in November 2015.
Resolution 22  EMTALA-Related Liability Reform (as amended)
RESOLVED, That ACEP support individual states in passing EMTALA-Related Liability Reform that increases the burden of proof and evidentiary standard in cases against those providing EMTALA related care.

Action: Assigned to the State Legislative/Regulatory Committee. Information was compiled to better communicate ACEP’s actions on this issue. The committee worked with the authors of the resolution to address this issue in their state. A Public Policy Grant was awarded to the Kentucky Chapter to work on liability reform in that state. The annual lobbyist/chapter executive conference call included state liability reform as one of the topics. Liability reform is included in state legislative tracking reports provided to ACEP chapters.

Resolution 23  Examination of Stark Law Potential Implications
RESOLVED, That ACEP investigate the potential Stark Law implications of various EMS medical director relationships and develop appropriate guidance and resources for members to help identify and avoid potentially problematic financial and contractual relationships.

Action: Assigned to the EMS Committee. An EMS Medical Directors Contracts Evaluation Toolkit was developed and reviewed by the Board in April 2016. It is available on the ACEP Website.

Resolution 24  Future Funding for ACEP Report Cards in the Emergency Care Environment (as amended)
RESOLVED, That the ACEP Board of Directors continue to identify potential private, public, foundational, and other funding sources to support future creation and dissemination of the ACEP National Report Card and that a report of this investigation be provided to the 2015 Council.

Action: Assigned to Grant Development and Foundation Development staff. The Board reviewed the report in June 2015 and it was provided to the 2015 Council.

Resolution 25  Human Trafficking (as amended)
RESOLVED, That ACEP and its chapters work together to coordinate with other agencies and participate with existing initiatives (e.g., National Human Trafficking Initiative, State Attorney General’s coalition, law enforcement, etc.) and to coordinate with EMS agencies, hospitals, and other members of the emergency medicine team to provide education on awareness and resources available to help reduce and eliminate human trafficking; and be it further
RESOLVED, That ACEP and its chapters work together to ensure indemnification for providers reporting suspected cases of human trafficking to the appropriate authorities.

Action: Assigned to the Public Health & Injury Prevention Committee to develop a paper, work with the Academic Affairs Committee (resident education perspective), Emergency Medicine Practice Committee, EMS Committee, and Medical-Legal Committee as needed and solicit input from ENA and NAEMSP. Assigned second resolved to the State Legislative/Regulatory Committee and Public Affairs staff for advocacy initiatives.

An information paper, “Human Trafficking – A Guide to Identification and Approach for the Emergency Physician,” was reviewed by the Board in October 2015. It was submitted to Annals of Emergency Medicine for publication consideration. The Public Health & Injury Prevention Committee was assigned an objective for 2015-16 to explore development of a policy statement on human trafficking. The policy statement “Human Trafficking” was approved by the Board in April 2016.

The State Legislative/Regulatory Committee identified an advocacy organization that compiled legislation of interest on this issue. An email to the State Advocacy Network provided a link to the information and included encouragement for chapters to advocate on this issue.

In January 2015, the House of Representatives passed several bills to combat human trafficking. An article was published in the December 2015 issue of ACEPNow on how to recognize and treat victims of sex trafficking. Another article about bringing awareness of human trafficking to the ED appeared in the June 2016 issue.

Resolution 26  Impact of High Deductible Insurance Plans (as amended)
RESOLVED, That ACEP convene a work group of subject matter experts to identify the impact that high deductible insurance plans have on patients seeking emergency care, emergency physicians, and emergency departments, and create a paper that will inform stakeholders about such impact.
Action: A task force was appointed. A report was reviewed by the Board in October 2015 and distributed to the Council. The December 2015 issue of ACEP Now included an article on how the increase in high deductible health insurance patients is raising payment concerns.

On May 9, 2016, ACEP launched the Fair Coverage Campaign. Campaign tools (press release, infographic, video, and audio news release) are available on www.FairCoverage.org. An advertisement also appeared in USA Today. Additionally, ACEP partnered with the Pennsylvania Chapter to run the same ad in the Philadelphia Inquirer with the chapter’s logo. Because this issue is being fought at the state level, the campaign is strategically state focused with limited national press as well. ACEP contacted other chapters to offer the advertisement and coordinate messaging. Working with the chapters, ACEP enlisted spokespersons in about 10 states to engage in media interviews. The campaign used the new Phone2Action service, which allows people to contact their state lawmakers by email and social media. Additionally, members were recruited to submit letters to the editor on fair coverage in their local areas.

ACEP filed suit against the federal government in May 2016. 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. According to the lawsuit, insurance companies have failed to provide fair coverage for their insured patients. They have forced health care providers out of their health plans by offering reimbursement that barely covers the cost of care and constructed narrow networks that offer little coverage for emergency care in many parts of the country. The lawsuit is still pending. A motion for summary judgement was filed on November 18, 2016. The government filed its Cross Motion for Summary Judgement and Opposition to Summary Judgement on December 9, 2016. ACEP filed its response by January 20, 2016. The U.S. District Court for the District of Columbia partially granted ACEP’s Motion for Summary Judgment on August, 31, 2017, and denied the Government’s counter motion in regards to its lawsuit against the federal government to contest a regulation that impedes emergency physicians from receiving accurate usual and customary payment for out-of-network services. The court reminded the matter back to the to the Centers for Medicare & Medicaid Services for further explanation of the regulation, saying that comments submitted to the federal departments (Departments of Health & Human Services, Labor, and Treasury) during its development expressed “concerns about the rule – for example, that the methods it used to set payments were not transparent and could be manipulated by insurers. Many of these commenters proposed using a transparent database to set payments instead. The Departments all but ignored these comments and proposals.” The ruling does not invalidate the regulation, but it is a clear step in the right direction and it forces the Government to respond to ACEP’s concerns in a substantive manner. The Parties (ACEP and the federal Departments) have been ordered to file a “joint status report” by October 30, 2017. This does not mean the Departments must respond by then, but that the Court will review and make a determination regarding its next steps from that point forward. The court has the right to move on to review the substantive issues raised by ACEP (i.e., that the entire rule is a violation of the Administrative Procedures Act and the Affordable Care Act) at that point. ACEP is now developing a strategy to emphasize our concerns with the new Administration pending a response from the agencies. The Departments will, at some point, file their response and may request additional comments or not. They may revise the regulation, or leave it as is.

Resolution 28  Fair Payment for Telemedicine Services (as amended)
RESOLVED, That ACEP work with appropriate parties at federal and state levels to advocate for legislation and regulation that will provide fair payment by all payers for appropriate services provided via telemedicine.

Action: Assigned to the Reimbursement Committee and to work with the Emergency Telemedicine Section as needed. Also assigned to Chapter & State Relations staff and Public Affairs staff for state and federal advocacy initiatives.

State Legislative/Regulatory Committee members participated in conference calls organized by the Federation of State Medical Boards regarding telemedicine services. Information was reported to state chapters on legislation introduced to address this issue.

Reimbursement Committee members reached out to the Telemedicine Section, the Rural Section, and the Iowa Chapter (authors of the resolution) for feedback on developing talking points and to identify opportunities for legislative advocacy on telemedicine issues. Work continues through the CPT process to get emergency department E-codes recognized for use with the new telemedicine modifier. The Reimbursement Committee continues to work with the Federal Government Affairs Committee and the State Legislative/Regulatory Committees as appropriate. The work group sought feedback from the Emergency Telemedicine Section and other potential sources regarding payment for telehealth services and helped design a survey on telemedicine use that the Section was implementing.

Resolution 29  Safe Citizen Day (as amended)
RESOLVED, That ACEP will embrace, support, and promote the concept of establishing “Safe Citizen Day” and to evaluate and develop promotional materials for distribution to the members and chapters that encourage training, education, and skill development in disaster and safety preparedness.
Action: Assigned to the Public Relations Committee. In June 2015, the Board approved the committee’s recommendations to implement the concept of Safe Citizen Day:

1. Conduct a review of disaster training classes available to ACEP emergency physicians and determine whether additional courses are needed. Develop another course, if needed.
2. Conduct a review of activities around September 11 and determine whether September 11, or another date, is the most effective to promote Safe Citizen Day.
3. Design a Safe Citizen Day logo for inclusion on materials that promote Safe Citizen Day.
4. Send an electronic message to ACEP members and chapter executives and presidents a month before Safe Citizen Day, with materials that promote disaster training. The materials can include a message from ACEP’s president, an article about the importance of disaster training (written by the chair of ACEP’s Disaster Preparedness & Response Committee) for promotion through chapter newsletters, a video featuring ACEP’s president, and marketing information about ACEP’s disaster courses.
5. Develop a Safe Citizen Day web page on ACEP.org, featuring the logo and materials. Feature logo on ACEP’s consumer website EmergencyCareforYou.org and link to the materials.
6. Develop a press release promoting public disaster preparedness for distribution a week before Safe Citizen Day. The press release and other campaign materials will include promoting the concept of CPR without rescue breathing.

A “Safe Citizen” logo was created and the concept was promoted during the 2017 EMS Week.

Resolution 30  Sexual Assault Victims’ DNA Bill of Rights (as amended)
RESOLVED, That ACEP members be encouraged to be familiar with and to follow all local law, policy, and procedure with respect to collection and submission of DNA evidence to law enforcement agencies; and be it further
RESOLVED, That ACEP support state legislative “Sexual Assault Victims’ DNA Bill of Rights” and similar initiatives regarding timely processing of submitted DNA evidence

Action: Assigned to the Public Health & Injury Prevention Committee. The committee developed the information paper, “Sexual Assault Victims’ DNA Bill of Rights” and it was reviewed by the Board in February 2016. The committee recommended that a policy statement not be developed at this time. The Board approved the committee’s recommendation in April 2016.

The second resolved was assigned to the State Legislative/Regulatory Committee for state advocacy initiatives. The committee identified the legislation in question and distributed it along with encouragement for chapters to support similar legislation in their states.

Resolution 31  Financing Health Insurance (as substituted)
RESOLVED, That ACEP create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Action: A task force (aka Alternate Payment Models Task Force) was appointed with the following objectives: 1) Develop consensus on definition of Alternative Payment Models (APMs) from an emergency medicine perspective; 2) Identify objective of APMs in private market and under MACRA and other federal statutes; 3) Work with consultant(s) to develop APM models that can be assessed, validated and potentially marketed/deployed; 4) Develop strategic plan to promote APMs approved by ACEP’s Board of Directors; and 5) Provide a report to the ACEP Board of Directors prior to the 2015 Council meeting on the feasibility of conducting a study of alternative financing models that foster competition and preserve choice for patients. The task force held in-person meetings and conference calls and is making progress on their objectives. Additional meetings were held on January 29 and May 14, 2016. The Board reviewed a status report of their work in October 2016. This is a complicated issue and the task force is continuing its work in 2016-17. Several payment models were developed and analyzed, which may require use of Medicare and emergency medicine group data. The next step is to use the results to address the questions put forth by MACRA’s Physician Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will provide technical assistance to applicants in bringing their proposals to a level for final review and submission to CMS.

Resolution 32  Anonymous Expert Physician Testimony for a State Medical Licensing Board (as amended)
RESOLVED, That ACEP develop and disseminate to every state medical licensing agency an official ACEP policy advocating that state licensing boards do not accept anonymous testimony as expert opinions for or against a physician under review.
**Action:** Assigned to the Medical-Legal Committee. The policy statement “Anonymous Expert Physician Testimony for a State Medical Licensing Board” was approved by the Board in June 2015. The policy was distributed to all state medical boards. Several state medical boards responded; some indicated they do not allow anonymous testimony and others defended their reasons for allowing it.

**Resolution 33 Bariatric Emergency Department Guidelines**
RESOLVED, That ACEP, in cooperation with relevant professional societies, develop bariatric emergency department clinical guidelines.

**Action:** Assigned to the Emergency Medicine Practice Committee to work with ENA and other relevant bariatric surgery organizations as needed. In 2014-15, the committee focused on the accommodations within the physical environment of the ED required to care for bariatric patients. In 2015-16, the committee worked with representatives from the American Association of Metabolic and Bariatric Surgeons (AAMBS) to compile resources for emergency physicians on the acute treatment of bariatric patients in the ED. In October 2016, the Board approved continuing collaboration with the AAMBS on the development of a practice resource on the care of the bariatric patient in the ED. The content for the “Bariatric Examination, Assessment and Management in the Emergency Department” (BEAM-ED) app is in process and availability to members is expected by October 2017.

**Resolution 36 Development of Telemedicine Policy for Emergency Medicine**
RESOLVED, That ACEP appoint a group, including members from the Emergency Telemedicine Section, to develop a comprehensive telemedicine policy that will define the principles and standards of care as it pertains to the appropriate delivery of acute and emergency medical care using telemedicine related technologies.

**Action:** Assigned to the Emergency Medicine Practice Committee. The policy statement “Emergency Medicine Telemedicine” was approved by the Board in January 2016. The Ethics Committee developed the policy statement “Ethical Use of Telemedicine in Emergency Care” and it was approved by the Board in June 2016.

**Resolution 39 Naloxone Prescriptions by Emergency Physicians (as amended)**
RESOLVED, That ACEP develops a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone.

**Action:** Assigned to the Clinical Policies Committee. After review of the literature, it was determined there was not quality evidence for a clinical policy on this topic and that, at most, the review would result in a consensus recommendation. The Board approved the policy statement “Naloxone Prescriptions by Emergency Physicians” in October 2015.

**Resolution 41 Pedestrian Injuries are Preventable**
RESOLVED, That ACEP supports public health initiatives to reduce pedestrian injuries; and be it further RESOLVED, That ACEP creates an information paper for members interested in implementing public health initiatives in their communities.

**Action:** Assigned to the Public Health & Injury Prevention Committee to develop a policy statement and information paper. The information paper, “Pedestrian Injury Prevention through Vision Zero Model,” was reviewed by the Board in October 2015. The policy statement “Pedestrian Injury Prevention” was approved by the Board in January 2016.

**Resolution 42 Reverse an Overdose, Save a Life (as amended)**
RESOLVED, That ACEP advocates and supports training and equipping first responders, including police, fire, and EMS personnel, to use injectable and nasal spray naloxone; and be it further RESOLVED, That ACEP advocates and supports the availability of naloxone being dispensed over the counter with overdose education by a pharmacist.

**Action:** The resolution provided the foundation for a policy statement. It was assigned to the EMS Committee to determine if additional information was needed for the policy statement and to work with the Emergency Medicine Practice Committee regarding the second resolved.

The EMS Committee determined that several other organizations were pursuing a similar objective. The committee contacted the National Association of EMS Physicians (NAEMSP) and the American College of Medical Toxicology (ACMT) to develop a joint policy statement. The policy statement “Naloxone Access and Utilization for Suspected Opioid Overdoses” was approved in June 2016.
Resolution 43  State Medical Licensing Board Anonymous Complaint (as amended)

RESOLVED, That ACEP oppose anonymous complaints from third parties not directly involved in the episode of care to state medical licensing boards.

Action: Assigned to the Medical-Legal Committee. The policy statement “Anonymous Complaints to State Licensing Board by Third Parties” was approved by the Board in June 2015. The policy was distributed to all state medical boards.

Resolution 44  Support for Clinical Pharmacists as Part of the Emergency Medicine Team

RESOLVED, That ACEP create a policy statement that supports clinical pharmacy services in emergency departments and collaboration among emergency medicine providers to promote safe, effective, and evidence-based medication practices, to conduct emergency-medicine-related clinical research, and to foster an environment supporting pharmacy residency training in emergency medicine.

Action: Assigned to the Emergency Medicine Practice Committee. Two clinical pharmacists worked with the committee to develop the policy statement “Clinical Pharmacist Services in the Emergency Department” and it was approved by the Board in June 2015. The committee was assigned an objective for the 2015-16 committee year to explore development of an information paper. Representatives from the American Society of Hospital Pharmacists worked with the committee to develop the information paper “Clinical Pharmacy Services in the Emergency Department. It was reviewed by the Board in April 2017 and has been submitted to Annals of Emergency Medicine for publication consideration.

Resolution 45  Trauma Center Certification Task Force (as amended)

RESOLVED, That the Board of Directors appoint a diverse task force comprised of members from College leadership, including existing College committees, members from state chapter leadership, members with expertise in the areas of trauma systems, certification and accreditation programs, and chapter executives to develop a strategy for ensuring significant and meaningful emergency physician input in trauma center and regional trauma system certification programs.

Action: A task force was appointed and their work continued in 2015-16. An initial list of 12 emergency physicians was provided to the American College of Surgeons (ACS) to serve as trauma center verification team members. A contact list was developed of the states that conduct their own trauma center verification so that coordination with the site visit team process can be initiated. Additionally, ACEP leaders met with the leadership of the American College of Surgeons-Committee on Trauma (ACS-COT) and discussed the verification criteria and who would be allowed to work in ACS-certified trauma centers. ACS agreed that physicians who are ABEM or AOBEM certified or who are ACEP fellows (FACEP) must have taken ATLS only once to maintain their current trauma center certification. Any physician board-certified in a specialty outside of emergency medicine can continue to work in trauma centers as long as they were board certified before December 31, 2016, and maintain current ATLS certification. This protects those legacy physicians working side-by-side with us in trauma centers, but it also recognizes the importance of residency training and fellowship status. A final report with recommendations from the task force was reviewed by the Board in October 2016. The following strategies developed by the task force strive to address the resolution while recognizing the vital role each state chapter must play in the process:

- Assist the state chapters in connecting and coordinating with the individual state agency that oversees the state trauma system.
- Assist the ACEP liaisons to the ACS-COT as needed in identifying additional emergency physicians to serve on national ACS-COT trauma center verification site teams.
- Assist the state chapters in developing a description of the needed experience that would prepare emergency physicians to serve on trauma center verification site teams and in developing any needed training programs for new emergency physician trauma center verification site team members.

Resolution 46  Triage Screening Questions (as amended)

RESOLVED, That ACEP create a practice resource that identifies best practice triage processes.

Action: Assigned to the Emergency Medicine Practice Committee. The information paper “Screening Questions and Streamlining Triage” was reviewed by the Board in October 2015. At that time, the Board supported development of a policy statement focused on triage screening questions. The Emergency Medicine Practice Committee was assigned an objective to “explore development of a policy statement on screening questions at triage.” A draft was reviewed by the ACEP Board in April 2016 and was referred back to the committee with the request that the Emergency Nurses
Association (ENA) review it and consider a joint policy statement. The joint policy statement, “Screening Questions at Triage,” was approved by ENA in September 2016 and the ACEP Board in October 2016.

**Resolution 47 In Memory of Karl Ambroz, MD**
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor the contributions made by Karl G. Ambroz, MD, as one of the leaders in Emergency Medicine; and be it further,
RESOLVED, That the American College of Emergency Physicians and the Illinois Chapter extends to his wife Clare, his children, Ryan, Sean, and Logan, his friends, family, and his colleagues our condolences and gratitude for his service to the specialty of Emergency Medicine.

**Action:** A framed resolution was prepared and sent to Dr. Ambroz’s family.

**Resolution 48 In Memory of George Podgorny, MD, FACS, FACEP**
RESOLVED, That the American College of Emergency Physicians memorialize and remember George Podgorny, MD, FACS, FACEP, for his indefatigable contributions to the creation and development of emergency medicine; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Dr. Podgorny its deepest sympathy for the loss of this wise, sagacious man and its gratitude for having shared and been enhanced by his exceptional life.

**Action:** A framed resolution was prepared and sent to Dr. Podgorny’s family.

**Resolution 49 In Memory of Otto Floyd Rogers, III, MD, FACEP**
RESOLVED, That the American College of Emergency Physicians and the North Carolina College of Emergency Physicians extends to his wife Ryn Rogers, his son Adam, and his other family, friends, and colleagues our deepest sympathy, our sense of loss, and gratitude for his service to his communities and the specialties of emergency medicine and palliative care.

**Action:** A framed resolution was prepared and sent to Dr. Rogers’ family.

**Resolution 50 In Memory of Francis M. Fesmire, MD, FACEP**
RESOLVED, That the American College of Emergency Physicians remembers with honor the contributions made by Francis M. Fesmire, MD, FACEP, to the state of Tennessee, to the specialty of emergency medicine, and to the ACEP Clinical Policies Committee; and be it further
RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Dr. Fesmire our deepest sympathy, our sense of sadness and loss, and our gratitude for his service to our specialty and our patient communities.

**Action:** A framed resolution was prepared and sent to Dr. Fesmire’s family.

**Resolution 51 In Memory of Richard V. Aghababian, MD, FACEP**
RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor the contributions made by Richard V. Aghababian, MD, FACEP, as one of the leaders in emergency medicine; and be it further
RESOLVED, That National ACEP and the Massachusetts Chapter of ACEP extends to his wife, Ann, his children Emily and Andrew, his friends, family, and colleagues our deepest sympathy, our sense of loss, and our gratitude for his service to the specialty of emergency medicine.

**Action:** A framed resolution was prepared and sent to Dr. Aghababian’s family.

**Resolution 52 In Memory of Gail V. Anderson, Sr., MD**
RESOLVED, That the American College of Emergency Physicians honors with the utmost gratitude and respect the significant contributions made by Gail V. Anderson, Sr., MD, as one of the pioneers of and great teachers in emergency medicine; and be it further
RESOLVED, That the American College of Emergency Physicians extend to his wife Alice, his five sons Gail Jr., David, Jerrold, Walter, and Mark, and to their wives and children, his brother Donald, and his many nieces and nephews, our sincerest condolences and deepest gratitude for his lifelong service to educating physicians and putting patients first.
**Action:** A framed resolution was prepared and sent to Dr. Anderson’s family.

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**College Manual Resolution**

**Resolution 11 Eligibility for Fellow Emeritus**

RESOLVED, That the ACEP College Manual, “Section II. Eligibility Criteria for Fellow Emeritus” be deleted and the remaining sections of the College Manual be renumbered accordingly.

**II. Eligibility Criteria for Fellow Emeritus**

To be eligible for election, a member must:

1. Be nominated by a member, chapter or section, or be self-nominated.
2. Have made a significant contribution to and enhanced the profile of the College or the specialty of emergency medicine through their professional and personal endeavors.

**Action:** The College Manual was updated.

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**Council Standing Rules Resolution**

**Resolution 6 Election Procedures**

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

**Election Procedures**

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.

When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, and Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, then the candidate who received with the lowest number of valid votes on the inconclusive ballot will be removed from all subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate’s total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, and Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, and Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.
Referred Resolutions

Resolution 8  Fellow Status Continued vs. Continuous Membership
RESOLVED, That the ACEP Bylaws, Article V – Fellowship, Section 1 – Fellow Status, be amended to read:

ARTICLE V — FELLOWSHIP
Section 1 — Fellow Status

Fellows of the College shall meet one of the following two sets of criteria:
1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been 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. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.

Note: This Article and Section of the Bylaws were revised by other resolutions. The proposed revision now appears in Article V – ACEP Fellows, Section 2 – Fellow Status and reads:

Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. 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.

Action: Assigned to the Membership Committee for review and provide a recommendation to the Board of Directors regarding further action. The committee recommended to the Board in June 2015 to submit a resolution to the 2015 Council amending the Bylaws to stipulate retention of ACEP fellow status is contingent on maintaining “continuous” membership (no lapse in dues) in the College instead of “continued” membership. The Board did not adopt the recommendation and the proposed resolution was not submitted to the 2015 Council.

Resolution 17  Advocacy for Professional Licensure of EMS Providers (as substituted)
RESOLVED, That ACEP reaffirm the critical importance of physician leadership of EMS as described in existing ACEP policies; and be it further
RESOLVED, That EMS personnel are not independent practitioners, but function only under direct physician oversight; and be it further
RESOLVED, That ACEP adopt a position that EMS personnel with training no less than the current national standard curriculum paramedic should be licensed health care practitioners licensed under state medical boards; and be it further
RESOLVED, That ACEP coordinate and collaborate with the Federation of State Medical Boards (FSMB), individual state medical boards, and other stakeholders to develop model statutory language for states to utilize in adopting professional licensing processes and standards for advanced EMS providers; and be it further
RESOLVED, That ACEP develop a policy statement and Policy Resource and Education Paper (PREP) supporting professional licensing of EMS personnel by state medical boards and provide informational resources to fellow stakeholders to promote such licensing.

Action: Assigned to the EMS Committee for review and to provide a recommendation to the Board of Directors regarding further action. A draft policy statement was developed and reviewed by the Board in October 2015. The Board determined that more information was needed and directed the EMS Committee to suspend its work. The work was reassigned to the Mobile Integrated Healthcare/Community Paramedicine Task Force. The task force developed the “Mobile Integrated Health/Community Paramedicine Primer” that was reviewed by the Board in June 2016 and it was submitted for publication consideration. The National Highway Traffic Safety Administration developed a multi-year project to update the “National EMS Scope of Practice Model.” The “Model” addresses professional licensure of EMS providers.

Resolution 38  Geriatric Emergency Department Accreditation (as substituted)
RESOLVED, That ACEP study the feasibility of developing an accreditation process for geriatric emergency departments, including the potential of partnering with other stakeholder agencies – work with regulatory agencies
that are or may become involved in the development of accreditation requirements for geriatric emergency departments.

**Action:** Assigned to the Emergency Medicine Practice Committee for review and to provide a recommendation to the Board of Directors regarding further action. The Board approved the committee’s recommendation in April 2015 to collaborate with regulatory agencies if they pursue development of accreditation requirements for geriatric EDs. The committee was assigned an objective for the 2015-16 committee year to develop a policy statement in support of quality improvement initiatives for the care of geriatric patients in the ED. The policy statement “Quality Improvement Initiatives for the Care of Geriatric Patients in the Emergency Department” was approved by the Board in April 2016.

The Board has discussed the potential of developing a Geriatric ED Accreditation program. In September 2016, the Board authorized staff to proceed in developing a formal business plan and framework of a Geriatric ED Accreditation Program. The business plan and accreditation program were approved by the Board in January 2017. The program was publicized in the April 2017 edition of ACEP Now.
President-Elect Candidates
2017 President-Elect Candidates

Vidor E. Friedman, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Hans R. House, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

William P. Jaquis, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

John J. Rogers, MD, CPE, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
**2017 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS**

Vidor E. Friedman MD, FACEP

**Question #1:** Given the uncertainty of the AHCA (ACA replacement) what are the fundamental tenets that need to be included that supports members and patients?

Coverage for Emergency Medical Services is an absolutely essential element to protect both patients and providers. Recent polling shows most Americans believe that if you have health insurance it should cover you in an emergency. Any healthcare reform legislation must include a mandate for emergency coverage. Healthcare bankruptcy is becoming all to common given that the average American household has only $750 in savings, with health insurance deductibles reaching into the thousands of dollars this is a recipe for disaster!

Congress is elected by & should represent the American People, not the Health insurance lobby!

Preserving the **Prudent Layperson Standard,** for both seeking care and payment, is fundamental for any reform regarding the PPACA (Patient Protection and Affordable Care Act). The prudent layperson standard is **THE** connection to the reimbursement side of EMTALA. EMTALA mandates the care and the prudent layperson standard serves to financially protect insured patients, guaranteeing payment to providers and hospitals.

Medicaid is another piece of the healthcare equation needing to be preserved. There are two very different cohorts of patients that are generally covered by Medicaid. In virtually all states, the largest cohort are children. In my home state of Florida over half of the children are covered by Medicaid. The other Medicaid cohort are the dual-eligibles; Medicaid/Medicare recipients who are desperately poor and/or very ill. Both of these populations need advocates & protection. In fact, these patients are the very reasons Medicaid was created in the first place.

Could Emergency medicine bring new ideas to help make Medicaid more efficient?

I think we are in a unique position to do so because we frequently take care of the emergent/urgent healthcare needs of these populations. The dual-eligible patients are the ones using the most resources per capita. If outpatient care was more actively managed for these patients, I am confident we would see a decrease in readmissions. Both improving the quality of life for this patient population & significantly decreasing the cost of care at the same time.

Healthcare reform is all about decreasing the overall cost of care. Emergency medicine, with our unique perspective on our healthcare system, can help point out where real savings are possible

**Question #2:** Given the differing viewpoints of ACEP members, how will you ensure that all voices within emergency medicine are represented before a national audience?

So that ACEP leadership understands all of the many viewpoints within the college, the first step is to Insure that there are adequate feedback loops via polling and social media platforms. We have a diverse and passionate membership wishing to express their opinions, it is vital they have forums where they can regularly communicate with leadership. We must strive to ascertain all viewpoints, and understand the nuances of a particular issue. We then must work hard to build consensus, whenever possible, around controversial issues. The crucial work of leadership is to distill the best elements of the diverse viewpoints amongst the college, and formulate a stance that presents a united front. Ultimately it is the responsibility of the President and the Board to represent the opinion of our membership to the nation. There will be occasions where ACEP must stake a position based on the best information currently available, with little time to thoroughly workshop the issue. At these times your choices in electing ACEP leadership are critical.
Especially in this time of national polarization, emergency medicine must band together and present a solid, unified voice as we represent our patients and our specialty.

**Question #3: How has the role of ACEP President evolved over the past 5 years and how will your abilities help in that role? What will you do as President to ensure that your initiatives meet member needs?**

Over the past 5 years the President’s activities have focused on being the Chief Advocacy Officer for the College. This advocacy can be seen both in the political realm and in increased collaborative efforts with other entities in the healthcare space. Alliances with other specialties within the house of medicine led to the recent AMA resolutions regarding Out of Network Care and the Opioid Crises. Partnership with organizations including the West Health Foundation and the John A Hartford Foundation have supported our engagement in Geriatric Emergency medicine. In all of these efforts, the President of the College has been both content expert and public spokesperson for the college.

I have been a staunch advocate for EM for over 15 years, *this is not new territory for me*. As Governmental Affairs Chair for the Florida College of Emergency Physicians, and as President of the chapter, I led our advocacy efforts in Florida for almost a decade. I was the Federal Governmental Affairs Committee Chair during the ACA deliberations, and was one of the architects behind the creation of the Emergency Medicine Action Fund (EMAF). EMAF was created to increase resources for regulatory lobbying in response to the passage of the ACA and is essential as we face current & future healthcare reform initiatives. The increased collaboration from having diverse elements from within our community all sitting at the table discussing our collective needs was as important a win to me as the success that EMAF has become.

As President, I would work to improve the feedback loop from our chapter leadership and the Council by engaging our social media platforms and enhancing our survey feedback tools. This will help to align ACEP’s initiatives with our members priorities. As your President and Chief Advocacy officer I will ensure that those priorities become results.
CANDIDATE DATA SHEET

Vidor E. Friedman MD, FACEP

Contact Information
13061 Water Point Blvd., Windermere, FL 34786
407 761 9661
vidorf@gmail.com

Current and Past Professional Position(s)
Florida Emergency Physicians; Maitland, Fl (*97-present, became FEP of TeamHealth 10/16)
Michigan Capitol Medical Center, Lansing, MI (89-97)

Education (include internships and residency information)
Internship and Residency Michigan State University Emergency Medicine Residency Lansing, MI (86-89)
University of Cincinnati College of Medicine, MD (82-86)

Certifications

Professional Societies
ACEP, FCEP, AMA, FMA

National ACEP Activities – List your most significant accomplishments
Board Member 2012-present, SEC/Treasurer ACEP 2016-17, EMF Chair 2014-15, EMF BOT 2011-2016, EMAF BOG 2011-present, Board Liaison to the QPC committee 2012-present, Chair FGA 2009-11, Council Steering Committee 2011-12, NEMPAC BOT 2005-09, 2016-present

ACEP Chapter Activities – List your most significant accomplishments
FCEP President 2011-12, Chair Governmental Affairs 2005-10

Practice Profile
Total hours devoted to emergency medicine practice per year: 1200 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
- Direct Patient Care 40 %
- Research ___%
- Teaching ___%
- Administration 60 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
I am an attending physician at FEP of TeamHealth which staffs 10 hospitals seeing over 700,000 patients per year. I work clinically primarily at Florida Hospital Celebration Health, a community hospital that sees approximately 85,000 patients per year. I served as FHCH medical director from ’98-00, and it’s Chief of Staff from ’06-08. I currently serve as the Vice President of Governmental Affairs.

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.
Defense Expert 0 Cases
Plaintiff Expert 0 Cases
# CANDIDATE DISCLOSURE STATEMENT

## Vidor E. Friedman MD, FACEP

1. **Employment** – *List current employers with addresses, position held and type of organization.*

   **Employer:** Florida Emergency Physicians of TeamHealth (as of 10/16)
   **Address:** 500 Winderly Place, Suite 115
   **Maitland, FL 32751**
   **Position Held:** VP of Governmental Affairs
   **Type of Organization:** Emergency Physician Group Practice

2. **Board of Directors Positions Held** – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

   **Organization:** ACEP
   **Address:** PO Box 619911
   **Dallas, TX 75261-9911**
   **Type of Organization:** Professional medical association for emergency physicians
   **Duration on the Board:** 2012–present

   **Organization:** Florida College of Emergency Physicians
   **Address:** 3717 S. Conway Rd
   **Orlando, FL 32812**
   **Type of Organization:** Professional medical association for emergency physicians
   **Duration on the Board:** 2003–present

   **Organization:** Emergency Medicine Foundation
   **Address:** PO Box 619911
   **Dallas, TX 75261-9911**
   **Type of Organization:** Foundation for emergency medicine research and education
   **Duration on the Board:** 2010 – present
Organization: Emergency Medicine Action Fund
Address: PO Box 619911
        Dallas, TX 75261-9911
Type of Organization: Advocacy for federal and regulatory issues
Duration on the Board: 2012-present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
If YES, Please Describe Below:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Vidor Friedman, MD, FACEP

Date

9/18/17
August 23, 2017

American College of Emergency Physicians
2121 K. Street, NW, Suite 325
Washington, DC 20037

Dear ACEP Councillors,

The Florida College of Emergency Physicians, (FCEP) strongly and enthusiastically supports Dr. Vidor Friedman for the position of President-elect of ACEP. Dr. Friedman has been an exemplary leader for ACEP for many years while serving on the Board, as well as a great leader for FCEP since he arrived in Florida from Michigan in the mid 90’s. He has served as Chair of our Government Affairs Committee, participated in essentially every FCEP Committee and officer position, including as our FCEP President, and continues to serve actively on our Board of Directors.

Dr. Friedman has demonstrated his key leadership qualities through his work with EMF, EMAF, NEMPAC and CEDR. He is currently seeking solutions for senior care and an education platform to help our growing Medicare population with access to education on advanced directives. This is an extremely important initiative in Florida. We are working closely with ACEP and ACEP Corporate Partners on this program.

Another priority area for Dr. Friedman is fair payment for our services. We are working diligently to educate policy makers on how this impacts access to care. While it is an uphill battle, it is achievable.

The Florida College of Emergency Physicians proudly endorses Dr. Vidor Friedman for the position of President-elect of ACEP.

Sincerely,

[Signature]

Joel Stern, M.D., FACEP
President
Vidor E. Friedman, MD, FACEP

Dear Esteemed Colleague,

Being the ACEP president is about being the spokesperson for our profession and having the vision to help move us towards a brighter future. I am running for ACEP President Elect because I am the right leader at the right time for ACEP. In this period of turmoil and change in healthcare, I have a proven record of being not just a strong voice for our profession, but an impactful innovator at both the state and national levels.

As your President, I would focus on these goals; Emergency Physician well being, promoting the value of emergency medicine, and collaboration with key stake holders in healthcare to develop innovative solutions to our greatest challenges.

ACEP’s first priority must be to meet the needs of our members. Emergency medicine is a noble profession. We treat our patient’s acute needs 24/7/365; who else can say that these are my regular hours? At the same time, the stresses that we work under seem to be increasing almost daily. ACEP should diligently work for our members, advocating for their practice, and providing the tools they need to succeed. ACEP must continue to develop effective resources to help emergency physicians find the joy in our profession, and what an awesome calling it is! Having these resources readily available and easily accessible can mean the difference between value added and value lost.

Emergency physicians are there at the patient’s most critical times, when they experience fear, significant pain, and what is perhaps the most terrifying time of their lives. We have the incredible opportunity to help people when they most need it! Stop and think about your last shift, reflect on the patients that you helped, that you sent to cath. lab, that you alleviated their suffering, their pain. This is one of the best ways to avoid burn out; spend some time after each shift reflecting on all the amazing things you were able to do for your patients.

My other priorities are closely related. I see the emergency department as a critical nexus point in the health care continuum. The ED is the premier acute care rapid treatment and diagnostic center. (patients seem to understand this far better than policy makers)

Healthcare reform is frankly about cost containment. Emergency medicine, with our unique perspective on our healthcare system can point out where real savings are possible. For instance, the top 10 percent of all spenders (enrollees) in Medicare are responsible for 52 percent of medical spending annually 1. Forty percent of all hospital inpatients are Medicare 2, no surprise to us Emergency Physicians! With a more robust outpatient system and efficient access, I am confident we would see a decrease in readmissions. Both improving the quality of life for this patient population and significantly decreasing the cost of care at the same time. To accomplish this, we must partner with other stakeholders throughout the house of medicine to create alternative pathways & new paradigms of healthcare delivery.

My decision to run for president elect was made after a great deal of thought and deliberation. This is a difficult decision, balancing family, career, and service to our college, but I feel that it is part of my calling to serve our profession and patients. Now, I am ready to serve you in this new role. I ask for your feedback, guidance, and support...above all, I ask for your vote!

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Who Am I?
• Longtime advocate devoted to Emergency Medicine
• ACEP Secretary/Treasurer
• Innovative fundraiser on state and national levels

Goals
• Improve Emergency Physician well being
• Promote the value and importance of Emergency Medicine
• Increased collaboration with key stakeholders in healthcare

National and Chapter Involvement
• Board Member 2012-present
• EMF Chair 2014-15, Board of Trustees 2011-16
• EMAF Board of Governors 2011-present
• Liaison to Quality & Performance Committee 2012-present
• Liaison to Medical Legal Committee 2014-15
• Liaison to Ethics Committee 2014-15
• Liaison to Public Relations Committee 2012-14
• Federal Government Affairs Chair, ACEP 2009-2011
• Council Steering Committee, ACEP
• NEMPAC Board of Directors, ACEP 2005 – 2009, 2016 - present
• President, Florida Chapter 2011-12
• Board Member, Florida Chapter 2003 - present
• Councilor, Florida Chapter 2005-12
• Governmental Affairs Chair, Florida Chapter 2005-10
• Developed Leadership Academy, Florida Chapter 2012

Proven Leadership
• Innovative leadership of physician-owned groups promoted growth, employee morale and patient satisfaction
• One of the first EM Physicians to serve as Chief of Staff at Florida Hospital Systems
• Engaged and empowered medical staff to drive change through participation and creativity
• VP of Governmental Affairs, Florida Emergency Physicians of Team Health
• Led the effort which tripled FCEP’s political contributions on an annual basis
• Championed the development of EMAF & CEDR

Practice Leadership in Multiple Environments
• Shareholder, Florida Emergency Physicians (17 years)
• Managing Director, Florida Emergency Physicians (9 years)
• Medical Director (11 years) - Orlando, FL

• Partner, 9 Hospital group - Orlando, Fl
• Partner, 2 Hospital group - Lansing, MI
• Clinical Faculty (8 years) - Lansing, MI

Vidor Friedman MD, FACEP

Leadership Experience Vision
2017 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Hans R. House, MD, FACEP

**Question #1:** Given the uncertainty of the AHCA (ACA replacement) what are the fundamental tenets that need to be included that supports members and patients?

Throughout Congress’s attempt to repeal or replace the Affordable Care Act, ACEP must focus on the words that are often left out of the act’s official title: Patient Protection. ACEP needs to protect our patients’ access to care as well as the careers of our members. Prior to the first version of the American Healthcare Act (AHCA) being introduced to the House of Representatives in March of 2017, ACEP issued a set of ten principles of healthcare reform. Chief among these principles are “protecting the prudent layperson standard” and “maintaining emergency services as an essential healthcare benefit.” As we have seen in several states, insurance companies like Blue Cross / Blue Shield (BC/BS) are trying to discourage and deny payment for emergency department visits. By retroactively denying coverage based on the final diagnosis, they are committing a gross violation of the prudent layperson standard.

If Congress allows states to opt out of essential health benefits, reimbursement for emergency care is threatened. Clearly, as evidenced by the actions of BC/BS in their denial of ED visits for certain conditions, insurance companies have no qualms about selling products without coverage for emergency services. Furthermore, by removing mental healthcare as an essential benefit, plans will be sold without access to psychiatric care. And, plans that include mental healthcare will become too expensive to the millions of people who need them.

Congress has clearly struggled with process of replacing the PPACA, and those efforts will likely turn now to improving the existing law. ACEP will have a seat at the table during this critical period of health policy. As President, I would direct ACEP’s team in Washington to lobby for protecting our patient’s access to care. This means strengthening Medicaid, which is now emergency medicine’s most frequent payer. The Medicaid expansion has also been the most effective element of the PPACA, in terms of expanding numbers of covered patients. I also want to see the individual insurance markets stabilized, thereby encouraging more enrollment and increasing competition between insurance companies. The challenge of high deductible plans needs to be addressed, as these defective products simply turn a patient’s status from privately insured into self-pay at their first presentation of the year to an ED. Worse, the physicians get blamed for a “surprise bill” when we are simply collecting the patient’s obligation under that insurance plan. Finally, I would emphasize the need for adequate mental healthcare to reduce the inhumane backlog of psychiatric patients lining the hallways of our ED’s.

**Question #2:** Given the differing viewpoints of ACEP members, how will you ensure that all voices within emergency medicine are represented before a national audience?

Based on an analysis by Eitan Hersh and Matthew Goldenberg from Yale University in August 2016, Emergency Medicine is the most politically diverse specialty in all of medicine. Emergency physicians are evenly split 51% / 49% between registered Republicans and Democrats. If ACEP issues a strong stance on any politically polarizing topic, we are certain to alienate half of our membership. But we must not allow this fear of offense to prevent the college from taking actions that are morally correct. When walking the tightrope of balancing our political affiliations, the moral compass of protecting our patients is surest way to seek firm footing.

To best represent the views of our membership and advance the practice of emergency medicine, ACEP must focus on its mission statement. We promote high quality emergency care and are the leading advocate for our physicians, our patients, and the public. Therefore, under my leadership as ACEP President, I would direct ACEP to focus on protecting our patients’ access to care and protecting the health of our physician’s careers.

As an academic leader from a small group practice at a university hospital, I understand the challenges in the EM marketplace faced by independent groups. As an educator, I understand the needs of residents and
medical students who are learning about our specialty and the needs of young physicians beginning their careers. As a representative from a rural state, I know that many of our patients are cared for by non-board certified physicians and advanced practice providers. And as a co-owner of a freestanding emergency department, I appreciate new models of care that prolong careers and provide outstanding service to patients. My experience gives me the insight to lead ACEP while upholding the best interests of our entire, diverse membership.

**Question #3: How has the role of ACEP President evolved over the past 5 years and how will your abilities help in that role? What will you do as President to ensure that your initiatives meet member needs?**

The ACEP President is the spokesperson of the college. Over the last five years, ACEP’s media relations team has done an incredible job of increasing the number of on-camera media interviews. The Washington, D.C. office has greatly increased the opportunities for in-person small group meetings with politicians. As the face and voice of the College, the president must be an articulate and effective public speaker. I am an experienced, dynamic, and charismatic speaker who can convey the energy and enthusiasm of our diverse specialty.

As president, I will focus on reducing burnout in our members by addressing system changes in our workplace. As work environments, emergency departments are dangerously prone to normalizing conditions that radically deviate from what is acceptable. The constant frustrations generated by enduring the sense of powerlessness and dysfunction in today’s healthcare system are cutting short the careers of brilliant and caring physicians. Panagioti, et al. (*JAMA Intern Med.* 2017;177(2):195-205) found that interventions that focus on system changes are almost twice as effective at reducing burnout than interventions that only address the individual physician. In other words, no amount of yoga and meditation is going to help until the underlying system frustrations are addressed.

As president, I would direct ACEP to aggressively target system changes, even on a local level. Important drivers of burnout that I would address include the boarding of inpatients (especially mental health patients), merit badge requirements for hospital credentialing, improving the Maintenance of Certification process, and encouraging stability in hospital contracts. Furthermore, our members can maximize control over their workplace by owning it themselves, so I embrace the trend towards opening Freestanding Emergency Centers. These centers revive career satisfaction, provide ideal access to care for patients, and bring sorely needed disruptive change to an entrenched and dysfunctional system.
CANDIDATE DATA SHEET

Hans R. House, MD, FACEP

Contact Information
Department of Emergency Medicine
200 Hawkins Drive, RCP 1008
Iowa City, IA 52242
Phone: 319-631-4770
E-Mail: hhouse@acep.org

Current and Past Professional Position(s)
Professor, Emergency Medicine, University of Iowa, 2013 – present
Associate Professor, Emergency Medicine, University of Iowa, 2006 – 2013
Assistant Professor, Emergency Medicine, University of Iowa, 2002 – 2006
Vice Chair for Education, Department of Emergency Medicine, University of Iowa, 2007 – present
Interim Vice Chair for Research, Department of Emergency Medicine, University of Iowa, 2012 – 2015
Residency Program Director, University of Iowa Emergency Medicine Residency, 2003 - 2012

Education (include internships and residency information)
MA, Academic Medicine, University of Southern California: 2011
DTMH, London School of Tropical Medicine and Hygiene: 2001
MD, University of Southern California: 1997
BS, Marine Biology, University of Southern California: 1993

Combined Internal Medicine- Emergency Medicine residency, UCLA -Olive View Medical Centers, 1997-2002

Certifications
American Board of Emergency Medicine, 2003, recertified 2013
American Board of Internal Medicine, 2002, recertified 2012

Professional Societies
American College of Emergency Physicians
American Medical Association
Iowa Chapter of the American College of Emergency Physicians
Iowa Medical Society
Society of Academic Emergency Physicians
Council of Residency Directors

National ACEP Activities – List your most significant accomplishments
Member, ACEP Board of Directors, 2011 – present
Emergency Medicine Foundation (EMF), Chair, 2017
EMF Board of Trustees, 2015 – present
Chair, Residency Visit Task Force, 2013 – 14
Chair, Aging Physician Task Force, 2017
Section Chair, Medical Humanities, 2008 - 11
Newsletter Editor, Medical Humanities (won Section Newsletter Award of Distinction, 2008)
Awarded best poster from Young Physicians Section for poster documenting the increase in the length of ED stays for psychiatric patients at Leadership and Advocacy Conference, 2014
ACEP Liaison to the Federation of State Medical Boards, 2013 – present
ACEP Liaison to the American Association of Emergency Nurse Practitioners, 2014 – present
ACEP Liaison to the American Association of Women Emergency Physicians, 2015 - 2016
Sections Task Force / Subcommittee, 2014 - present
Maintenance of Licensure Task Force, 2014
Rural Education Program Task Force, 2014
Procedural Sedation Task Force, 2010 - 11
Summit of Emergency Medicine, 2010
Board liaison to the Academic Affairs, Research, and Membership Committees
Board liaison to the Dual Training and Medical Humanities Sections

ACEP Chapter Activities – List your most significant accomplishments
President, Iowa chapter of ACEP, 2006 – 09
Secretary-Treasurer, Iowa ACEP, 2004 - 2006

Practice Profile
Total hours devoted to emergency medicine practice per year: 1840 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 35 % Research 10 % Teaching 20 % Administration 35 %
Other: %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
University employee in a teaching hospital

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 4 Cases Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Hans R. House, MD, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: University of Iowa
   Address: 200 Hawkins Drive, RCP 1008
             Iowa City, IA 52242
   Position Held: Professor, Vice Chair for Education in Department of Emergency Medicine
   Type of Organization: University

   Employer: Code3 Emergency Room
   Address: 4228 N. Josey Lane, Suite 100
             Carrollton, TX 75010
   Position Held: Emergency Physician, part-time independent contractor
   Type of Organization: Freestanding Emergency Center and Urgent Care

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: American College of Emergency Physicians
   Address: 1125 Executive Cir, Irving, TX 75038
   Type of Organization: Healthcare association, non-profit
   Duration on the Board: 2011 - present

   Organization: Emergency Medicine Foundation
   Address: 1125 Executive Cir, Irving, TX 75038
   Type of Organization: Healthcare charity
   Duration on the Board: 2015 - present
Organization: Iowa Chapter of the American College of Emergency Physicians  
Address: PO Box 1408  
Waterloo, IA 50704  
Type of Organization: Healthcare association  
Duration on the Board: 2003 - 2008

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE  
☐ If YES, Please Describe Below:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE  
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE  
☐ If YES, Please Describe: I own 1% in the Code3 Dallas-Ft Worth Airport development, a freestanding ED on the airport property and an urgent care clinic inside Terminal D.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE  
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☐ NO  
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Hans House, MD, FACEP  
Date  
July 20, 2017
September 1, 2017

Dear Members,

The Iowa Chapter of ACEP is pleased to enthusiastically endorse Dr. Hans House’s candidacy for President-elect of ACEP. With extensive organizational experience, genuine passion for improving patient care, and a bold vision for the future of ACEP, Dr. House is uniquely suited to lead our organization during a crucial period.

Dr. House has a long history of service to ACEP. Soon after moving to Iowa to begin the state’s first emergency medicine (EM) training program, Dr. House was elected President of Iowa ACEP. Three years after that, he was elected to the ACEP Board of Directors, a position he continues to hold today. After serving as an award-winning Editor for ACEP’s Medical Humanities Section Newsletter, Dr. House was elected Chair of the Section. Currently, he serves as the Chair of the Emergency Medicine Foundation. This consistent pattern of excellence and growth in leadership is a testament to Dr. House’s dedication and efficacy in organized medicine.

The Iowa Chapter of ACEP has encouraged Dr. House to adopt his chosen goals for his candidacy: access to care for our patients and relief from burnout for our members. Access to care is a major issue in a rural state like Iowa. ACEP is fortunate to have a dedicated leader like Dr. House to advocate for unique problems faced by rural emergency departments. He understands the needs of rural patients and providers better than anyone we know.

ACEP needs a leader with robust organizational experience, passion for patient care, and courage to tackle the toughest challenges emergency physicians face today. Iowa ACEP fully supports Dr. Hans House as the candidate who best exemplifies these qualities, and we are extremely pleased to endorse his candidacy.

Sincerely,

[Signature]

Ryan Dowden, MD, FACEP
President, Iowa ACEP
Hans R. House, MD, FACEP

Dear ACEP Councillors,

It is my honor to take this opportunity to introduce myself as a candidate for President-Elect and describe my vision for the future of ACEP. Under my leadership, I would have ACEP focus on two critical goals:

1) Ensure access to care for our patients.
2) Relief from burnout for our members.

ACEP’s mission statement states that we promote high quality emergency care and are the leading advocate for our physicians, our patients, and the public. Advocating for access to care for our patients is a goal that everyone in the College can support. Patients should not be deterred from the ED by violations of the Prudent Layperson standard. High deductible plans shock patients with their surprise lack of coverage and saddle them with impossible debt. Inadequate access to mental health care has directly lead to the repugnant epidemic of psychiatric boarding in our ED’s. The Affordable Care Act is hardly perfect, but I believe it should be improved, not scrapped altogether.

As president, I will focus on reducing burnout in our members by addressing system changes in our workplace. As work environments, emergency departments are dangerously prone to normalizing conditions that radically deviate from what is acceptable. The constant frustrations generated by enduring the sense of powerlessness and dysfunction in today’s healthcare system are cutting short the careers of brilliant and caring physicians. No amount of yoga and meditation is going to cure burnout unless the underlying system frustrations are addressed.

As president, I would direct ACEP to aggressively target system changes, even on a local level. Important drivers of burnout that I would address include the boarding of inpatients (especially mental health patients), merit badge requirements for hospital credentialing, improving the Maintenance of Certification process, and encouraging stability in hospital contracts. Furthermore, our members can maximize control over their workplace by owning it themselves, including opening Freestanding Emergency Centers. These centers revive career satisfaction, provide ideal access to care for patients, and bring sorely needed disruptive change to an entrenched and dysfunctional system.

My experience gives me the insight to lead ACEP while upholding the best interests of our entire, diverse membership. As the Chair of the Emergency Medicine Foundation (EMF), I frequently engage donors to honor the history and development of Emergency Medicine, while creating a shared vision for the future growth of the specialty. As an academic leader from a small group practice at a university hospital, I understand the challenges faced by independent groups in the EM marketplace. As an educator, I understand the needs of residents and medical students who are learning about our specialty and the needs of young physicians beginning their careers. As a representative from a rural state, I know that many of our patients are cared for by non-board certified physicians and advanced practice providers. And as a co-owner of a freestanding emergency department, I appreciate new models of care that prolong careers and provide outstanding service to patients.

By working collectively and speaking with one voice, we can ensure the best possible care for our patients, and ensure the security and longevity of our member’s careers. I ask for your vote for ACEP President, so I can make emergency medicine better for our College, for our patients, and for ourselves.

Hans House, MD, MACM, FACEP
MY GOALS

Access to care for our patients
Relief from burnout for our members

ACEP EXPERIENCE

ACEP Board of Directors
Chair, Emergency Medicine Foundation
Iowa ACEP State Chapter President
Medical Humanities Section Chair
ACEP Liaison to Federation of State Medical Boards
ACEP Liaison to the American Academy of Emergency Medicine Nurse Practitioners
Chair, Residency Visit Task Force
Rural Education Program Task Force
Board Liaison to Academic Affairs and Membership Committees

Academic and Independent

HANS HOUSE
Candidate for President-Elect
2017 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

William P. Jaquis, MD, FACEP

**Question #1: Given the uncertainty of the AHCA (ACA replacement) what are the fundamental tenets that need to be included that supports members and patients?**

Regardless of the details of any legislative action, there are three concepts that need to be at the forefront. The first is that access to emergency care be a key part of any law. This concept is not new – prudent layperson law has been a component of federal legislation and is also covered in legislation in most states. In the Patient Protection and Affordable Care Act, emergency services were established as essential health services. Despite that, we have seen the payers methodically and progressively challenge the law, and they continue to get more creative. The leadership of ACEP has kept this issue in the forefront, with legislative, regulatory, and media attention at both the federal and state levels, but there is no doubt this will continue to be a key issue. The work of the Reimbursement and State Legislative Committees, the Joint Task Force with the ED Practice Management Association, the newly chartered Physicians for Fair Coverage, the Emergency Medicine Action Fund, and the consensus building with other specialties leading to an AMA resolution show our resolve. Not only must these efforts continue, but we must find additional opportunities to address these battles. A fundamental part of our care system is the service only the ED provides, and our patients expect that high level of care to be there when it is most needed. They need the peace of mind that they will not suffer financial difficulty in an emergency because their “plans” have failed to plan.

The second tenet is the presence of universal coverage. In the ED, we have the privilege and the challenge of being the site that is often the first choice with an acute need but the last option for many who have no access. The impact of the ACA can be debated on many levels, but it did transition a significant number of patients from uninsured with no access to at least having some form of coverage. Whether you view health care as a right or a privilege, our country and its significant resources should be able to find a way to provide a basic level of health care, including emergency care, to all of its citizens. We can point to every other industrialized nation as examples that have provided care for all, yet we consume more of our national revenue without very good results. Our national leaders must show the necessary resolve to find a solution, and we have a unique platform from which we can help them.

The third component of any new law or regulation is the fair treatment of our members. Despite federal law requiring our ED physicians to see all patients as we provide care every hour of every day, this mandate is unfunded. In addition, the continued threat of legal action in many if not most of the areas we practice creates a very difficult practice environment. Again, federal law has established a means to get to fair payment, but has not developed a system to enforce fair payment. The action of the CMS through the Center for Consumer Information and Insurance Oversight (CCIIO) has made this worse and not better. Payment reform and liability reform must be a component of law and regulation that is audited and enforced.

In addition to those three concepts, I would add a personal request – be more innovative. Especially in emergency medicine, we have a wealth of creative people who find a way, but the path to better care and a lower cost is often fraught with regulatory and legislative barriers.

**Question #2: Given the differing viewpoints of ACEP members, how will you ensure that all voices within emergency medicine are represented before a national audience?**

The beauty of our democracy is best demonstrated in the diversity it represents and when all of its communities can be expressed. Having experienced many years of the ACEP Council, visited many Chapters, worked with Committees, Sections and Task Forces, and worked with numerous providers over 25 years, our College is a good representation of society. I continue to be educated by the breadth of opinions and experiences of our members. As with any important principle, the first action is often no action but to listen. I hope that many of you who have worked with me with attest to my ability to involve and solicit the views of the individuals. I understand also the need for critics. I have learned a lot from those who are willing to swim upstream and provide important dialogue on a topic that I might not have considered. I was intrigued a few years ago to read about the “tenth man rule” attributed to the Israeli leadership. The tenth man was chartered to provide the opposing opinion what all others were in agreement. Whether true or fictional, the concept is importance in
considering all important decisions.

Having said that, listening is not enough. We must continue a purposeful effort to be inclusive in hearing “all voices.” Fortunately our Committee and Section structure do give us a point of reference for many of our members’ interests. As President I will rely on that structure to continue to provide expertise related to our collective experiences. In addition, should the need arise, I will work with the ACEP team to address a new consideration quickly. Our newly appointed Diversity and Inclusion Task Force is a good example of creating a purposeful project to a concern that needs to be improved. I look forward to their work as well. I also appreciate the push to find new pathways to leadership. Not only does it show engagement, but we must continually assess how to keep the College vibrant and relevant.

Finally, I understand that despite all of the above efforts that decisions must be made and outcomes achieved even when some will disagree. To achieve the agenda and plan of the College, at times a direction is absolutely needed without 100% agreement. As a leader, it has been and will continue to be part of the role of leadership to move the work of the College and the needs of our members and our patients forward. While I certainly want to hear the voice of the critic, there is at times a need for the greater good. This is particularly important as we face the many foes outside our family, and that we maintain a unified message on the clearly important matters.

**Question #3:** How has the role of ACEP President evolved over the past 5 years and how will your abilities help in that role? What will you do as President to ensure that your initiatives meet member needs?

The past five years have brought significant change in health policy, market consolidation and the role of social media to emergency medicine (EM). The role of the President has changed to meet those needs in two major areas. First, responding promptly to issues that would dramatically alter care is paramount and teams led by the Presidents have adjusted accordingly. Failure to address prudent layperson and fair coverage issues would otherwise lead to broad-based changes to access to care. Second, many of the current issues occur at a state level, and the Presidency has needed to assist those states with national resources to mitigate state-based regulatory and legislative challenges.

My 25 years of EM experience has been clinical and in leadership. At the local level, leading four different departments in two states has advanced my ability to listen, learn, and move forward to outcomes. At the national level, my broad-based experience in ACEPs many Committees, Sections, and Task Forces has engaged a wide range of members, and I have both learned from them and established relationships that will assist me in the Presidency. My learning has also been formal as I work through a degree in Health Care Quality and Safety. Listening and learning are the tools that will help me regardless of what the needs are.

As President, my initiatives are those of the members, expressed individually, through the Chapters, and through the Council. My experience through both the departments locally and the work with ACEP leaves me with a good understanding which key areas of EM need to be addressed. My ability to engage the many experts I have met, and to develop new thought leaders, will help me new challenges. I look forward to the opportunity to serve as your President.
CANDIDATE DATA SHEET

William P. Jaquis, MD, FACEP

Contact Information
1216 S Bouldin St
Baltimore, MD 21224
Phone: 410-300-7242
E-Mail: wjaquis@acep.org

Current and Past Professional Position(s)
Chief of Emergency Services, LifeBridge Health 16 years
(As of September 1 my position will be Senior Vice President, East Florida Division, Envision Health)

Medical Director, St. James Hospital, Chicago Heights, IL

Interim Medical Director, Holy Cross Hospital, Chicago, IL

Education (include internships and residency information)
Emergency Medicine Residency, Case Western-Mt. Sinai Medical Center, Cleveland Ohio

MD – Medical College of Ohio (now Toledo College of Medicine), Toledo, OH, 1989

Certifications
Board Certified in EM (ABEM) through 2025

Professional Societies
ACEP
AMA
Maryland Chapter - ACEP

National ACEP Activities – List your most significant accomplishments
Vice President, ACEP – current
Secretary-Treasurer, ACEP
ACEP Board of Directors
Currently Board liaison to
  Alternative Payment Model Task Force
  Bylaws Committee
  Emergency Medicine Residents Association
  Joint Task Force for Reimbursement (Out-of-Network and Balance Billing, Medicaid)
  National Chapter Relations Committee
  Single Payer Task Force
ACEP Chapter Activities – List your most significant accomplishments

Immediate Past President, Maryland ACEP

Practice Profile

Total hours devoted to emergency medicine practice per year: 2000 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 35% Research ____% Teaching 5% Administration 60%

Other: ________________________________ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Employed by national group (EmCare) working as the Chief of Emergency Services for two Departments. The main campus is an urban teaching hospital with comprehensive service lines. The second hospital is a community hospital.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases Plaintiff Expert 0 Cases
# CANDIDATE DISCLOSURE STATEMENT

**William P. Jaquis, MD, FACEP**

## 1. Employment – *List current employers with addresses, position held and type of organization.*

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>EmCare – LifeBridge Health</td>
<td>100 Witmer Ave Suite 220</td>
<td>Chief Emergency Services</td>
<td>Physician practice management</td>
</tr>
<tr>
<td>Envision (as of Sept 1)</td>
<td>18167 US Highway 19 N Suite 650</td>
<td>Senior Vice President</td>
<td>Physician practice management</td>
</tr>
</tbody>
</table>

## 2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Type of Organization</th>
<th>Duration on the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEP</td>
<td>4950 Royal Lane</td>
<td>Specialty society</td>
<td>5 years</td>
</tr>
<tr>
<td>Maryland Chapter ACEP</td>
<td></td>
<td>Specialty society</td>
<td>6 years</td>
</tr>
</tbody>
</table>
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

As above – EmCare/Envision

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

As above – EmCare/Envision

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

William Jaquis		Date		July 15, 2017
Members of the Council,

The Maryland Chapter of the American College of Emergency Physicians enthusiastically supports the candidacy of Dr. William Jaquis for President-Elect. We firmly confidently believe that the leadership he has shown during the past 25 years on the local, state, and national levels have prepared him well to serve as the leader of ACEP.

Bill’s commitment begins at the local level. His 25 years of clinical work have included a leadership commitment for most of that time as well. For 16 years he served as the Chief of Emergency Services for LifeBridge Health, a growing health care network in the Baltimore area. In that role, he integrated the ED with comprehensive service lines and clinical initiatives, including education, trauma, stroke, and cardiac programs.

At the local chapter level, he has been an active participant with the Maryland team through his 16 years in Maryland. His input into our committee structure has continued throughout this time despite his many other activities. He served on our Board for two terms, and has held every officer position culminating in the Presidency. During that time, he also extended his leadership to the Maryland community through other volunteer service. He was appointed by the Governor to be a Commissioner on the Community Health Resources Commission, looking for ways to direct state grant activities to the underserved people and communities in Maryland.

Likely, you are more aware of the governance Bill has shown at the national level from committee member to committee Chair then to the Board of Directors. As a member of the Board, he has guided the work of multiple committees, sections, and task forces. He was elected by his peers to be the Secretary-Treasurer and currently the Vice President of ACEP. He continues to lead on many topics that are key to the continued ability of our members to practice effectively, including the issues of balance billing and payment models. His experience in Maryland has also given him experience on the integration of the ED into Population Health.

In summary, both personally and as the current President of Maryland ACEP, I strongly recommend that you consider electing Bill to be the next President-Elect of ACEP.

Respectfully,

Drew White, MD, FACEP
Maryland ACEP President
“The only thing that is constant is change”. Given the nearly constant evolution of health care, we must be prepared to be a specialty that continues to adapt our model of care to meet the needs of a changing system. In cases, we will need to react quickly to threats and opportunities. In other ways we must look to define our role in ways only we can understand given our unique position in health care. Currently, the connection is tenuous between acute, episodic care and chronic care. The challenge and the opportunity in that void is where emergency physicians have always led, and we must continue to develop that model for the near future.

As I have grown with all of you for the past two decades, the ability of emergency medicine to adapt quickly has become more clear. The details may change, but we are at the forefront of developing skills and teams to deliver high quality care to whomever needs it at any time. While many of those in medicine and policy debate, we act. Our members have not only led at the highest levels of medicine, but at the bedside in creating better options for care. We adapt our practices to an opioid crisis while others are still deciding whether it exists. We define what the true measures of quality are while others study. And, we develop care models that bring teams together to figure out how to navigate the local system in order to get the best care in the most timely and cost effective way. Working in Maryland for the last 16 years, I have helped to define and develop systems of health that define the health of populations. Those experiences have brought all of us again to the forefront of the health care system by having to meet the needs of the patients where they are actually receiving care.

Given those opportunities, we are certainly not without challenges. To provide the best and most cost effective care, the connection between access and coverage must be strong. While we continue to develop new care processes, the ability of our patients to be adequately covered for that care has fluctuated greatly. High deductible plans, variability in Medicaid expansion, and the exchanges through PPACA have challenged the question of access versus coverage, and nowhere is that felt more than in the acute care realm. The balance billing and out-of-network discussion is occurring in almost every state, and EM is caught in the middle. Our resources in ACEP have expanded greatly in this area. I have been fortunate to represent the Board in the Joint Task Force on Reimbursement as we meet these challenges. We have had some successes in this area, but we continue to fight entities with far more financial power, and the efforts on our behalf must continue.

As I look across my history with ACEP, especially with the experience I have had on the Board, I know we can meet these challenges. I am constantly amazed by the dedication and passion that each of you exhibit and represent. Another desire, possibly a mandate, that I feel as a leader is to continue to develop the leaders that are engaged in our mission. The challenges of today are likely to continue, and new ones will be defined. We need experienced, passionate leaders to meet those needs. As a leader I will continue to find ways to create an inclusive College that has the knowledge and skills to be leaders in our communities. Thank you for the opportunity and for your vote.
WILLIAM JAQUIS, MD, FAC EP

CANDIDATE
• PRESIDENT ELECT

THE FUTURE IS NOW

Protect our Mission
Enhance our Value
Build our Bench

Experienced Leader

❖ Vice President ACEP
❖ Secretary Treasurer ACEP
❖ Past President Maryland ACEP
❖ Board Liaison
  Reimbursement Task Force
  APM Task Force
❖ Past EM Practice Chair
❖ Chief of Service 16 years
❖ EM Clinician 25 years
Question #1: Given the uncertainty of the AHCA (ACA replacement) what are the fundamental tenets that need to be included that supports members and patients?

The cacophony of chaos and confusion from Congress over reforms to the Patient Protection and Affordable Care Act (PPACA) are not only disheartening but reveal underlying Congressional dysfunction, and dereliction of its duty to the American public. From the beginning, during the debate over PPACA itself and ever since, ACEP has focused on principles not politics.

Our principles remain as they always have, focused on patients, protecting patients, and we must continue steadfast in that regard. It is not the Affordable Care Act it is the Patient Protection and Affordable Care Act. We must not dismiss the patient protections and focus only on affordability, nor on cost controls.

No matter what happens - repeal, replace, reform, revise - we must advocate for, and insist upon the following:

1. Emergency care as an essential covered benefit
2. No prior approvals for emergency care
3. Uphold the prudent layperson standard
4. Maintain the greatest of three rule

Any legislation or regulation that does not include these patient protections is inadequate, fails America, is unacceptable, and will require our opposition. However, the debate over healthcare does give us an opportunity to seek further clarity on these patient protections. This is particularly true for prudent layperson, and the greatest of three rule.

Currently insurance plans are attacking prudent layperson and implementing reimbursement strategies based on final diagnosis. This clearly violates the intent, if not the letter of the law. Stronger language, and that which clarifies this standard are necessary to protect patients and prevent insurance plan misbehavior.

Congress, in its wisdom, added the greatest of three rule because they knew that they had to include provisions to pay fairly for the care patients receive, for the care mandated by EMTALA. Again insurance plans are manipulating one of the three provisions, namely that regarding usual and customary reimbursement. The phrase usual and customary lacks a clear definition and insurance plans have used this to their advantage. This lack of clarity is the basis for the current legislative flurry over balance billing and out of network concerns. As changes to current healthcare law are being debated, we must seize this opportunity to clarify the term usual and customary, and do so in a way that pays fairly based on a rational and reasonable standard such as Fair Health.

Tort reform is another potential new opportunity, and we should welcome any effort to address this at a federal level. However, we cannot insist on this if it would endanger ensuring legislative clarity on the other patient protections.

Question #2: Given the differing viewpoints of ACEP members, how will you ensure that all voices within emergency medicine are represented before a national audience?

Emergency medicine and ACEP itself began when a handful, a minority, of physicians had a unique vision and acted upon it. Initially ridiculed and vilified, their vision has not only become a reality, it has garnered the respect of patients and other physicians. Minority opinion deserves our respect and I will ensure it is not only heard, but is seriously considered. We must consider all views, so we will make the right decisions, we will do the right thing. And if those minority ideas are right, then we must have the courage to do them, to say them, and not merely do or say what is popular or politically correct.

This past year as Chair of the Board, I have consistently sought out minority opinion, and as your President I will continue to do so. I will not passively wait for those ideas and opinions to present themselves, but actively ask for them. Though all
voices must be heard within the College, to the outside world we must speak as one, with clarity and conviction. The President is our spokesperson, and speaks not from their personal opinions or convictions, but from the policies and positions of the College as established by the Council, or the Board. As your President, that is exactly what I will do.

**Question #3: How has the role of ACEP President evolved over the past 5 years and how will your abilities help in that role? What will you do as President to ensure that your initiatives meet member needs?**

(As submitted to ACEPNow in July 2017)

**How has the role of ACEP President evolved over the past 5 years and how will your abilities help in that role?**

The President’s primary duty is to speak for the College. The other main responsibility is to organize the work of our Committees and appoint a Task Force when needed. It has been so since the founding of the College. What has changed, especially recently, is the scope of these duties.

The issues, problems, and unexpected crises that arise over a President’s term have expanded both in number and complexity. Often requiring a rapid response. In addition, the number of Committees and work of the College has grown exponentially. Being President requires constant attention and action.

My ability to speak, to persuade, and to inspire, as well as my skills at organizing and directing the work of others, should be self-evident, by my service in multiple positions of leadership – as a member of the ACEP Board, Chair of the ACEP Board, EMF Chair, Chapter President, Delegate to the Medical Association of Georgia, and multiple terms as the President of the Medical Staff of my hospital. These are skills for which I am known, and can only be confirmed by those who have witnessed them.

**What will you do as President to ensure that your initiatives meet member needs?**

The President’s initiatives should match the concerns expressed by our members, the Council, and our Strategic Plan, as established by the Board. Wisdom is not always found in the majority. It is often first revealed by the minority, and has always been so. Thus the importance of listening to, and seeking out their opinions.

Our Committees, or a Task Force does the majority of the work of the College. Both serve at the direction of the President. It is the President who appoints its members, and establishes its objectives. Not only understanding what is needed but why, is essential to properly organize this work, with clear and specific goals and expectations.
Contact Information
Address: 10673 Estes Road, Macon, GA 31210
Phone: 478-342-2805
E-Mail: johnrogersmd@bellsouth.net

Current and Past Professional Position(s)
Current:
Co – Medical Director at Coliseum Northside Hospital, Macon, GA
Staff ED Physician at four locations in the central Georgia area

Past:
ED Medical Director, Monroe County Hospital, Forsyth, GA
Interim Co – Medical Director, Fairview Park Hospital, Dublin, GA
Interim ED Medical Director, Peach County Hospital, Fort Valley, GA
Co – Medical Director, Coliseum Medical Center, Macon, GA
Faculty and Clerkship Director, Mercer University School of Medicine
EMS Medical Director, Monroe County Georgia
Member of the Georgia Regional Trauma Advisory Committee

Education (include internships and residency information)
Undergraduate Studies, Ohio University, Athens Ohio
Bachelor of Arts, Augustana College, Rock Island Illinois
Medical Degree from the University of Iowa, Iowa City Iowa
Internship, University of Iowa, Iowa City Iowa
Residency, Medical Center of Central Georgia, Macon GA (now Mercer University)

Certifications
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Advanced Trauma Life Support
American College of Surgeons in 1986, 1995
American Association for Physician Leadership

Professional Societies
American College of Emergency Physicians - Fellow
American College of Surgeons - Fellow
Georgia College of Emergency Physicians
Society of Academic Emergency Physicians
American Medical Association
Medical Association of Georgia
Bibb County Medical Society
American Association for Physician Leadership
Wiegenstein Legacy Society
Will C Sealy Surgical Society

**National ACEP Activities – List your most significant accomplishments**

ACEP BOD
ACEP Secretary – Treasurer
ACEP Vice President
ACEP Chair of Board
EMF BOT and served as its Chair
Coalition Opposed to Medical Merit Badges – ACEP Representative
Sepsis Expert Panel
Rural TF Chair
Rural Section Chair
EM Telemedicine Section - Founder
Workforce Section Chair
Firearms Policy TF
Choosing Wisely Delphi Panel
Member of the following Committees: Bylaws, National Chapter Relations
Liaison to the American Geriatric Society – American College of Surgeons Committee on Geriatric Trauma
Associate Membership TF
Section Grant TF
Council Reference Committee Chair
Membership TF
Awards Committee
ACEP Representative to The Future of Emergency Medicine Summit
Reviewer for The Annals of Emergency Medicine

Accomplishments:

1. Published the first annual financial report to members in ACEP Now
2. Revised EMF Bylaws to allow participation by members other than those appointed by the ACEP President, and will allow a non-ACEP BOD member to serve as Chair
3. Organized and directed the work of the Rural TF and presented its Report to the BOD
4. Was the initiator of the new EM Telemedicine Section
5. Changed the focus of the Certification Section to Workforce issues and changed its name to reflect this new direction
6. Helped to write ACEP’s current definition of an emergency physician
7. Helped to write ACEP’s current firearms policy
8. Participated in the Delphi panel that selected our Choosing Wisely recommendations
9. Participated in the selection of the sepsis quality measures for CEDR, the sepsis education programs, and the E-Qual initiative on sepsis (CMS Transforming Clinical Practice Initiative)
ACEP Chapter Activities – List your most significant accomplishments

Rewrote the Chapter Bylaws
Instituted a Leadership Development Program
Instituted an Awards Program
Developed Committees more fully
Re-organized the leadership of the PAC
Developed stronger affiliations with the Medical Association of Georgia
First to participate in the MAG Leadership Academy and then the Chapter began to sponsor a member each year
Grew membership to allow an additional Counsellor
Instituted Medical School SIG Visits
Revamped the Chapter’s quarterly newsletter
Helped to develop a joint annual conference with North Carolina and South Carolina
Participated in the development of an annual state ED Directors and Leaders Conference
Encouraged and promoted more participation in ACEP National Committees
Encouraged and promoted more participation at LAC
Helped in the fight against ban on balance billing
Helped to institute a rural education/outreach program
Initiated local quarterly meetings for emergency physicians in Middle Georgia

Practice Profile

Total hours devoted to emergency medicine practice per year: 2000 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

- Direct Patient Care 70%
- Research 0%
- Teaching 0%
- Administration 30%
- Other: ____________________________________________________________________________ __%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Independent contractor at 4 separate community hospital emergency departments. Employed as a Co-Medical Director, the duty is split 50/50 with another.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

- Defense Expert 0 Cases
- Plaintiff Expert 0 Cases
# CANDIDATE DISCLOSURE STATEMENT

**John J. Rogers, MD, CPE, FACEP**

1. **Employment** – *List current employers with addresses, position held and type of organization.*

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Health</td>
<td>265 Brookview Centre Way, Suite 400, Knoxville, Tennessee 37919</td>
<td>Staff Physician</td>
<td>Physician Staffing</td>
</tr>
<tr>
<td>EmCare</td>
<td>18167 US 19, Clearwater, Florida 33764</td>
<td>Staff Physician and Co - Medical Director</td>
<td>Physician Staffing</td>
</tr>
</tbody>
</table>

2. **Board of Directors Positions Held** – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

<table>
<thead>
<tr>
<th>Organization</th>
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<th>Type of Organization</th>
<th>Duration on the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Emergency Physicians</td>
<td>4950 West Royal Lane, Irving, Texas 75063</td>
<td>National specialty society</td>
<td>5 years and still serving</td>
</tr>
<tr>
<td>Emergency Medicine Foundation</td>
<td>4950 West Royal Lane, Irving, Texas 75063</td>
<td>Non-profit foundation to advance education and research</td>
<td>6 years but no longer serving</td>
</tr>
<tr>
<td>Organization</td>
<td>Address</td>
<td>Type of Organization</td>
<td>Duration on the Board</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Bibb County Medical Society</td>
<td>770 Pine Street, Suite 150, Macon, GA 31201</td>
<td>County medical society</td>
<td>3 years and currently serving</td>
</tr>
<tr>
<td>Coliseum Health System</td>
<td>350 Hospital Drive, Macon, GA 31217</td>
<td>Hospital system governing body</td>
<td>2 years but no longer serving</td>
</tr>
<tr>
<td>Physicians Institute for Excellence in Medicine</td>
<td>c/o The Medical Association of Georgia, 1849 The Exchange SE, Suite 200, Atlanta, GA 30339</td>
<td>Non-profit foundation to advance education and research</td>
<td>2 years but no longer serving</td>
</tr>
<tr>
<td>Georgia Medical Political Action Committee</td>
<td>c/o The Medical Association of Georgia, 1849 The Exchange SE, Suite 200, Atlanta, GA 30339</td>
<td>PAC for the Medical Association of Georgia</td>
<td>Two years and currently serving</td>
</tr>
<tr>
<td>Georgia College of Emergency Physicians</td>
<td>6134 Poplar Bluff Circle, Norcross, GA 30092</td>
<td>State specialty society</td>
<td>10 years but now serving as an Ex-Officio Member of the BOD</td>
</tr>
</tbody>
</table>
I hereby state that I, or members of my immediate family, have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe Below:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:
On occasion I give a presentation on intra-osseous vascular access and airway management for Teleflex. I do not believe this constitutes a conflict, but report it to allow an impartial and objective determination as noted at the top of this page.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John J. Rogers

Date 16 July 2017
Component Body Endorsement
John J. Rogers, MD, FACEP
Candidate for President-Elect

20 August 2017

Councillors:

The Board of Directors of the Georgia College of Emergency Physicians unanimously and heartily endorses Dr. John J. Rogers, MD, FACEP for President-Elect. Not only has John been an exceptional leader, he has been a strong voice for the Georgia Chapter, and for the specialty itself.

During his term on the Chapter Board and as our President, he led many initiatives that have had long lasting benefits. Our leadership development program was established, an award program implemented, our newsletter was improved, an outreach program for rural emergency physicians was established, regular medical school and residency visits were begun, and our membership grew by one-third.

As the first emergency physician in the Medical Association of Georgia’s Physician Leadership Development Program, he established firm relationships with MAG that have served the Chapter well. Now other emergency physicians have followed the same path.

We can think of no other candidate more suited to be our President, by temperament, diplomacy, vision, leadership, and ability to speak for us and to speak for the College.

Most sincerely,

Matt Keadey, MD, FACEP
President
Georgia College of Emergency Physicians
If you think things are as they should be
If you are pleased with patient satisfaction surveys
If you are content with contract turnovers
If you are not troubled by the lack of due process
If you agree that administrators should decide how you practice
Then we need to do nothing

But if you are like me
If you believe things can be better
If you believe patients deserve better
If you believe physicians should be in control of their profession
Then work with me to take back control

Our best long-term strategy
To protect patients
To allow physicians to flourish
To preserve our profession
Is physician leadership

Let us take back control
Let us lead
Let us create the future
That patients deserve and in which physicians will thrive
JOHN ROGERS, MD, FACEP
CANDIDATE FOR PRESIDENT-ELECT

PROVEN LEADERSHIP
Council Officer Candidates
2017 Council Officer Candidates

Speaker

John G. McManus, MD, MBA, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Vice-Speaker

Sabina A. Braithwaite, MD, MPH, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Andrea L. Green, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Gary R. Katz, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
Question #1: Discuss the similarities and differences in the skill sets of the Council Officers and Board of Directors. Describe your skills, background, knowledge, or unique abilities that will make you an effective Speaker or Vice Speaker.

After serving for over 15 years on the Council and the last two years as the vice speaker I have come to recognize that most of the Council possess leadership skill sets. The Board of Directors and Council officers are very collaborative in nature and possess the obvious characteristics of leaders. As elections occur, often the Council will place certain leadership traits higher than others to balance out opinion and promote diversity for society decision making. My own leadership background is diverse and unique in many ways. I’ve spent several years working in both medicine and the military for many great leaders and much to my surprise the leaders at most of my jobs did not fit commonly espoused theories of leadership. Although several of my previous leaders and mentors were charismatic, possessed a commanding presence, were visionary and educated at elite schools, the most successful of these were servant leaders. Over the past 2 decades as I have moved up in the leadership ranks, I have relied on being a servant leader as one of my most prized qualities to build consensus, motivate colleagues and peers as well as mentor future medical providers off and on the battlefield. A servant leader is one who leads by example and is people-centric. This leader is valued service to others and believes they have a duty of stewardship. I tend to be a humble, but passionate operator in my organizations who believes every member should be treated with equal respect and their opinions valued. These qualities of servant leadership have served me well and will be ideal to aid in running a successful Council. To be able to devote myself to serving the needs of the individual councillor allows me to focus on meeting the needs of the Council itself. This leadership skill helps develop individual members to bring out the best in themselves and encourages self-expression, facilitates personal growth and builds a sense of community and joint ownership. Servant leaders are felt to be effective because the needs of followers are so looked after that they reach their full potential, hence perform at their best. I really look at this leadership trait as working for the Council, rather than leading it per se. The strength of this way of looking at leadership is that it forces one away from self-serving, domineering leadership and makes one who is leading think harder about how to respect, value and motivate people working with them. I look forward to the potential opportunity to serve the Council in this capacity.

Question #2: Describe how you would manage a controversial issue in the Council with split opinions about that issue.

In the past, the ACEP Council has often been quick to refer to the Board resolutions and issues that have often been controversial or that have equal opposing views. Recently, the Council has been more efficient and decisive in rendering guidance to our board through consensus. The leadership has been more effective with earlier dissemination and editing of resolutions prior to reference committee debate and editing. Use of experts, ACEP committees and staffers has allowed more concise resolutions to be submitted and debated. Furthermore, the reference committees have improved in clarifying most of the controversial issues and wording within a resolution before it is presented to the entire Council. As the potential speaker, I will improve on this process as well as ensure fair and impartial oversight and debate on controversial or split opinion resolutions. Most of these types of resolutions that seem to not achieve consensus often could have been prevented with improved preparation and discussion prior to floor presentation. I would improve the ability of our Council to debate and edit resolutions prior to reference committee work. As the potential Speaker, I will ensure fair and thorough debate, particularly with these types of resolutions.

Question #3: Provide an example of how the Board and Council may not share the same view on an issue and how you would navigate through that challenge.

Our ACEP societal leadership is set up much like a corporation with an elected Board and a Council, which mimics the shareholders. Sometimes shareholders lack information or are even are misinformed on matters on which the Board is better informed. The catch in organizational decision making is that shareholders need to be able to recognize their blind spots and the extent of the Board’s private information. The ACEP speaker is much like the shareholder president and presides over the
Council business and attends board of director’s meetings with the ability to address matters of discussion. Although not frequent, the ACEP Council and board have had previous disagreements on certain resolutions and policies. Despite such rare conflict, both entities advocate the ACEP mission of supporting quality emergency medical care and promoting the interests of emergency physicians. The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions and other actions or appropriations enacted by the Council. As speaker, one’s duty is to guide the Council agenda with knowledge of both previous and current board opinion on the matters at hand. The speaker is the key to building consensus between these two entities as the Council leader when possible differences of opinion arise. An example of such a conflict would be to create an associate membership category for allied emergency medical professionals. Because this type of category had existed in the past and had previous board action, it would be necessary to understand the complete history and reasons why such a category had been established and then abolished. As speaker one would have to understand the previous and current boards opinion on the matter as this resolution went through reference committee and then through debate. The speaker needs to ensure that the Council is not ill informed or is overconfident in their ability to understand issues involved in a decision. Often, conflict can be mitigated with early wordsmithing and consensus building prior to an unfavorable resolution reaching the Board. The speaker needs to be directly involved in Board matters and must possess the reasoning behind current opinion which can aid in the Council crafting a more favorable, agreed upon resolution. One of the biggest challenge as speaker during a conflict between the Council and the Board is developing that ability to eloquently present a neutral, but informed position to each entity. A well-versed speaker will be able to have favorable relationships with both the Council and the Board to help mitigate such conflict as well as prevent wasted effort on resolutions that potentially have no chance of reaching consensus by one of the entities.
CANDIDATE DATA SHEET

John G. McManus Jr., MD, MBA, FACEP

Contact Information
1071 Peninsula Crossing, Evans, GA 30809
Phone: 210-240-6995
E-Mail: docmcmans@hotmail.com

Current and Past Professional Position(s)
- EMS FELLOWSHIP DIRECTOR AND PROFESSOR OF EMERGENCY MEDICINE
  Georgia Regents University (2013 - Present)
- RETIRED COLONEL JULY 1, 2012 FROM U.S.ARMY
- OFFICER IN CHARGE (CMO) OF 47TH COMBAT SUPPORT HOSPITAL IN IRAQ 2011 AUG-DEC
- EMS/EMERGENCY MEDICINE CONSULTANT TO SURGEON GENERAL IRAQ 2011 AUG-DEC
- DIRECTOR, US ARMY EMS (EQUIVALENT TO ASSOCIATE DEAN)
- EMS FELLOWSHIP DIRECTOR
- CLINICAL ASSOCIATE PROFESSOR
  Department of Surgery and Emergency Medicine, University Of Texas Health Science Center San Antonio (2006-11)
- DIRECTOR, U.S. ARMY CENTER OF PRE-DEPLOYMENT MEDICINE (EQUIVALENT TO ASSOCIATE DEAN)
  U.S. Army Medical Department Center and School, Fort Sam Houston, Texas (2008-2010)
- ASSISTANT CHIEF, ACADEMIC AFFAIRS: DEPARTMENT OF EMERGENCY MEDICINE
  Brooke Army Medical Center, Fort Sam Houston, Texas (2007-08)
- COMBAT EMERGENCY MEDICAL PHYSICIAN
  28th Combat Support Hospital Mosul, Iraq (June – October 2007)
- CLINICAL INVESTIGATOR, TACTICAL COMBAT CASUALTY CARE;
  TEACHING FACULTY FOR DEPARTMENT OF EMERGENCY MEDICINE
  U.S. Army Institute of Surgical Research and Brooke Army Medical Center, San Antonio, Texas (2004-2007)
- TRANSITIONAL PROGRAM DIRECTOR
- ASSOCIATE PROGRAM DIRECTOR EMERGENCY MEDICINE RESIDENCY PROGRAM
  Darnall Army Community Hospital, Ft. Hood, TX (2001-2002)
- RESEARCH DIRECTOR EMERGENCY MEDICINE RESIDENCY PROGRAM AND IRB LIAISON
  Darnall Army Community Hospital, Ft. Hood, TX (2000-02)
- CHIEF RESIDENT EMERGENCY MEDICINE
  Ft. Lewis, WA (1998-1999)
- OFFICER IN CHARGE OF TUZLA MAIN MEDICAL CLINIC, OPERATION JOINT ENDEAVOR
  123rd MSB, Tuzla, Bosnia, (Dec 95- June 1996)

Education (include internships and residency information)
- TRANSITIONAL INTERNSHIP
  Eisenhower Army Med Center, Augusta, Ga (1992-1993)
- CHIEF RESIDENT EMERGENCY MEDICINE
  Ft. Lewis, WA (1998-1999)
- MASTERS OF BUSINESS ADMINISTRATION
  Brenau College of Georgia (2012)
- MASTERS OF CLINICAL RESEARCH
  Oregon Health and Sciences University (2004)

MD 1992 Medical College of Georgia 1992
Certifications
- ABEM 2000/2010
- Current Medical License State of Texas (#K9124) / Georgia (#37620)
- Current Instructor of ACLS, PALS, and ABLS
- Current instructor for Tactical Combat Casualty Care, BLS, AHLS, and ATLS Provider

Professional Societies
International:
- Planning and Committee member for the Targeted Area Program of “Golden Hour” for the 15th World Congress on Disaster and Emergency Medicine Amsterdam (2005-2006)

National:
- American College of Emergency Medicine Physicians (ACEP) (1996-present)
- National Association of EMS Physicians (NAEMSP) (2002-present)
  - Board of Directors x 2 elections

National ACEP Activities – List your most significant accomplishments
- Disaster Preparedness & Response Committee member (2006-2012)
- Steering Committee member (2009-11)
- Reference Committee (2008-09)
- Tellers Committee member (2005-08)
- EMS Committee member (2005-08)
- Tactical Emergency Medical Section (2003-present)
- Disaster Section member (2003-present)
- DHS Grant to ACEP Disaster Preparedness – site surveyor and panel member (2006-present)
- “Annals of Emergency Medicine” Editor in Chief Task Force (summer 2006)
- Liaison to the Committee on Trauma (2008-present)
- Chair ACEP sponsored Assistant Secretary for Preparedness and Response (ASPR) Fellowship selection
- Proposed and spoke at several national and chapter meetings

ACEP Chapter Activities – List your most significant accomplishments
- Government Services Chapter ACEP (GSACEP) member 1996-present
  - President (2006-07)
  - Sec/Treasurer (2003-05) and Councilor (2003-present)
  - Chair of annual meeting (2002-6)
  - Chair EMS and Research committees variable years
  - Received highest award

Practice Profile
Total hours devoted to emergency medicine practice per year: # hrs Total Hours/Year
Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care  50 %  Research  10 %  Teaching  20 %  Administration  20 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
Academic center – serve as Professor and EMS Fellowship Director, Georgia Regents University, Augusta, GA.

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.
Defense Expert  2 Cases
Plaintiff Expert  Cases
CANDIDATE DISCLOSURE STATEMENT

John G. McManus, Jr., MD, MBA, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: Georgia Regents University
   Address: 15th Street
   Augusta GA 30912
   Position Held: Professor and EMS Fellowship Director
   Type of Organization: Academic/State run Medical Hospital

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: NAEMSP
   Address: PO Box 19570
   Lenexa, KS 66285
   Type of Organization: EMS Society
   Duration on the Board: 4 years

   Organization: Government Services Chapter, ACEP
   Address: 243 Fifth Avenue, Suite 118
   New York, NY 10016
   Type of Organization: Professional medical association for military emergency physicians
   Duration on the Board: 2003-08

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe Below:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:
4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:
Provide CME as a partnership (LLSAPrep) for board review and LLSA review for emergency medical physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John G. McManus, Jr

Date August 23, 2017
Dear Councillors,

The Government Services Chapter of ACEP endorses COL (ret.) John McManus, MD, MBA, MCR, FACEP for the position of ACEP Council Speaker in the 2017 elections.

Dr. McManus’ background includes a four-year emergency medicine residency in 1999 at Madigan Army Medical Center and University of Washington; an EMS fellowship at Oregon Health and Sciences University; and a Master’s Degree in Clinical Research. He completed his MBA in 2012 from Brenau University. In 2012, he also retired as a Colonel from the United States Army, with a combined Federal service record of over 28 years as a Medical Corps Officer and decorated combat veteran. He served on active duty in numerous medical leadership assignments throughout the world, including deployments to Bosnia, Kuwait, and Iraq. He had the honor to serve as the Chief Medical Officer of the last Combat Support Hospital (47th CSH) in Baghdad, Iraq in 2012.

Prior to his role as Vice Speaker, COL (ret) McManus served extensively within ACEP and other civilian emergency medical and EMS societies and departments. In the Government Services Chapter, he has been GSACEP president, conference chair, and councilor. He has also served on the board twice for the National Association for EMS Physicians as well as served on many committees. He was active in the ACEP council for over a decade serving on the Tellers, Steering, and Reference committees. He also served as a liaison to other organizations for ACEP, and has represented ACEP at several research, leadership and educational meetings throughout the world.

Dr. McManus currently serves as a professor and EMS Fellowship Director in the Department of Emergency Medicine and Region 6 EMS Medical Director at Georgia Regents University. His academic leadership positions have included Director of the U.S. Army’s EMS Department and Director for the Center of Pre-deployment Medicine, at the U.S. Army Medical Department Center and School, Fort Sam Houston, Texas. Dr. McManus also founded and served as the program director for both the U.S. Army’s first emergency medicine subspecialty fellowship, at the San Antonio Military Medical Center (2007-11) and at the University of Texas Health Science Center San Antonio (2010-11).

In his role as Council Vice Speaker, Dr. McManus has brought his natural leadership qualities. He has been goal-oriented enthusiastic, and hardworking in this role and has successfully worked to achieve consensus with his peers. GSACEP gives Dr. McManus our highest endorsement for the position of Speaker.

Sincerely

LTC Nadia Pearson, DO, FACEP
GSACEP President
Salutations friends and colleagues,

I want to thank the ACEP Council for their visionary leadership of this organization; and for the indelible and truly historic role that you, my colleagues, have played in advancing the fight for our emergency medical providers to deliver safe, expedient healthcare to the masses.

I am COL (ret) John McManus and retired in 2012 from the United States Army with a combined Federal service record of over 24 years as a Medical Corps Officer and decorated combat veteran. I now am able to commit to a full time leadership position in ACEP having no threat of deployment overseas anymore. I want to thank each of you for your service and commitment to our college and your valued time to allow me to provide a few words on my background and commitment to serve as your next Speaker.

I currently serve as a Professor and EMS Fellowship Director for Medical College of Georgia and have practiced in academic and community emergency medicine for almost 2 decades. While on active duty in the U.S. Army, I served in numerous leadership assignments and deployments (Bosnia, Kuwait, Iraq) throughout the world. I was director for the U.S. Army’s EMS Department and also the Director for the Center of Pre-deployment Medicine, at the U.S. Army Medical Department Center and School, Fort Sam Houston, Texas (equivalent to Associate Deans). However, I am most proud of my final assignment commanding the last combat support hospital (47th CSH) in Baghdad in 2011. Furthermore, I have served ACEP, the council and the field of Emergency Medicine for two decades in numerous committees and positions as evident in my link to my bio: https://www.linkedin.com/in/col-ret-john-mcmanus-md-mba-mcr-facep-faaem-b78b21a/

My past service, leadership and commitment have prepared me well to serve as your next Vice-Speaker. All the candidates certainly have served and led as well. However, my intention to continue to serve our college is based on deep intangible values rather than past experience or future accolades. Providing guidance and building consensus to improve our emergency medical care has been a constant passion for me. Emergency providers turn people’s fear into hope and alter the outcomes of the worst days of their lives. Few other jobs offer anything so profound on a daily basis. Current presidential candidate, Dr. Ben Carson states, “When I treat other people with kindness and love, it is part of my way of paying my debt to God and the world for the privilege of living on this planet… Happiness doesn’t result from what we get, but from what we give.” It would be an honor to serve the college and “give” back to ACEP and our members to show the deep respect and gratitude I hold for what they have done for emergency medical care. Thank you in advance for your support.

John McManus

COL (ret) John McManus
MD, MBA, MCR, FACEP, FAAEM
Professor & EMS Fellowship Director
Augusta University

Vice-Speaker
American College of Emergency Physicians

Phone: 210-240-6995
Email: jmcm anus@augusta.edu

Linked In

https://www.linkedin.com/in/col-ret-john-mcmanus-md-mba-mcr-facep-faaem-b78b21a/
I am committed to continued service and support to our college!

Current Position
EMS Fellowship and Region VI Medical Director
Professor Emergency Medicine
Georgia Regents University

LEADERSHIP
• Combat Veteran with over 24 years active duty service and leadership to our nation
• Commander last combat support hospital (47th CSH) in Iraq, 2011
• Director U.S. Army EMS (equivalent to Associate Dean) 2010-11
• Director U.S. Army Center for Pre-Deployment Med (equivalent to Associate Dean) 2008-10
• Vice Chair Emergency Medicine: Academic Affairs Brooke Army Med 2007-8
• EMS Fellowship Director, U.S. Army 2007-11
• GSACEP President (2006-8)
• 20 plus years as an academic and community emergency medicine physician

SERVICE
• ACEP
  o Vice Speaker
  o Steering committee member (2009-11)
  o Reference committee (2008-09)/ Tellers committee member (2005-08)
  o EMS committee member (2005-08)
  o Disaster preparedness committee member (2006-2012)
  o Tactical Emergency Medical and Disaster Section (2003-present)
  o DHS Grant to ACEP Disaster Preparedness – site surveyor and panel member (2006-10)
  o “Annals of Emergency Medicine” Editor in Chief Task Force (summer 2006)
  o Liaison to the Committee on Trauma (2008-10)
  o Representative for Terrorism Injuries: Information, Dissemination, Exchange (2009-2011)
  o Chair of Assistant Secretary for Preparedness and Response fellowship selection
  o Presenter at several national and chapter meetings

• Government Services Chapter
  o Sec/Treasurer (2003-05) and President (2005-07)
  o Councilor (2003-present)
  o Chair of annual meeting (2002-6)

HONORS
• Father of McTwins (Aoife & Aedan)
• Legion of Merit, U.S. Army
• International man of mystery
2017 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Sabina A. Braithwaite, MD, MPH, FACEP

**Question #1:** Discuss the similarities and differences in the skill sets of the Council Officers and Board of Directors. Describe your skills, background, knowledge, or unique abilities that will make you an effective Speaker or Vice Speaker.

Both Council Officers and Board members must maintain awareness of issues facing not only the organization itself, but emergency medicine in general, so they are best able to facilitate ACEP’s mission to support quality emergency care and promote the interests of emergency physicians. Both groups must be able to:

- entertain views on various sides of the issues
- step back and look through the lens of the organization or the profession, not solely their personal opinion
- recognize their fiduciary responsibility to the organization and its members

At the most basic level, Council Officers are primarily being asked to use their meeting management skills to constructively lead a fast-paced, intense, and often passionate and emotionally charged meeting to a productive conclusion reflective of the will of the Council. Their job is to bring hundreds of voices into one with a sense of community with the Council as well as a sense of humor. Their responsibility carries forward between Council meetings in their work with the Steering Committee, looking for ways for Council to be most effective in being the voice of the membership, and working with the Board to accomplish the organization’s priorities as identified in the annual meeting. In contrast, the Board is a contemplative team that thoughtfully and thoroughly reviews, considers, and responds to issues facing the organization, the members, and our field of practice, with a considerably different time line than the Council.

Council officers are charged with collating, focusing, and amplifying the collective opinion of the Council representatives, who in turn represent the full ACEP membership on the front lines of emergency medicine. These opinions, in the form of passed resolutions and referred issues, form the “marching orders” that then guide the Board’s work on behalf of the membership until the next Council meeting.

**Question #2:** Describe how you would manage a controversial issue in the Council with split opinions about that issue.

The goal with any issue before Council is to air the various stances on the issue and their reasoning, objective and subjective. In the perfect world, these can be distilled down and a compromise found through the reference committee process. Lest that not be possible, the full Council’s time on the issue should focus on salient “big picture” differences airing the rationale various views, and encouraging the factions to spend time in finding a common course. If the issue is so polarizing that consensus is not possible (universal health care and gun control come to mind), the focus needs to be on helping the Council to make an informed decision on an appropriate course of action that is representative of the ACEP membership as a whole, and in keeping with the organization’s mission and values.

**Question #3:** Provide an example of how the Board and Council may not share the same view on an issue and how you would navigate through that challenge.

Board and Council may well have differing views on a specific issue, particularly since the granularity of their knowledge on that issue may be significantly different. Clarity on the specific roles and responsibilities which fall to each group under the Bylaws is critical to navigating this challenge and assuring that Council is informed on the available options to share their will on the matter to the Board.

For example, Council might consider a controversial resolution. Individual Board members may choose to present dissenting information in testimony before Council in an effort to educate the Council (or perhaps to sway its direction). If, in spite of
this, the sentiment of Council still seems weighted in favor of passing the resolution. I would remind the Council of pertinent Bylaws. Specifically, that prior to a vote, the Board must act on this resolution within 2 meetings by either implementing it, overrule it with a ¾ roll call vote which is reported to the Steering Committee and Council, or amend it while retaining the original intent. If it appears the Board is signaling that there is significant risk that it would overrule the resolution, I would first verify advice with the parliamentarian. I would then give the Council the options of temporarily postponing (tabling) the resolution to allow for further deliberation and potential for finding middle ground at the current meeting, versus choosing to proceed with passing the resolution to force each individual Board member to go on record with their position if the Board chooses to overturn it. Council may pass the resolution regardless to send a message to the Board. There is always the potential that passionate Council testimony might change the position of enough Board members, since ultimately they are elected to do the day-to-day work of ACEP and act on the advice of the Council between annual meetings.

Should Council ultimately pass the resolution, I would seek to discuss the issue with both the Board and engaged Council members prior to the next Board meeting to try to come to some actionable result that reflects the direction of Council, rather than have the issue come up again unresolved at the next year’s Council meeting.
CANDIDATE DATA SHEET

Sabina A. Braithwaite, MD, MPH, FACEP, FAEMS

Contact Information
PO Box 31608
St Louis, MO 63131
Phone: 316-644-3700
E-Mail: Sabina.Braithwaite@gmail.com

Current and Past Professional Position(s)

Current:
Associate Professor of Emergency Medicine and EMS Fellowship Director, Washington University in St Louis, 2016-present
Clinical Educator, Teleflex, 2015-present

Past:
Staff Emergency Physician:
EMCare, Hutchinson Regional Medical Center, Hutchinson, Kansas, 2013-14
River City Baptist Emergency Physicians, Baptist Hospital System, San Antonio, Texas, 2012-13
ECI, Chippenham Medical Center, Richmond, Virginia, 1996-98
Coastal, Halifax Regional Hospital, South Boston, Virginia, 1995-96

Attending Emergency Physician, Emergency Medicine Residency Programs:
University of Oklahoma, Green Country Emergency Physicians, Hillcrest Medical Center, Tulsa, Oklahoma, 2014-2016
University of Kansas Medical Center, Kansas City, Kansas, 2011-13
Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, Texas, 2010-11
University of Virginia Health System, Charlottesville, Virginia, 1998-2010.

EMS:  Associate Medical Director (Part time), Medical Control Board, EMS System for Metropolitan Oklahoma City and Tulsa 2015
EMS System Medical Director (Full time), Wichita-Sedgwick County EMS System, Kansas. 2010-2015.
Medical Director (Part time), Albemarle County Fire-Rescue, Charlottesville, Virginia. 1999-2010.

Education (include internships and residency information)
Georgetown University, BS, majors in German and Biology, 1986
Medical Internship, Medical College of Virginia, 1992
Emergency Medicine Residency, Medical College of Hampton Roads, 1995
University of South Florida, MPH, 2009; Disaster Management Certificate, 2010
Medical College of Virginia, MD, 1991

Certifications
Professional Societies
American College of Emergency Physicians, 1990-present; EMS Section member, AAWEP member
National Association of EMS Physicians, 1991-present
Society of Academic Emergency Medicine, 2000-2010, 2017-present

National ACEP Activities – List your most significant accomplishments
Steering Committee member, 2014-2016
Reference Committee C member, 2016
Education Committee, 2015-2016
EMS Committee chair (2 yearly appointments), 2010-2012
  Position statement: Management of Patients with Potential Spinal Injury
Chair, EMS Culture of Safety Strategy project. Cooperative agreement between NHTSA / HRSA / ACEP. 
  www.emscultureofsafety.org, 2010-2013
Councilor: Virginia Chapter 2005-2008, EMS Section 2012-2015; Alternate for Kansas and Missouri

ACEP Chapter Activities – List your most significant accomplishments
Virginia College of Emergency Physicians Board of Directors, 1996-2010
  1995-2000 Basic Trauma Life Support Medical Director
  1999-2000 Chair, EMS Committee
  2001-2003 Secretary
  2003-2004 Treasurer; Chair, Finance Committee
  2004-2005 Legislative/Advocacy Committee
  2006-2007 President
Missouri Chapter ACEP, Board member, 2017-present

Practice Profile
Total hours devoted to emergency medicine practice per year: 2500+ Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 30% Research 5% Teaching 25% Administration 40%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
Employee, academic emergency medicine faculty and EMS fellowship director
Facility: urban level 1 trauma center and suburban community hospital sites

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.
Defence Expert 0 Cases Plaintiff Expert 0 Cases
# CANDIDATE DISCLOSURE STATEMENT

**Sabina A. Braithwaite, MD, MPH, FACEP, FAEMS**

1. **Employment** – *List current employers with addresses, position held and type of organization.*

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington University in St Louis</td>
<td>660 S Euclid, Campus Box 8072, St Louis, MO 63110</td>
<td>Associate Professor of Emergency Medicine, EMS Fellowship Director</td>
<td>Emergency Medicine Residency Program</td>
</tr>
<tr>
<td>Teleflex / Arrow International</td>
<td>4350 Lockhill Selma, Suite 150, Shavano Park, TX 78249</td>
<td>Contract educator</td>
<td>Medical equipment</td>
</tr>
</tbody>
</table>

2. **Board of Directors Positions Held** – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Type of Organization</th>
<th>Duration on the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Trauma Life Support</td>
<td>3000 Woodcreek Drive, Suite 200, Downers Grove, IL 60515</td>
<td>Educational organization</td>
<td>Board of Directors: 16 years (1998-2014)</td>
</tr>
<tr>
<td>Missouri College of Emergency Physicians</td>
<td>113 Madison Street, P.O. 1028, Jefferson City, MO 65102</td>
<td>State ACEP Chapter</td>
<td>&lt; 1 year to date</td>
</tr>
<tr>
<td>Committee on Accreditation of Educational Programs for the EMS Professions (COAEMSP)</td>
<td>8301 Lakeview Parkway Suite 111-312 Rowlett, TX 75088</td>
<td>EMS educational program accreditation organization</td>
<td>3 years (2010-2013)</td>
</tr>
</tbody>
</table>
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE
☒ If YES, Please Describe:
  • Teleflex / Arrow, contract instructor for cadaver labs on IO / airway devices. < $10K income for 2016, anticipate < $5K income for 2017.
  • Editorial Board member, International Trauma Life Support. Provides trauma education (in partnership with ACEP).

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☒ If YES, Please Describe: Teleflex / Arrow – as described above.

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Sabina Braithwaite

Date

August 5, 2017
August 24, 2017

Dear Councillors,

It is with great pride that on behalf of the Missouri Chapter of the American College of Emergency Physicians, (MOCEP), I nominate Dr. Sabina Braithwaite for the Office of Vice Speaker of the Council.

Dr. Braithwaite’s passion for our field is obvious in all that she does, and it is a passion that is hard to find. Her dedication for getting involved began in the 1990s as she joined EMRA, then continued on in committee roles with ACEP. She also has been very active in EMS and ITLS, including joining the National Association of EMS Physicians in the 1990s and currently serving as the Emergency Physician representative of the National EMS Advisory Council, in which she was appointed by Secretary of Transportation Foxx.

Dr. Braithwaite has led action compelled by the Council while serving two terms as Chairperson of the ACEP EMS Committee. Notably, she shepherded numerous ACEP Policy Statements to approval by the Board of Directors, including a joint position statement with three other professional organizations.

She has represented the College to a widespread audience of peer medical specialty organizations, nursing, and emergency medical services associations. She has represented emergency physicians as a liaison to numerous federal and state initiatives. Dr. Braithwaite has a proven track record of successful leadership, fostering productive dialogue and creating consensus-based results.

Dr. Braithwaite understands the importance of education in our specialty. She is residency trained and board certified in emergency medicine. She is also one of the first 200 physicians to hold the distinction of being boarded in EMS Medicine by the American Board of Emergency Medicine. Additionally, she holds a Master of Public Health degree from the University of South Florida. Currently, Dr. Braithwaite serves as an Associate Professor in Emergency Medicine and an EMS Fellowship Director at Washington University in St. Louis. Throughout her career she has served as faculty or played a major teaching role at emergency medicine residency training programs or fellowships and has frequently volunteered as a speaker or visiting professor at a variety of others.

Dr. Braithwaite is a shining example of leadership and dedication in Emergency Medicine and would be the perfect individual for the role of Vice Speaker of the Council.

Sincerely,
Jonathan Heidt, MD, MHA, FACEP
President, Missouri College of Emergency Physicians
Dear Fellow Councillors:

The Council has evolved considerably in membership numbers and demographics over the last decade. Is it time for us to reassess Council operations to best utilize the talents, opinions, and time of our Councillors? While the Council is the voice of the membership, fully sharing and debating issues in this large body is becoming increasingly challenging within the framework of a two-day meeting. Our Bylaws provide the foundational structure within which this conversation occurs, but a strong, informed facilitator is vital to success. As your Council Vice Speaker, I will meet these challenges by:

- **bringing together people and ideas**, to promote well-informed decisions by the Council as a whole.
- **listening actively** to channel diverse opinions into an actionable consensus outcome.
- **respecting the Council’s time** by doing my due diligence to prepare and assure that the meeting time is productive and the business of the body is addressed.
- **promoting opportunities for engagement** and situational awareness of Council activities. While the most visible Council function is the annual meeting, interim engagement of the wisdom of this representative body can make those two-day meetings more productive. Mentorship of the next generation of leaders is also vital to assure appropriate representation of the range of our members.
- **being the Council’s voice with the Board** throughout the year
- **maintaining focus on our mission** of supporting quality emergency medical care and promoting the interests of emergency physicians by using an organized, informed approach.

I welcome your thoughts on how to best apply the collective wisdom of the Council to help move the ACEP strategic goals of reforming and improving the emergency care delivery system and enhancing membership value and member engagement. Please feel free to use my contact information below to share your thoughts at any time.

I ask for your vote for Vice Speaker and promise to serve the Council and membership well in this role.

**Sabina Braithwaite, MD, MPH, FACEP**

Sabina.Braithwaite@gmail.com
316-644-3700
Sabina Braithwaite, MD, MPH, FACEP, FAEMS
Council Vice-Speaker Candidate
Endorsed by Missouri College of Emergency Physicians

Why?
I have the passion, skills, and time to devote to serving Council and the College membership:
- by helping to lead a productive and collegial annual meeting
- by representing Council and the membership with the Board the remainder of the year
- by working with the Steering Committee to find ways for Council to be more effective.

Why now?
I have transitioned out of other leadership roles to focus my energy on fulfilling the role of Council Officer.

Why me?
Diverse Emergency Medicine Experience:
- Licensed in six states (VA, TX, KS, MO, OK, AR)
- Emergency medicine practice in diverse settings, including rural, urban and suburban, military and federal. Varied practice model experience including academic, democratic group, contract management group.

Long term ACEP Advocacy support:
- Many years as NEMPAC Give-A-Shift supporter
- Annual attendance at ACEP Leadership and Advocacy meeting for > 20 years

Council experience:
- Councilor / Alternate for Virginia, Kansas, Missouri, EMS Section
- Reference Committee Member
- Steering Committee Member

Demonstrated leadership skills:
- ACEP: Virginia ACEP Board and President, Missouri ACEP Board, ACEP EMS Committee 10 yrs and Chair 2 terms
- National / International: International Trauma Life Support Board and Board Chair, National EMS Advisory Council Appointee and Vice-Chair, National Association of EMS Physicians Quality Committee Chair

Demonstrated collaborative skills:
- ACEP position statement, joint with NAEMSP, AAEM, AMPA: Appropriate and Safe Utilization of Helicopter Emergency Medical Services, created and approved by all organizations during my EMS committee chair terms
- Chair, EMS Culture of Safety Strategy Project: ACEP cooperative agreement with HRSA and NHTSA which brought together diverse EMS stakeholders to produce a Culture of Safety Strategy to move EMS toward greater responder, patient, and community safety.

Most of all, because I have the passion to do be your Vice Speaker, and to have fun doing it!
I ask for your support, input, and vote for me as Vice Speaker!

Respectfully,

Cell: 316-644-3700
2017 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Andrea L. Green, MD, FACEP

Question #1: Discuss the similarities and differences in the skill sets of the Council Officers and Board of Directors. Describe your skills, background, knowledge, or unique abilities that will make you an effective Speaker or Vice Speaker.

Our Council Officers and Board of Directors share the same high level leadership skill sets. It is the differences in their responsibilities that will dictate utilization of specific skills. The Council Officers, charged with speaking for and representing the interests of the Council, will use skills working with the Council to craft resolutions, lead large group discussions, lead timely Council meetings, manage committees, and solve problems collaboratively. The Board of Directors, with responsibility for governance of the organization, and setting policy, will use specific skills for fiduciary expertise, strategic vision, policy development, and building quality networks and relationships with organizations. Regardless of the role, both must use their skills to work collaboratively to advance the goals and values of ACEP.

Having experience as President of TCEP, Chair of TCEP Committees, Emergency Department(s) Chair, Director of a Junior College EMS Program, Director of a 12 Hospital Domestic Violence Program, and CEO of an Emergency Physician Group are but a few career roles that have permitted me the opportunity to develop expertise and successfully demonstrate all of the leadership skills needed for Vice Speaker. My skills include the ability to shape and lead timely, productive group meetings, manage committees, negotiate agreements, problem solve collaboratively, and create policies. I am familiar with parliamentarian procedures and am comfortable bringing order and closure to discussions.

I am able to use these skills to serve you. My goals include providing orderly but engaging Council experiences, working to implement effective virtual Resolution chat rooms, exploring paths for sharing the council meetings with Colleagues back home (perhaps live streaming), expanding high-tech avenues to facilitate Councilors’ participation in multiple reference committees simultaneously and developing more mentoring and leadership training opportunities for EMRA on Council Committees.

I look forward to the opportunity to serve you.

Question #2: Describe how you would manage a controversial issue in the Council with split opinions about that issue.

Where there is a group of passionate, committed, highly accomplished professionals, it is to be expected that there will be varying ideas and opinions on the approach to some issues. Often this exists in a positive environment where the opposing side(s) respect the insights of the other(s) and move forward to find common ground. There will be occasions when this is a more challenging process, when the divide is so great, that extended efforts and creativity is needed to connect opposing views. As a Council Officer, it is critical to not take sides while working to build a bridge between the oppositions in a trustful environment.

G. K. Chesterton said, “it isn’t that they can’t see the solution, they can’t see the problem”. I believe that this is too often the root cause of controversy. Assume a situation where fair discussions and reasonable debate (assuring all sides have been heard) has failed. The next step would be getting the key players together in an environment of openness and transparency, along with any experts on the subject from within the council. Their task would be listening carefully to each other to identify common ground and points of disagreement, framing the issues clearly, and outlining options leading to the creation of a resolution that a majority of Councilors can adopt.

Given the talent within our council I am hopeful that these efforts will be successful, and the group will be able to come to a consensus decision such that a constructive resolution can be drafted and resubmitted. If by chance this group is still unable to draft a successful resolution and the Council remains split, ongoing efforts to communicate with and educate Councilors concerning the issue would be implemented in preparation for revisiting it in the future.

Question #3: Provide an example of how the Board and Council may not share the same view on an issue and how you would navigate through that challenge.

The Council and ACEP Board of Directors have worked collaboratively for many years creating visions, successful policies, and leading edge approaches to the challenges we face as we advance in this unique field of medicine. There have been times in
the past when the Board and Council did not share the same view on how to proceed but for the most part as a committed team have prevailed and positively transformed the conflict continuing on the road toward our missions. Recognize that within any body of individuals there may never be total agreement on any issue but there must be productive conflict transformation. Trusting a constructive partnership makes this journey possible.

For this discussion let’s say that the Council presents a Resolution requesting the Board support elimination of Patient Satisfaction Scores from performance evaluations of Emergency Physicians but the Board has divergent views on the subject. As Council Officer it is imperative to continuously represent the members of the Council and work diligently with the BOD to understand and respect the will of the Council.

I would initiate communications between the Councilors and the Board, imploring the BOD to listen to the values and perspectives of the Council. Building from that, I would make sure that the Board clearly understands the will of the Council on the matter as well as the background and evidence behind the issue. Transparency and trusting is critical with any effort to transform conflict. So, I would seek that conflicts of interest be clearly identified to promote open and honest dialogue and move forward collaboratively. Often, providing information, allowing all sides to be heard and fairly debated is helpful in diffusing a conflict. I would make sure that the Council is educated concerning their options for managing this situation if the BOD persist in their position.

If the diverging views emerge within the Board of Directors meetings once the resolution has been passed, I would remind the Board of the will of the Council concerning this issue. I would implore the Board to consider ways to address the issue that would incorporate the resolves of the Council. I would request that the Board revisit the background and evidentiary materials, get additional information from experts on the subject, and consider a neutral task force to evaluate the issue and options prior to an unfavorable decision. I would exhaust every effort to build consensus, reminding the Board of the value of the Council and the potential outcomes of actions contrary to the expressed will of the Council.

“Could a greater miracle take place than for us to look through each other's eyes for an instant?”, Henry David Thoreau
CANDIDATE DATA SHEET

Andrea L. Green, MD, FACEP

Contact Information
5 Twin Springs Dr., Dalworthington Gardens, TX 76016
Phone: 817.233.2896
E-Mail: eli.chason.green@prodigy.net

Current and Past Professional Position(s)
Staff Physician, ESP/USACS, Travel Team
TeamHealth Medical Advisory Board
Interim Medical Director, Memorial Hermann the Woodlands, The Woodlands, TX, THW Travel Team
Interim Medical Director, El Centro Regional Medical Center, El Centro, CA, THW Travel Team
Interim Medical Director Redwood Memorial Hospital, Fortuna, CA, THW Travel Team
Interim Medical Director, St Joseph Hospital, Eureka, CA, THW Travel Team
Medical Director, Swedish Medical Center, Denver, CO
CEO, 1st Care Health Group Emergency Physicians
CEO, 1st Care Hospitalist Group
Chairperson, Texas Health Resources Family Violence Prevention Initiative
Medical Director, Arlington Memorial South Medical Center, Arlington, TX
Chairperson, Arlington Memorial Hospital Emergency Department, Arlington, TX
Medical Director, Tarrant County Junior College EMS Program
Chairperson, Sinai Samaritan Medical Center, Milwaukee, WI
Medical Director, Worcester Hahnemann Hospital, Worcester, MA

Education (include internships and residency information)
Howard University Hospital Emergency Medicine Residency, Washington, DC
Sparrow Hospital/University of Michigan Emergency Medicine Residency Program, Lansing, MI

University of Iowa College of Medicine, 1979

Certifications
American Board of Emergency Medicine

Professional Societies
American College of Emergency Physicians
Texas College of Emergency Physicians
American Medical Association
Texas Medical Association
**National ACEP Activities – List your most significant accomplishments**

- ACEP Council Strategic Issues Forum Facilitator
- ACEP Council Steering Committee
- ACEP Council Tellers, Credentials, and Elections Committee
- ACEP Reference Committee
- ACEP Nominations Committee
- ACEP Awards Committee
- ACEP Council Forum Subcommittee

**ACEP Chapter Activities – List your most significant accomplishments**

- President, Texas College of Emergency Physicians
- Texas College of Emergency Physicians Board of Directors
- Texas College of Emergency Physicians Secretary
- Texas College of Emergency Physicians Treasurer
- Texas College of Emergency Physicians Reimbursement Committee, Chairperson

**Practice Profile**

*Total hours devoted to emergency medicine practice per year: 2,520 Total Hours/Year*

*Individual % breakdown the following areas of practice. Total = 100%.*

- Direct Patient Care 94%
- Research 0%
- Teaching 3%
- Administration 3%

Other: ____________________________ __%

*Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)*

I am a full time employee for ESP/USACS Travel Team. This is a multi-practice group covering a variety of hospitals including urban, suburban, rural, and free standing emergency facilities. I provide coverage at a variety of hospitals depending on the needs of the company. I also work as an independent contractor at an inner city facility for a multiple hospital group.

**Expert Witness Experience**

*If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.*

| Defense Expert | 0 Cases | Plaintiff Expert | 0 Cases |
CANDIDATE DISCLOSURE STATEMENT

Andrea L. Green, MD, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: ESP/USACS
   Address: 6300 La Calma Dr. #200
   Austin, TX 78752
   Position Held: Staff Physician
   Type of Organization: Medical Services Organization

   Employer: Andrea Green, MD, PA
   Address: 5 Twin Springs Dr
   Dalworthington Gardens, TX 76016
   Position Held: President
   Type of Organization: Independent Contractor

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: Texas College of Emergency Physicians
   Address: 2525 Wallingwood Dr,
   Austin, TX
   Type of Organization: 501c Chapter of ACEP
   Duration on the Board: 1998 - 2007

   Organization: Holt Bowser Charity Scholarship Foundation
   Address: 904 Dover Heights Trail
   Mansfield, TX 76063
   Type of Organization: 501C3 Christian Scholarship Foundation
   Duration on the Board: 2013 - current
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

NONE

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

NONE

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

Andrea Green, MD, PA is my own entity providing independent contractor services.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

NONE

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

NO

I certify that the above is true and accurate to the best of my knowledge:

Andrea Green, MD, FACEP  Date  August 3, 2017
Dear Councillors:

The Texas Chapter proudly endorses Andrea Green, MD, FACEP, as a candidate for the ACEP Council Vice Speaker position.

Dr. Green is well known to everyone at ACEP leadership. She has been around the Council and the Board for years. She has served on numerous committees, task forces, and special projects. The full list is on her CV, but special note should be made of her long Council service, dating back to 2000 (16 years of Council meetings), and her wide range of Emergency Medicine Experience.

She has worked in multiple states, in large and small ED’s, as a physician, as a director, as a travel team regional director, for small groups, and for mega groups. This range of experience means she can identify with virtually everyone who might speak at Council, and understand their positions so she can give them a fair hearing.

Another thing you will note in her work history is that she has been a ‘firefighter’ going into difficult to staff locations and getting them stable. Even more impressive is that she has been a travel team firefighter medical director, dropped into EDs that were in trouble, where everyone was already upset, which were dysfunctional. She was able to get them under control, work through all the personal dynamics, and soothe angry administrators. All of these skills are useful for a Vice Speaker.

Her speaking experiences include serving as a co-speaker at a past ACEP Town Hall meeting. She has courtroom experience working as an expert witness with a DA in Wisconsin to try Pediatric Sexual Assault cases. She was involved in the development, and served as the Medical Spokesperson for the THR (Texas Health Resources) Systemwide Domestic Violence program, which included organizing these continuing medical education events and giving lectures to multiple hospital medical staff groups as well as lecturing at community events. She was a speaker in the Domestic Violence Video that was produced for that training. Her hospital and work career leadership roles involved running innumerable meetings. She has done classroom teaching in a number of settings, including EMS training, and has created and taught in programs to provide training to medical residents at non-academic sites.

She has developed and implemented clinical and administrative programs at many facilities. She managed an Emergency Medicine Physician Staffing group and a Hospitalist Staffing group. These skills will translate into an ability to work cooperatively with many physicians and staff to do the pre-meeting prep that makes the actual council meeting flow smoothly.

Granted that they are not as large as Council, the dynamics of controlling difficult personalities is always present as an Emergency Physician Leader. Andrea’s great strength is that she doesn’t get rattled, and can bring an out-of-control meeting back under control.

She continues to be a major donor to EMF and NEMPAC, and is a member of the Wiegenstein Legacy Society. This speaks to her commitment to ACEP and the field of Emergency Medicine.

Throughout her long EM career, Andrea has dedicated extensive time and efforts toward the American College of Emergency Physicians. She is ready to lead the ACEP Council as Vice Speaker and then Speaker.

Heidi Knowles, MD, FACEP
President
WHO IS ANDREA GREEN?

The name may read Green, but I can guarantee you there is nothing green about this package. Your vote for Green will give you a package of experience and skills that will amaze you. Let me tell you about myself.

THE PASSION

The Council is the heart and soul of our College. Council members are zealous about what they believe. They maintain their fingers on the pulse of our specialty, patients, and colleagues, fighting fearlessly on their behalf. They volunteer considerable amounts of time, energy, and resources on behalf of our College; asking for nothing in return. Theirs is a servant mentality like my own. All of this has inspired my desire to serve the Council. This passion has caused me to extensively prepare for the Vice Speaker candidacy by working within the Council for 20 years, serving on each Council Committee, facilitating a Council Forum meeting, and attending over 30 ACEP Board of Director meetings. Doing so allowed me to study the processes and procedures of our Council, and provided the opportunity to observe and learn from many of our Speakers and Vice Speakers.

Through the years, many Council Officers and their Committees have worked to improve our Council Meetings. Work has been done adding technology, improving communications, streamlining and improving the quality of the meetings. Last year our Speaker, Vice Speaker, and their committees did a tremendous job raising the bar to new heights. Kudos to them! What a challenge to incoming Speaker and Vice Speaker teams. Count me in!

I want to continue to provide engaging Council experiences, create robust virtual chat rooms for resolutions pre-meeting, explore possibilities to share the council meetings with our Colleagues back home (perhaps by live streaming the meetings), and explore high-tech avenues to improve Councilors’ abilities to participate in multiple reference committees simultaneously. I want to include more mentoring and leadership training opportunities for EMRA on Council Committees.

THE LEADERSHIP

I have served as Past President of Texas College of Emergency Physicians (TCEP), on TCEP Board of Directors and on numerous TCEP committees, on numerous ACEP Committees, as CEO of an Emergency Physician Group, as Emergency Department Chair, as Junior College EMS Program Medical Director, and as Chairperson of a 12 hospital Family Violence Prevention Program which involved working with the local district attorney’s office, churches, police departments, and women’s shelters. These experiences provided many opportunities for public speaking, directing productive meetings, creating engaging programs, appointing and overseeing committees, negotiating agreements, and developing major projects. These experiences have helped prepare me to lead our Council and Council Committees.

THE EM EXPERIENCE

I have practiced community Emergency Medicine for over 30 years in a variety of emergency departments and settings. Having spent the past 10 years as a traveling emergency physician and traveling interim ED director “hit team member”, I have had the pleasure of working in many states and listening to some of the issues you face. I have also enjoyed opportunities to share helpful processes as well as hear your fresh ideas.

THE TIME

Since detoxing from traveling around the country as mother and private emergency physician of a competitive snowboarder who has found a life as a chemical engineering student, I can now get on with my life. My passion has long been to serve the Council. I am prepared, enthusiastic, and available to serve as your Vice Speaker. My comprehensive experiences give me the edge as a well rounded, ideal, candidate for Vice Speaker.

So, go ahead, feel assured, go Green (Andrea Green) for your next Vice Speaker. I want to serve you.
COUNCIL EXPERIENCE
✓ 20 Years Council Service
✓ Reference Committee
✓ Tellers and Credentials Committee
✓ Steering Committee
✓ Awards Committee
✓ Nominating Committee
✓ Candidate Forum Committee
✓ Town Hall Facilitator

QUALITIES
✓ Leadership
✓ Integrity
✓ Engaging
✓ Closer
✓ Listener

Andrea L. Green M.D., FACEP
Vice Speaker Candidate
FORMER PRESIDENT TCEP (TEXAS)

Vote Green FOR VICE SPEAKER
Andrea L. Green MD, FACEP  
Vice Speaker Candidate  
Greand52@gmail.com

EDUCATION
Howard University Hospital  
Emergency Medicine Residency  
Michigan State University  
Affiliated Emergency Medicine Residency  
University of Iowa College of Medicine

CERTIFICATIONS
American Board of Emergency Medicine

MEMBERSHIPS
American College of Emergency Physicians  
Texas College of Emergency Physicians  
American Medical Association  
Texas Medical Association  
AAWEP  
ACEP Young Physicians

REVIEWER
Texas State Board of Medical Examiners

BENEFACCTOR
Wiegenstein Legacy Society  
NEMPAC Major Donor  
EMF Major Donor

ACEP
Diversity and Inclusion Task Force  
Finance Committee  
CNAC Committee  
Reimbursement Committee  
EM Practice Committee

TCEP
Board of Directors  
Practice Enhancement Committee  
Reimbursement Committee  
Government Affairs Committee  
EMS Committee

FACULTY
Director, Tarrant County Junior College Training Program  
Affiliated Physician Assistant Program, University of Wisconsin  
Dept. of Allied Health, Youngstown State University

CHAIRPERSON
Arlington Memorial Hospital Dept. of Emergency Medicine  
Sinai Samaritan Medical Center Dept. of Emergency Medicine  
Family Violence Prevention Initiative Steering Committee  
Patient Encounters Task Force, Texas Health Resources  
Mahoning Valley Paramedic Advisory Board, Youngstown State U  
Health Awareness-Health Professions Project SNMA, U of Iowa

SPECIAL PROJECTS
USACS Diversity Committee  
USACS Wellness Committee  
Director TeamHealth West Travel Team  
TeamHealth Medical Advisory Board

CEO
1st Care Health Group Emergency Physician  
1st Care Hospitalist Group

CONSULTANT
Free Standing Emergency Department  
T-Systems Physician Documentation
2017 COUNCIL OFFICER CANDIDATE WRITTEN QUESTIONS

Gary Katz, MD, MBA, FACEP

**Question #1:** Discuss the similarities and differences in the skill sets of the Council Officers and Board of Directors. Describe your skills, background, knowledge, or unique abilities that will make you an effective Speaker or Vice Speaker.

There is no stronger voice than that of our ACEP Council. The Council Officers play an essential role in facilitating activation of this potential. To do this, the officers must utilize distinct skills that separate them from the Board of Directors.

In particular, the Speaker and Vice-Speaker must facilitate the councilors’ efforts to find unification and solidarity for our positions. While finding consensus may be easy; many times, it is not. It is during these times of disparity the Council Officers must bring these unique skills to bear. We must, at all times, follow the will of the majority, but we must equally protect the rights of the minority to be heard.

The manner through which the Council Officers ensure adequate attention to these two competing factors is, in its very base, founded in the rules of procedure. I have enjoyed many experiences where my expertise in the fundamentals of Parliamentary Procedure have been required to move massive agendas forward. I have served as Speaker via my time as Chair of the American Medical Association’s Young Physicians Section (YPS). Here, I was responsible for running the YPS assembly, a group that functions much like our ACEP Council. I am pleased that our peers report that I dispensed of these duties with accolade and success. Further, I have just completed a three-year term, including time as Chair, of the AMA’s finance and governance reference committee. Again, this was a chance to demonstrate success in the very environment we mirror here.

I recognize that fairness and justice must be exhibited in more ways than simply employing parliamentary procedure. These traits must be exhibited all year-round, to assure that the voices of the Council are developed with a broad base of participation. While the former skill set described a unique function of the Council Officers, this latter skill of incorporation and co-optation are similar to the skills necessary for a Board of Directors candidate.

As a Vice-Speaker who would be your voice in Board meetings, I would seek to work with the membership to promote discussion throughout the year. Such an opportunity exists in growing social media where our peers share their insights, experiences, frustrations and solutions to our profession’s challenges. I am active on EM Docs and believe forums like this one serve as fertile ground upon which to bring solutions to our profession. No longer are we limited to interacting only one or two times a year. This effort can be spent fine-tuning critical actions that carry a broad base of national expertise, input, and support. Through such effort, our Council voice can be further strengthened and made even more meaningful.

I’m fortunate to have had experience as OH-ACEP President for two terms. During my tenure, I led in a massive restructuring effort that coincided with the 2008-2009 recession. This multi-year process was made successful by the ongoing discussions with membership to identify areas of concern and foundations of agreement. The investment in this process was worthwhile as we have growing engagement in our chapter and increased participation of chapter members in national ACEP affairs. Our Council remains the best channel to strengthen the voice of ACEP’s membership and further the cause of Emergency Medicine. The duties of the Council Officers carry unique requirements to achieve success. I’m happy to bring experiences that will provide attributes unique to the BOD as well as enhance those strengths that are similar.

**Question #2:** Describe how you would manage a controversial issue in the Council with split opinions about that issue.

During the 2012 presidential cycle, the Council was surveyed during the demographics questions to query how the people stood on the candidacy of Romney and Obama. The result was nearly a 50-50 split. This is important because it represents the wide breadth of opinions held by individuals of our EM family. Our expectation should be that we always anticipate disparate opinions. Thus, we are compelled to prepare all items of business in such a fashion that we enable open discussions based on both the science and mores that impact our organization. We must recognize that personal experience can cause individuals to review the same facts, yet come to different conclusions about the preferred course of action. And, we must look to achieve stepwise success on the items where we find agreement, and be willing to depart as friends and colleagues on the topics where disparity may not be immediately resolvable.

There are three scenarios where managing this disparity must take unique and independent action. The first begins in the best of circumstances where ongoing dialogue, as I’ve proposed, will help with early identification of such controversial topics. With
such knowledge, we can create townhall meetings and educational forums that help the membership explore and discuss how the topic and potential solutions might impact their profession and their patients. Town halls may even build over multiple meetings, culminating in an action based on unified application of data and goals.

Another scenario: a controversial topic becomes known at the time resolutions are submitted. In such an event, assuring that there is adequate background information, affiliated research, and other supporting documents provided to the councilors well ahead of the Council meeting. Staff is an excellent resource for this, but we should also reach out to the membership. I have long advocated for open and ongoing communication in forums that are even more engaging that our current list-serve. The use of such forums, while they cannot replace reference committees, can certainly help people consider the positions of their peers, investigate the background materials for supporting and controverting research, and help us arrive at council with an already building appreciation for the varied opinions within our organization.

Finally, the event where items of controversy are introduced or identified on the council floor. In this circumstance, the Speaker must be adept at assuring that each party has an opportunity to state its case. There are times when items of business can be both controversial and impact people on a deeply personal level. In these circumstances, the Speaker must assure that decorum is maintained and that we recognize the difference between disagreeing and being disagreeable. This is one area where a firm command of procedure can help stabilize the conversation and help keep emotion from overpowering debate and reasoned decision making; managing such an event is one impetus for my reason to study parliamentary procedure.

**Question #3:** Provide an example of how the Board and Council may not share the same view on an issue and how you would navigate through that challenge.

The Council Officers share the duty to be Council’s advocates. This obligation requires an expanded skill set beyond the most visible role of running the Council meeting. The other 363 days of the year, your Council Officers are your voice in representing your views in Board discussions.

Imagine that Council passed a resolution that ACEP should align itself with other hospital based medical societies to advocate and promote payment reform for hospital based physicians. Further, imagine the ACEP Board feels that such alignment would threaten EM’s unique beneficent status. In such a case, it would be critical for your Council Officers to understand the components of advocacy, negotiation, and bring the dissenting groups together for our common cause.

Parties can look at the same set of circumstances and draw different conclusions. The significance of data is often colored by the lens one wears. This may be due to a lack of aligned goals, the influence of personal agendas, or other externalities. When such pressures lead to divergence it becomes essential to identify obstacles and create solutions. Much of this is the art of negotiation where understanding the perspective of the other group creates win-win results. For this reason, it is important that your Council Officers be well acquainted with ACEP’s strategies so they may understand, predict, and even head off barriers before opponents obstruct progress.

My experience within organized medicine allows me to understand the strengths and weaknesses found throughout the house of medicine. In this example, it would serve by providing insight to the benefits that aligning with outside organizations will bring. I will draw on this knowledge and strengthen the partnership within the board and other interested parties as we gain appreciation for any concerns. From this we would mitigate perceived risk and create solutions. Your Council Officers are not in this alone. We would have access to the testimony you provided at Council and use it to drive the conversation supporting your position.

In the end, I believe it is necessary for your Council Officers to be your advocates at all times. True success comes through teamwork and collaboration and this is an area in which I am a proven leader. My experience and personal philosophy would allow me to be your champion.
CANDIDATE DATA SHEET

Gary R. Katz MD, MBA, FACEP

Contact Information
7195 Wilton Chase, Dublin OH 43017
Phone: 614-207-6882
E-Mail: Katz.123@me.com

Current and Past Professional Position(s)
Varsity Healthcare – FCP, Chief Medical Officer
System Medical Officer, The Schumacher Group
Vice President Clinical Quality and Service Excellence, Premier Physician Services
Facility Medical Director, Memorial Health, Marysville, OH
Assistant Professor, The Ohio State University, Department of Emergency Medicine, Program Director Administrati Fellowship
Assistant Professor, Eastern Virginia Medical School, Department of Emergency Medicine

Education (include internships and residency information)
Trained Parliamentarian – University of Wisconsin, 2015
Masters of Business Administration – 2005, Fisher College of Business at The Ohio State University
Residency, Emergency Medicine, 2001, Summa Health System
Internship, Emergency Medicine, 1999, Summa Health System
Doctor of Medicine, 1998, Medical College of Ohio

Certifications
ABEM, Certified in 2002, recertified in 2012

Professional Societies
ACEP 1998 – Present
ACEP, VA Chapter, 2001 – 2003
EMRA, 1998 – Present
American Medical Association 1995 – Present
Columbus Medical Association, 2003 – Present
American Association for Physician Leadership 2006 - Present

National ACEP Activities – List your most significant accomplishments
Federal Government Affairs, 2016 - 2017
Council Steering Committee 2011 - 2013
Council Tellers Committee 2010
Section Council on Emergency Medicine, 2003 - 2009
ACEP Young Physicians Section (Secretary), 2003
EMRA Board of Directors, 1998 - 2000
Resident Representative to the RRC - EM from EMRA, 1999 - 2001

ACEP Chapter Activities – List your most significant accomplishments

OH ACEP
  Recipient, Physician Leadership Award, 2015
  Chapter President, two terms, 2009, 2010
  Board of Directors, 2006 - 2015
  Leadership Development Committee Chair, 2012 - 2013
  PAC Board Chair, 2009, 2010
  Founding Member, Dr. Rivers Charitable Foundation for Resident Education

Practice Profile

Total hours devoted to emergency medicine practice per year: 1200 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 30%  Research <5%  Teaching 15%  Administration 50%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am clinical faculty, see patients, and instruct residents at The Ohio State University EM residency program

Expert Witness Experience - I have not participated in this category

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases  Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Gary R. Katz, MD, MBA, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: The Ohio State University
   Address: 400 W. 10th Ave
            Columbus, OH 43210
   Position Held: Clinical Faculty
   Type of Organization: Academic EM

   Employer: Varsity Healthcare - FCP
   Address: 855 Gold Hill Rd
            Ft. Mill, SC
   Position Held: Chief Medical Officer
   Type of Organization: Practice Management

(If additional space is needed, attach an additional sheet.)

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: ACEP – Ohio
   Address: 3510 Snouffer Road, Suite 100, Columbus, Ohio 43235
   Type of Organization: Medical Association
   Duration on the Board: 8 years

   Organization: Ohio State Medical Association
   Address: 5115 Parkcenter Avenue Suite 200 | Dublin, OH 43017
   Type of Organization: Medical Association
   Duration on the Board: 3 years
Organization: The Buddy Group
Address: 5 Baker Dr, Irvine CA
Type of Organization: Marketing and Advertising
Duration on the Board: 5 years

(If additional space is needed, attach an additional sheet.)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑️ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑️ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑️ NONE
☐ If YES, Please Describe:
5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

NONE

If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

NO

If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Gary Katz

Date 3 AUG 2017
"Building strength through a fair and faithful deliberative process."

The Board of Directors of the Ohio Chapter, American College of Emergency Physicians, enthusiastically nominates and endorses our friend and colleague, Gary R. Katz, MD, MBA, FACEP, for ACEP Council Vice-Speaker in 2017.

The Ohio Chapter has benefited immeasurably from Dr. Katz’s leadership and dedication. He has served on our Board of Directors (2007-2015), as Chapter President for two terms (2009-2011), and has actively participated in key Chapter committees, including the Government Affairs (Chair), Leadership Development (Chair), and Medical Education Committees. During his two terms as Chapter President, Dr. Katz’s guidance was invaluable, especially in bringing Ohio ACEP leaders together around a plan to refine the Chapter’s strategic focus. Dr. Katz has also served as a trustee of the Ohio ACEP PAC (2006-2011). For his ongoing leadership to the Chapter and Emergency Medicine in Ohio, we were honored to present Dr. Katz with the Ohio ACEP Emergency Physician Leadership Award in 2015.

He has represented the Chapter as a Councillor since 2008 and, in 2011, was recognized with the Council Horizon Leadership Award. His service to the College includes a term as Secretary of the YPS (2002-2004) and service as the Young Physicians Delegate to the AMA Section Council on Emergency Medicine. Dr. Katz currently sits on ACEP’s Federal Government Affairs Committee where he offers his expertise on matters of policy and advocacy.

Dr. Katz has also demonstrated leadership in the College Council, serving on Reference Committees (2009, 2014), the Council Tellers, Credentials, & Elections Committee (2011), and Council Steering Committee (2012, 2013).

Dr. Katz has always exhibited the highest level of commitment to Emergency Medicine, our Chapter, and to the College. He is an established leader who has compiled an impressive record of service and accomplishment including two decades of activism within organized medicine, along with posts in EMRA, ACEP, Ohio ACEP, the Ohio State Medical Association, and the AMA. He is a trained parliamentarian and member of the National Association of Parliamentarians. Without question, he is prepared and highly motivated to serve as Council Vice-Speaker.

The Ohio Chapter ACEP is pleased to support Gary R. Katz, MD, MBA, FACEP for election as ACEP Council Vice-Speaker. Please don’t hesitate to contact me with questions regarding our Vice-Speaker endorsement.

Sincerely,

Purva Grover, MD, FACEP
President
Ohio ACEP
Dear Councillors,

Emergency Physicians share a passion of creating order from chaos, finding the heartwarming story, a critical save, or salvaging some humor from a hard-fought battle. Most of all, at the end of the shift, ED docs want to leave work knowing their efforts made a difference. When viewed through a particular lens, this is not too different from our time at council.

Our Council is a remarkable conduit to create solutions that improve our work environment and the duties of our profession. While the diversity of opinion makes us rich, it is our ability to achieve consensus and move forward on difficult topics that makes us strong. Together we are stronger, and navigating the course from division to solidarity requires a fair and deliberative process.

Your Council Officers are tasked with the mission to craft an environment that facilitates a journey to unity. I have often described this as focusing “the power of many into a voice of one.” As a steward of this process I have the background to carry this tradition forward. I have served our ACEP Council as a member of Steering Committee, Tellers & Credentials, Reference Committee, and Awards and Nominations. I have served our profession on the AMA Section Council for Emergency Medicine, as ACEP YPS Secretary, and two terms as OH-ACEP Chapter President. I have served organized medicine as an EMRA board member & RRC EM representative, as Chairman of the AMA’s Young Physician Section, and as board member of the Ohio State Medical Association.

However, it is not just my organized medicine experience that qualifies me for the Vice-Speaker position. A few years ago, became a formally trained Parliamentarian. Before your “nerd alarm” rings too loudly, I took this training to learn how I could use common tools and help people gain stronger voices. I have honed these skills running assemblies comparable to our ACEP Council and have proven that I can move sizable agendas in a fun, fair, and efficient manner.

Yet, the Vice Speaker does more than to just help run meetings. The Vice Speaker also aids in assuring your voice is considered as the ACEP Board deliberates and implements policy. Our Council wields considerable influence in our college, yet I believe we can do more to incorporate the will of our members into our decisions. A willingness to innovate will drive this enterprise. One of the advances I helped develop is a resolution writing tool that helps transforms ideas into easily communicated actions for consideration. Instruments like these can be quite empowering.

Through focused effort, we can manifest the power of many into the voice of one.

It is with earnest humility, and yet a sense of excitement, that I ask for your vote for Vice Speaker of our ACEP Council.

I look forward to seeing you in D.C.

Gary
Gary Katz, MD, MBA, FACEP
PRINCIPLES & VALUES

• Engage members with ongoing resolution and policy development.
• Use innovation and technology to incorporate member input prior to Council meeting.
• Adopt best practices from medical societies to keep our Council effective, productive, and rewarding.

SERVICE TO ACEP

Ohio Chapter ACEP
• Two-Term Chapter President
• Board of Directors
• Government Affairs Member
• Leadership Development Committee Cochair
• ACEP Councillor

ACEP & Council
• Federal Government Affairs Committee
• Steering Committee
• Tellers, Credentials & Elections Committee
• Reference Committee Member (Boston & Chicago)
• Section Council on Emergency Medicine
• Young Physician Section, Secretary
• Council Awards Committee

SERVICE TO ORGANIZED MEDICINE

OUTSIDE OF ACEP

• EMRA Board of Directors
• EDPMA Board of Directors
• Ohio State Medical Association (OSMA) Board of Directors
• Ohio State Medical Association Delegate (OSMA) to the American Medical Association (AMA)
• American Medical Association (AMA) Chairman Young Physicians Section
• Liaison Committee on Medical Education (LCME)
• Residency Review Committee - Emergency Medicine

GARY KATZ, MD, MBA, FACEP
FOR ACEP COUNCIL VICE SPEAKER

“Invest in leadership development, councillor value, and effective policy-making.”

“Invest in leadership development, councillor value, and effective policy-making.”
Board of Directors Candidates
2017 Board of Directors Candidates

Stephen H. Anderson, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Kathleen J. Clem, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Carrie de Moor, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

John T. Finnell, MD, MSc, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
Alison Haddock, MD, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Jon Mark Hirshon, MD, PhD, MPH, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Aisha T. Liferidge, MD, MPH, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Virgil W. Smaltz, MD, MPA, FACEP
- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?

Experience, passion & a commitment to the future define my skillset for the Board. For over 30 years I’ve practiced EM and devoted myself as a Department Chairman, Chair of Education, & Chief of Staff at my hospital. I honed the abilities to prove the value of Emergency Medicine to my partners and colleagues. Leadership in your own shop focuses your commitment, while teaching you the value of teamwork that works across all lines of service. What’s best at the gurney needs to be the easy solution hospital wide (be it EHR’s, Boarding, or continuity of care). I’m grounded in my patient’s best interests.

With many of our strategic battles now being waged on the state level with Medicaid and insurance companies, I’ve fought and won against flawed policy at that level. Having found Win-Win solutions by developing a care coordination program in WA that is now a blueprint nationally for state programs, I understand how to stand up for Prudent Layperson access to care, while achieving better health outcomes, increased provider satisfaction, & SAVE MONEY. We don’t need more roadblocks or revolving doors; we need more tools like we created with the Washington State 7 Best Practices that I co-wrote.

That experience and passion got me elected to the Board 3 years ago. There we created CEDR (to augment reimbursement while owning our Metrics), created a Diversity & Inclusion Task Force (to remove obstacles to success), & fought “Balanced Billing” and the flawed policies of the AHCA. I was honored to give the Colin Rorrie Health Policy lecture on Coordinating Care at ACEP15. These, and countless other battles, I worked tirelessly to find solutions to over the last 3 years on the Board.

I don’t feel as though my work is done.

So my focus is still 3-10 years down the line, through advocacy, mentoring, and creating a structure within ACEP to continue to keep us at the head of the table in the House of Medicine. “Been there, done this. Proud but not satisfied”, yet I’m still passionate about continuing to help lead for years to come.

Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?

For thousands of years physicians have been among the most trusted and revered leaders in their communities. The hours and devotion have always demanded this to be more than a job, even more than a career; it’s a life. Yet anyone who interviews with my group is told upfront that our priorities are in order: 1) Family first 2) What ever makes you whole second 3) Job third. For some, ACEP is their family and what makes them whole, but most of us need to always remember this order. While we create Wellness Week to remind us to exercise, eat right, sleep, find your “happy place”, I believe our focus needs to be in two areas.

First, making our workplace less chaotic, less frustrating, and returning us to the bedside where we get that endorphin bolus from helping people. EHR’s need to free us from the computer. Supervisor’s need to understand that patients that are admitted do better moved out of the ED space (especially our critical care and Mental Health patients). Administrators and colleagues need to grasp that to change medicine from quantity to quality we must have care coordination of our highest utilizers so the door at discharge isn’t a revolving one, but actually leads to warm handoffs. Above all else, we need to find the pride and ownership in our departments that comes from being at the leadership table that makes decisions, and allows us to be heroes, not employees.

Finally, we need to grasp the concept that the enemy of burnout, mental health spirals, and depression is engagement and self worth. We are heroes, and we need to think of ourselves that way. The surest way to do that, is getting involved in endeavors
that move the milestones of humanity forward. We can find self worth easiest, when we help others find theirs. Mentorship of our younger colleagues is a great starting point. It grows others, enriches our own souls, while ensuring Medicine for years to come as an institution where you will feel safe being cared for. Personally, I also believe fiercely in volunteer work. If you want to refresh your spirit, give more then a check to someone that is in need. Give your time, your heart, and your soul and it will be refilled at a tenfold greater level. Helping ACEP members find that precious time, carved away from work, while not stealing from family, is what helps to make us whole (see #2 above).

**Question #3: How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?**

In my chapter and residency visits I stress the top 10 reasons to stay a member of ACEP:

1. **Practice resources** - through rigorous scientific analysis, ACEP creates and posts on their web site Clinical Policies and practice guidelines for best practices in clinical care.

2. **Legal Protections and surveillance of ethical violations** - We offer advice during litigation, and sanction members who give false testimony.

3. **Sections** - Find your personal passion in one of 37 areas from Critical care, to Social Medicine to name two.

4. **Proof of worth to the House of Medicine and reimbursement entities** - Fighting at the RUC and against Surprise Coverage. Your efforts need to translate into your economic security.

5. **Research & Science** - Through EMF and Annuals. Just two of the examples of ongoing Scientific expansion that leads the world in Emergency research.

6. **CEDR** - Securing dollars for the metrics that define quality, while Medicare transitions from SGR to MIPS.

7. **Advocacy** - We are the voice for our specialty, our colleagues & our patients when Policy matters. Through LAC, our DC office, NEMPAC, etc., we work 24/7/365 to be the trusted voice our legislators and the public turn to for answers.

8. **Education** - Ask most members what they think of first when ranking the benefits of ACEP, they will say enhancing their skills and knowledge. ACEP17, virtual ACEP, Directors Academy, Coding & Reimbursement conference, Peds EM, Podcasts, etc. are just a headliner list of ongoing CME from ACEP. As FOAM expands, ACEP leaders are leading that endeavor to recognize where scientific discussion can be innovative, but trustworthy.

9. **Networking** - Why do I devote myself so fully to ACEP…the power of camaraderie. These are my most trusted peers, whose goals and motivations align with mine. These are my fellow soldiers in the daily battles against the common adversaries, in similar trenches across the continent. Ultimately we all define ourselves by the care delivered at a bedside, to that one patient. These are my mentors, my allies, and my friends that I gain personal strength from sharing my purpose with.

The list can be expanded to 20, 50 or 100 reasons. But with everyone asking for my time, my money, and my loyalty…ACEP is the organization I always reap more from than I donate to.
CANDIDATE DATA SHEET

Stephen Huntley Anderson MD, FACEP

**Contact Information**
34926 SE Brinkley Street  
Snoqualmie, WA 98065  
**Phone:** (253) 951-8881  
**E-Mail:** skkanderson@comcast.net  
sanderson@acep.org

**Current and Past Professional Position(s)**
Staff ED physician at MultiCare Auburn Medical Center (30 + years, including 15 years Chairman of Emergency Services, Chief-of-Staff, Chair of Education, Trauma, Stroke, Credentials, Resident education, etc. Member Critical Care, Founder first Urgent Care center in system, etc).  
Critical Access Hospital staff physician multiple hospitals including Enumclaw Hospital >15 years ago through Team Health.  
Original Staff at St. Joseph’s Free Standing Emergency Department, Federal Way, WA >25 years ago.

**Education (include internships and residency information)**
Undergraduate & Medical school (combined 6 year BS & MD) University of Michigan, graduated 1981.

Internship & R2 General Surgery at U of Michigan  
Chief resident ED, U of Michigan (with Survival Flight project )1984  
General Surgery U of Washington 1984-1986

**Certifications**
FACEP

**Professional Societies**
ACEP  
AMA

**National ACEP Activities – List your most significant accomplishments**
National Board of Directors (liaison to Public Relations Comm, Education Comm, Medical-Legal Comm, Critical Care section, Democratic Group Practice section, Social Medicine Section, Diversity & Inclusion Task Force, among others)  
National ACEP Councilor along with Steering Committee, Reference Committee on Public Policy, among others.
National Spokesperson of the Year 2013  
Scientific Assembly speaker (including Colin Rorrie Jr. Lecture on Health Policy 2015).  
Emergency Medicine Foundation, EMF, Board of Directors, Sec./Treasurer 2017.
ACEP Chapter Activities – List your most significant accomplishments
WA State Board of Directors including all executive leadership roles (Treasurer, President, Founder of State PAC, etc)
Co-founder WA Journal Club & State Summit (Summit to Sound Conference)
Co-Author WA State 7 Best Practices (Blueprint for Medicaid reform while preserving Prudent Layperson access)
First recipient WA State “Guardian of Emergency Medicine” award

Practice Profile
Total hours devoted to emergency medicine practice per year: 1700 + Total Hours/Year
National ACEP time

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 90 % Research 0 % Teaching 2 % Administration 8 %
Other: Active advocacy & National ACEP duties

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
Senior Partner in independent democratic group practice in medium sized (40K+ visit/year) single suburban hospital which is part of a 6 hospital system in South Seattle/Tacoma WA

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 2 Cases  Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Stephen Huntley Anderson MD, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: Cascade Emergency Physicians
   Address: 202 North Division Street
            Auburn, WA 98002
   Position Held: Senior member & Staff Physician
   Type of Organization: Contracted Physician group with MultiCare Auburn Medical Center

   Employer: American College of Emergency Physicians
   Address: 4950 W Royal Lane
            Irving, TX 75063
   Position Held: Stipend for Board of Directors
   Type of Organization: Greatest Professional Organization on Earth

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: American College of Emergency Physicians
   Address: 4950 W Royal Lane
            Irving, TX 75063
   Type of Organization: Possibly Greatest Professional Organization in the Universe
   Duration on the Board: 3 years

   Organization: Emergency Medicine Foundation EMF
   Address: 4950 W Royal Lane
            Irving, TX 75063
   Type of Organization: Charitable Organization dedicated to funding research in EM
   Duration on the Board: 2 years
<table>
<thead>
<tr>
<th>Organization</th>
<th>MultiCare South King County Health Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>202 N. Division Street</td>
</tr>
<tr>
<td></td>
<td>Auburn, WA  98002</td>
</tr>
<tr>
<td>Type of Organization</td>
<td>Hospital charitable wing supporting/coordinating all aspects of charity</td>
</tr>
<tr>
<td>Duration on the Board</td>
<td>4 years, founding chair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization</th>
<th>WA State ACEP chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Organization</td>
<td>State chapter of greatest professional organization, including at the state level</td>
</tr>
<tr>
<td>Duration on the Board</td>
<td>&gt;10 years, presently ad hoc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization</th>
<th>TNTC over 30 years. None active at this time, no conflicts, but some include: American Heart Association of King County, Nick of Time Foundation, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Organization</td>
<td>All Charitable Organizations for advancing Health Care</td>
</tr>
<tr>
<td>Duration on the Board</td>
<td>3-8 year terms</td>
</tr>
</tbody>
</table>

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe: unless EMF falls under this category. In which case I receive no compensation other than travel & lodging to destinations for B of D meetings. Usually covered under ACEP travel.

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:
5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO- Have been careful over last 3 years to ensure no conflicts.
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Stephen H. Anderson MD, FACEP          Date          July 4, 2017
September 7, 2017

Dear Members:

On behalf of the Washington Chapter of the American College of Emergency Physicians, I would like to wholeheartedly endorse the candidacy of Stephen H. Anderson, MD, FACEP for re-election to the American College of Emergency Physicians’ National Board of Directors.

Steve has been a true leader throughout his career in emergency medicine, including serving as Medical Group Director, Hospital Chief of Staff, member of the Washington State EMS and Trauma Care Council, Chapter President of WA-ACEP, ACEP Public Relations Committee, ACEP Council Steering Committee and ACEP Board Member. He brings a wealth of experience and passion to the ACEP Board of Directors.

Steve’s experience and leadership alone would make him well-qualified for a Board of Director position. What truly sets him apart as a candidate is his experience on working on the opioid epidemic that currently grips our country. Steve has had great success working with legislators and the public, and educating emergency physicians about solutions when treating patients dealing with opioid-related issues. Steve famously championed the Washington State Best Practices Initiative, now promulgated across the country. Steve was a voice of reason who explored solutions that would reduce costs for Washington State while preserving the Prudent Layperson Standard and protect the rights of Medicaid patients. The “7 Best Practices” Initiative was created and saved Washington State more than $32 million, while decreasing the rate of prescription drug abuse in our state. Steve has also championed proper narcotic prescribing behaviors for our specialty, and his work has resulted in countless saved lives through the prescribing guidelines recently implemented in Washington State, and now being modeled across the country. He now lectures across the country on issues regarding opiate prescribing and treatment, and is one of the strongest voices we have in the college on this important issue.

The Washington Chapter is proud of the work that Steve Anderson has accomplished while on the Board of Directors, and fully supports his work to improve emergency care for all patients. I hope that all ACEP members will give him the strongest consideration in re-election to the ACEP Board of Directors.

Sincerely,

Patrick Solari, MD, FACEP
Washington ACEP President
Re-Elect

Stephen H. Anderson MD, FACEP
ACEP Board of Directors

Passionate & Engaged - Treasurer/Chair Elect of EMF, Liaison to Education, Critical Care, Public Relations Committee, Among many regional & national involvements.

Experienced - Present Member ACEP & EMF Board of Directors, Past Chair of Department & Chief of Staff, among many roles

Spokesman/ Leader - Past ACEP Spokesperson of the Year, Colin Rorrie Jr. Lecturer at ACEP15 on Health Care Policy

“Proud, but Not Satisfied”
We can be proud of the accomplishments of our College and our Colleagues in leading us to a position of leadership in our Nation, and in the House of Medicine.

But we cannot be satisfied with where we are.

We’ve repealed the SGR, and replaced it with MIPS, but we remain in a constant battle for fair reimbursement and for fair coverage/access for our patients.

We’ve created a Clinical Emergency Data Registry, but still battle to prove our worth to the public and government. We’ve battled Merit Badge mandates and created state-to-state license reciprocity, but we’ve only started the process to revamp Maintenance of Certification.

We’ve begun to link all hospitals ED’s with an Emergency Department Information Exchange. Yet we continue to fail as a profession to secure widespread solutions to Mental Health Boarding, & opiate abuse.

The lists go on. WE CAN DO BETTER, and I DON’T FEEL AS THOUGH MY JOB IS COMPLETED!
### Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?

I recognize that the current challenges facing our specialty and indeed, the entire house of medicine, are unprecedented. ACEP needs experienced leaders to lead through this critical time in health care. I have been an involved ACEP member since 1991 and have over 20 years of experience as leader for both community and academic emergency medicine. I know how to work within and for complex systems as we shape the future of Emergency Medicine.

I have served as a medical director, tackled reimbursement issues for my group, tort reform at the state level, residency support issues, and understand that unnecessary requirements of our time and energy matter. I also understand the challenges associated with addressing these issues. As a past academic chair, current Chief Medical Officer and health system Vice President, I bring additional experience to navigate challenges to our specialty. I have led efforts for hospitals to be incentivized to rapidly admit patients, supported resources for timely consults, and worked to build bridges with other specialties. I value, seek out, and treasure opportunities to listen to physicians. The importance of listening-to-understand cannot be overstated. I would continue to seek these opportunities as a member of the BOD and then collaborate with the board to incorporate the concerns and solutions offered by our members into the work we do at ACEP.

I would continue ACEP’s focus on specific strategies to recruit and retain young physicians by increasing designated chapter leadership positions for residents and leadership development tracks. I would continue to work with CORD and EMRA to bring synergy around these efforts as well.

I spent 18 years as academic chief and chair at level 1 trauma centers, started the Emergency Medicine residency at Duke, and was the Chair at Loma Linda during the San Bernardino mass shootings. I have worked my share of nights, weekends, and holidays, and have worked in small single-coverage EDs too. My current employer has enthusiastically endorsed my involvement with ACEP. I recognize that emergency departments and the physicians who staff them are crucial to America’s healthcare. I want the opportunity to be at the forefront of ACEP’s work to promote our core values and continue to deliver the highest quality of care for our patients.

### Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?

We need to further leverage and build on the work that ACEP has initiated to address burnout and resiliency. As the Chair for the inaugural ACEP Wellness Week I am proud of the initiatives we have put into place. One success story is ACEP’s resiliency and mindfulness training. We need to continue our focus on physician wellness, improved access to resources/networking for physician wellbeing, and we need to develop toolkits to help members build their village of support. Doctors are starting to recognize that it is OK to talk about burnout. This is a key step and provides ACEP with an unprecedented opportunity to help our members on their individual journeys to wellbeing. Emphasis and accessibility to ACEP wellbeing resources will make it easier for physicians to both meet their own needs and to reach out to peers showing signs of burnout.

That said, the sources of burn-out are directly related to the stressors associated with our everyday practice of emergency medicine. I have mentored peers as they dealt with the aftermath of litigation, walked fellow emergency physicians through complex decisions as they faced the reality of their personal career burn-out, and helped colleagues move through career transitions. But it is not just about personal resiliency. ACEP must continue to address unnecessary stressors such as: nursing staff shortages, unreasonable documentation demands, unrealistic expectations for EDs to solve hospital through-put issues without administrative commitment/action, and inappropriate patient satisfaction demands. Data show that ED patient...
populations are sicker than in the past. The administrative demands to do more with less are our reality. We must take control of the metrics and quality measures as applied to the practice of emergency medicine. This not only is important for our specialty; it will decrease burnout. When we can deliver the excellence that we expect of ourselves within a supportive system, the true joy of practice can be realized.

**Question #3: How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?**

Our newest members need increased opportunities for Emergency Medicine physician mentorship and connectivity. Establishing strong professional relationships early in our career is one of the best ways to insure ongoing success. ACEP provides this network. My experience as a department chair has shown the importance of sponsorship and mentoring. As a leader for the Association of American Women Emergency Physicians (AAWEP) Leadership Pipeline initiative we have experienced success in working with AAWEP members. Some of the success of this intentional work is reflected in the diversity of the 2017 ACEP BOD candidates. When a physician joins an ACEP section that reflects their interests, it provides a key resource to advance career passions. The AAWEP mentoring model could be replicated by other sections/interest groups as we grow the emergency medicine leaders of the future.

ACEP is our professional home and the premier organization to provide guidance, support, mentoring and professional networking throughout our careers. I would not be where I am today without ACEP’s support, resources, and guidance. Young emergency physicians will find a wealth of crucial tools to help them succeed when they tap into ACEP career resources. ACEP provides professional networks that are vital to build and sustain professional skills, knowledge, and resources to prevent burnout. There is no better source for the ongoing career needs of emergency physicians.
CANDIDATE DATA SHEET

Kathleen J. Clem, MD FACEP

Contact Information
998 Warehouse Road Apt 120106 Orlando, Florida 32803
Phone: (919) 599-9660
E-Mail: kathleen.clem@ahss.org

Current and Past Professional Position(s)

HOSPITAL APPOINTMENTS
Loma Linda University Medical Center 1992-1998
Riverside General Hospital 1992-1998 (per diem)
San Antonio Community Hospital – 1991-1998 (per diem)
Suburban Hospital, Maryland 1993-1998
(per diem to care for family member with terminal illness)
Duke University Medical Center 1998 – 2007
Loma Linda University Medical Center 2007-2016
Loma Linda University Children’s Hospital 2016
Florida Hospital – current

CURRENT ACADEMIC APPOINTMENTS
Professor Emergency Medicine, University Central Florida, College of Medicine

PAST ACADEMIC APPOINTMENTS
1992 Instructor LLSOM – Department of Emergency Medicine
1994 Assistant Professor LLSOM – Department of Emergency Medicine
1999 Associate Professor Duke University SOM – Department of Surgery
2007 Professor Emergency Medicine and Pediatrics, LLU School of Medicine

LEADERSHIP POSITIONS
Chief, Division of Emergency Medicine, Department of Surgery, Duke University 1999-2007
Chair, Department of Emergency Medicine, Loma Linda University 2007-2016
Chief Medical Officer, Vice President, Florida Hospital East Orlando 2016-present

Education (include internships and residency information)

EDUCATION AND TRAINING
ASN Loma Linda University School of Nursing
BSN Tennessee Technological University
1989 Loma Linda University School of Medicine
1989-1992 Residency Loma Linda University- Emergency Medicine

MD 1989

Certifications
ABEM
1994 Emergency Medicine – initial
2004 Emergency Medicine – recertification
2013 Emergency Medicine – recertification
Professional Societies

ACEP
Florida Chapter
Vermont Chapter
SAEM

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians (ACEP) Steering Committee 2016-2018
ACEP Well Being Committee – 2015-2016
Wellness Week Task Force Chair 2016
Association of Women Emergency Physicians (AAWEP) – Chair 2013-2015
American College of Emergency Physicians (ACEP) 1992-present

ACEP International Section Councilor 2000-2001
ACEP American Association of Women in Emergency Medicine 1992-present
ACEP Public Relations Committee member 2002-2008 Chair 2002-2004
ACEP Council Awards Committee 2008-2009
ACEP Membership Committee 2014-2016
Chair 2016-2017
ACEP Reference Committee Chair - 2014
ACEP National Chapter Relations Committee 2008-2015 Chair 2008-2010
ACEP Speakers Bureau Subcommittee – 2006
ACEP Geriatrics Subcommittee – 2006 - 2007
ACEP Candidate Forum Subcommittee 2005-2006
ACEP Council Steering Committee 2005-2007, 2017-present
ACEP Emergency Preparedness Steering Committee 2007
ACEP State Chapter Grants in Public Relations and Chapter
Grant Review for National/State Chapter Relations Committee 2004-to present

ACEP Chapter Activities – List your most significant accomplishments

North Carolina Chapter of ACEP - Councilor 2005-2008
North Carolina Chapter ACEP – Board Member 2001-2007
California Chapter ACEP Education Committee 1996-1998, 2008
Florida Chapter – Task Force to implement statewide implementation of EDIE

Practice Profile

Total hours devoted to emergency medicine practice per year: \(432\) Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care \(15\) % Research \(1\) % Teaching \(10\) % Administration \(74\) %
Other: Vice President of Emergency Services for Emergency Medicine \(\) %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.) Group Employment – multi-hospital -community hospital with affiliated ACGME accredited EM residency.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 2 Cases Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Kathleen J. Clem, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Florida Hospital  
   Address: 7727 Lake Underhill Road  
   Orlando, Florida 32822  
   Position Held: Chief Medical Officer, Vice President Emergency Services  
   Type of Organization: Hospital System

   Employer: TeamHealth  
   Address: 500 Winderley Pl Ste 115  
   Maitland, FL 32751  
   Position Held: Staff Physician  
   Type of Organization: Physician led employment company

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

   Organization: SAEM Board of Directors  
   Address: 1111 East Touhy Avenue, Suite 540  
   Des Plaines, IL 60018  
   Type of Organization: Academic Emergency Medicine Society  
   Duration on the Board: 2013-2016

   Organization: Women Executives in Science and Health Care Board of Directors  
   Address: 100 N 20th St Fl 4  
   Philadelphia, PA 19103-1462  
   Type of Organization: Women's Studies Research Institute  
   Duration on the Board: 2009- 2014
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Kathleen J. Clem, MD FACEP     Date 7/9/2017
May 10, 2017

The American Association of Women Emergency Physicians (AAWEP) along with the Florida College of Emergency Physicians (FCEP) are extremely pleased to endorse the candidacy of Kathleen Clem, MD, FACEP, for a position on the American College of Emergency Physicians Board of Directors.

Over the past 25 years, Dr. Clem has dedicated her career to building up organizations and individuals. The notable number of “firsts” among her many accomplishments speak to a combination of superlative leadership skills and infectious passion. Examples include inaugural Division Chief of Emergency Medicine at Duke University, first female Division Chief within Surgery at Duke University, first female Chair of a Department at Loma Linda University School of Medicine, and founding president of the AAWEP’s sister organization, the Academy for Women in Academic Emergency Medicine (AWAEM).

Reviewing her accomplishments, it should come as no surprise that Dr. Clem has established a reputation as a worthy role model for women in Emergency Medicine, and her award-winning service as Chair of the AAWEP Section is yet further evidence of her broad impact. Beyond her work with AAWEP, Dr. Clem’s contributions to ACEP over the last two decades also include Chair roles for the Public Relations Committee, the Wellness Week Task Force, the Membership Committee, and the National Chapter Relations Committee. Additionally, her experience as Councilor for both the ACEP International Section and the North Carolina Chapter, her service on the North Carolina Chapter Board of Directors, as well as her extensive committee work all demonstrate an in-depth understanding of ACEP policies and priorities befitting a candidate for the Board of Directors.

I first met Dr. Clem upon succeeding her as the Chair-Elect for AAWEP. In what I have since come to know as typical fashion, she quickly took me “under her wing” as Chair and assigned me to a high-impact role as AAWEP representative to a newly formed collaborative best practices task force charged with developing recommendations for recruiting, retaining, and advancing women in the emergency medicine workforce. This work ultimately led to other “firsts,” including successful passage of a Policy Statement Supporting Women in Emergency Medicine by the ACEP Board of Directors, an “Editor’s Pick” publication in Academic Emergency Medicine, and a recently submitted ACEP grant application to define and characterize individual best practices supporting women. Looking back, this is a perfect example of how Dr. Clem’s investment in individuals and organizations reaches far past her own tenure of leadership to positively influence generations in moving our specialty forward.

Since taking the Chief Medical Officer at Florida Hospital East, Dr. Clem has become very active in ensuring quality measures and patient satisfaction measures are in place at the multiple emergency departments under her jurisdiction with the hospital system. Dr. Clem is also participating in a Task Force created by Florida Hospital Association and FCEP to encourage statewide implementation of EDIE. Dr. Clem is also working clinically and has developed great relationship with the EM residents as well as all residents at Florida Hospital East.

Dr. Clem’s leadership, passion, and experience make her a uniquely qualified candidate for the ACEP Board of Directors, and AAWEP and FCEP are very pleased to fully and enthusiastically endorse her candidacy.

Mary Westergaard, MD, FACEP
President, AAWEP

Jay Falk, MD, FCCM, FACP
President, FCEP
Dear Colleagues,

Thank you for the service you provide to our patients and ACEP. ACEP needs experienced leaders to lead through this critical time in health care. I have been an involved ACEP member since 1992 and have over 20 years of experience as a leader for both community and academic Emergency Medicine. Now is the time for me to give back. I know how to work within and for complex systems as we shape the future of Emergency Medicine.

I have served as a medical director, tackled reimbursement issues for my group, tort reform at the state level, residency support issues, and understand the burdensome requirements of our time and energy. I also understand the challenges associated with addressing these issues. I continue to work shifts, so I live, breathe, and experience what all Emergency physicians do. As a past academic chair, current Chief Medical Officer and health system Vice President, I bring additional experience to navigate challenges to our specialty. I value, seek out, and treasure opportunities to listen to physicians. The importance of listening-to-understand cannot be overstated. I would continue to seek these opportunities as a member of the BOD and then collaborate with the board to incorporate the concerns and solutions offered by our members into the work we do at ACEP.

I would continue ACEP’s focus on specific strategies to recruit and retain young physicians by increasing chapter leadership positions for residents and leadership development tracks. I would continue to work with CORD and EMRA to bring synergy around these efforts as well. As the current ACCEP Membership Committee Chair, I understand that our newest members need increased opportunities for Emergency Medicine physician mentorship and connectivity. ACEP provides professional networks that are vital to build and sustain professional skills and resources to prevent burnout. Establishing strong professional relationships early in our careers is one of the best ways to insure ongoing success. As lead for the Association of American Women Emergency Physicians (AAWEP) Leadership Pipeline initiative we have experienced success in working with AAWEP members. Some of the success of this intentional work is reflected in the diversity of the 2017 ACEP BOD candidates.

We need to build on the work that ACEP has initiated to address burnout and resiliency. As the Chair for the inaugural ACEP Wellness Week I am proud of the initiatives we have put into place. Emphasis and accessibility to ACEP wellbeing resources will make it easier for physicians to both meet their own needs and to reach out to peers showing signs of burnout. That said, the sources of burn-out are linked and directly related to the stressors associated with our everyday practice of Emergency Medicine. ACEP must continue to addresses unnecessary stressors such as: nursing staff shortages, unreasonable documentation demands, unrealistic expectations for EDs to solve hospital through-put issues without administrative commitment/action, and inappropriate patient satisfaction demands.

Data show that ED patient populations are sicker than in the past. The administrative demands to do more with less are our reality. We must take control of the metrics and quality measures as applied to the practice of Emergency Medicine. When we can deliver the excellence that we expect of ourselves within a supportive system, the true joy of practice can be realized. I want the opportunity to be at the forefront to promote our core values and continue to deliver the highest quality of care for our patients by serving as a member of the ACEP Board of Directors. We can and must take control of our specialty – the health of the nation depends on it. Kathleen Clem, MD FACEP
KATHLEEN J. CLEM, MD, FACEP
ACEP Board of Directors Candidate
Proudly Endorsed by AAWEP and the Florida Chapter of Emergency Physicians

I am proud to be an emergency physician and will work to make our specialty even stronger. I am honored and humbled to have served ACEP throughout my career, and my focus has always been on ensuring that emergency physicians have the resources they need to enjoy their practice and give great patient care. I am ready to serve on the ACEP BOD to find and develop new opportunities for our specialty to lead in the House of Medicine. It would be my honor to advocate for my fellow emergency physicians as a member of the ACEP BOD. I will work tirelessly to contribute and fight for the values most important to emergency physicians and our patients. I ask for your support and I will make your vote count.

Kathleen Clem, MD, FACEP

ACEP SERVICE HIGHLIGHTS

+ Membership Committee Chair 2016-present
+ Diversity and Inclusion Task Force
+ Well-Being Committee – Wellness Week Task Force – 2016 Chair
+ California - (Cal-ACEP) Education Committee
+ International Section Councillor
+ AAWEP – 2013-2015 Chair
+ Public Relations Committee – past Chair
+ Council Awards Committee
+ National Chapter Relations Committee – 2002-2004 Chair
+ Speakers Bureau Subcommittee
+ Spokespersons Network
+ North Carolina (NCEP) Board member
+ Emergency Preparedness Steering Committee
+ Candidate Forum Subcommittee/moderator
+ Current Steering Committee member and SAEM Councillor

CLINICAL EXPERIENCE / LEADERSHIP

+ 18 years’ leadership in Level 1 trauma centers
+ Community EDs – single and double coverage
+ Established new community ED -California
+ Community ED directorships North Carolina and California
+ Current – CMO/Vice President Emergency Services at Florida Hospital
+ Current – clinical practice community ED >120K/yr and teaches EM residents

PROFESSIONAL SERVICE HIGHLIGHTS

+ Experienced in reimbursement, tort reform, residency support issues
+ Fights back against unreasonable demands on physician time
+ Work for hospitals to be incentivized to rapidly admit patients and support resources for timely consults
+ Litigation support for physicians
+ Continued focus on diversity and inclusion. Works with the Association of Academic Chairs in Emergency Medicine (AACEM).
+ Increased opportunities for Emergency Medicine physician mentorship.
+ Focus on physician wellness
Joint American Association Women Emergency Physicians (AAWEP) and Florida College of Emergency Physicians (FCEP) endorsement

The American Association of Women Emergency Physicians (AAWEP) along with the Florida College of Emergency Physicians (FCEP) are extremely pleased to endorse the candidacy of Kathleen Clem, MD, FACEP, for a position on the American College of Emergency Physicians Board of Directors.

Over the past 25 years, Dr. Clem has dedicated her career to building up organizations and individuals. Reviewing her accomplishments, it should come as no surprise that Dr. Clem has established a reputation as a worthy role model for women in Emergency Medicine. Dr. Clem’s contributions to ACEP over the last two decades includes service as Committee Chairs, Councilor, and extensive committee work, and more. She demonstrates an in-depth understanding of ACEP policies and priorities befitting a candidate for the Board of Directors.

Since becoming the Chief Medical Officer at Florida Hospital East, Dr. Clem has become very active in ensuring quality measures and patient satisfaction measures are in place at the multiple emergency departments under her jurisdiction with the hospital system. Dr. Clem is also participating in a Task Force created by Florida Hospital Association and FCEP to encourage statewide implementation of communication between EDs and to implement a statewide policy on narcotic use. Dr. Clem works clinically and has developed a great relationship with the EM residents at Florida Hospital.

Dr. Clem’s leadership, passion, and experience make her a uniquely qualified candidate for the ACEP Board of Directors, and AAWEP and FCEP are very pleased to fully and enthusiastically endorse her candidacy.

Mary Westergaard, MD, FACEP
President, AAWEP

Jay Falk, MD, FCCM, FACP
President, Florida ACEP
2017 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Carrie de Moor, MD, FACEP

**Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?**

Although I have an early career background in Academics and as a Medical Director at a Level 1 Trauma Center, what differentiates me as a candidate and where I can fill a void on the ACEP Board right now is my significant experience in not only starting, managing, and growing a physician owned business, but also my experience in both facility based and physician billing. We all know that the insurance industry has taken aim at Emergency Medicine. Despite this assault, I have devoted a large amount of my administrative time to protecting and defending my group’s independent practice by carefully studying insurance company behavior, learning their games, and devising strategies to overcome their predatory practices. I don’t have all the answers and at times I have had occasional setbacks and challenges. I have learned a lot of things along the way. I am proud to say I have created a practice environment that allows physicians to be back in the driver’s seat and in control of their practice. It is possible to standup to the insurance industry that doesn’t want to appropriately pay us. It is possible, no matter what your practice environment, to have a career that you enjoy and where you have a sense of ownership or control. I will bring the business know how, resiliency, strategic thinking, negotiation skills, and a deep understanding of payor behavior to the Board. But more importantly, I will bring optimism. The future can be better than the present for ALL Emergency Physicians, and we have the ability to make certain that it is so. I will not represent one type of practice, I will represent all Emergency Physicians and do so without influence and will be fearless in the pursuit of a better tomorrow for all of us.

**Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?**

Emergency Physicians are resilient in nature. We are all resilient, but we experience repetitive intense stress, often without feeling a true sense of relief or reward. All too often, finances push us to work more hours. You come out of residency ready to pay off your student loans, buy a home, start a family. So, you work as hard as you can- knowing all along that perhaps you are focused too much on taking care of others, and not taking care of yourself. With the highest percentage of burnout in medicine belonging to our specialty, we need to do more than focus solely on providing tools to members so that it “doesn’t happen to them too”. As a college, we need to take an approach that overhauls the entire way we think about “normal” practice of Emergency Medicine. We need to take a step back and evaluate what is sustainable for a human being to endure without experiencing burnout. When isolated events of burnout occur in any job, that may be an example of where providing individuals with tools to avoid it may help. In our case, the prevalence is astronomically high and none of us, not me, not you, are immune- no matter how much we consider ourselves a BAFERD. We need to take a strategic approach that tackles the systematic problems that are plaguing all Emergency Physicians and work to eliminate the barriers that prevent all of us from achieving the wellness we desire. We need to heal our entire specialty, and fix the problems that we know exist today for ourselves and for the Emergency Physicians of tomorrow.

**Question #3: How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?**

“You must see it all.”- If you are like me, you hear that phrase all the time from friends, family, and new acquaintances when they ask what it is that you do. You smile and tell a funny or exciting story that you have probably told a thousand times. Yet, in the back of your head, you think to yourself how they could never understand exactly what it is that you do- everyday. We save lives. We see people at their worst. We witness miracles and we witness immense sadness- all in a day’s work. When young emergency physicians ask me, why join ACEP? My answer is simple: community and solidarity. We are all strong
individuals, but we are stronger together. We are all different, but the practice of Emergency Medicine is the common thread that ties us all together. The only way we can make a difference for ourselves and our patients is with a unified powerful voice. That voice is ACEP. To retain and incentivize members, we need to be sensitive to financial struggles that may make ACEP membership dues a burden. Adding a confidential option for physicians struggling with finances to have discounted access to membership and increasing services that help to avoid those struggles like financial counseling as a benefit of membership are ways that I believe we can avoid a decline in membership. Most of us love to go to Scientific Assembly every year not only for CME, but to see our friends. I believe ACEP could help encourage chapters to do frequent local events in the communities where physicians live. ACEP Members night out in your community- a frequent opportunity to socialize with your fellow EM Docs. If organized by the College, this could provide immense value to membership and help alleviate a degree of burnout. No matter what we do, we must create value for our members and we must listen to them. You can see by social media that non-members are not shy about vocalizing their opinions. We should take criticism seriously and find ways to improve based on that feedback, whatever it may be.
CANDIDATE DATA SHEET

Carrie de Moor, MD, FACEP

Contact Information
4701 Paxton Lane
Frisco, TX 750324
Phone Cell 469-815-4142 Home- 214-705-9884
E-Mail: cdemoormd@code3emdocs.com

Current and Past Professional Position(s)
Current: Chairman, President and CEO- Code 3 Emergency Partners, LLC; Chairman/Founder- Code 3 Emergency Physicians. PA
Past : EmCare
John Peter Smith Health Network
Emergency Department
Medical Director 6/2012- 11/2013
ED Trauma Director 8/2011- 11/2013
Associate Medical Director 9/2010-6/2012
Core Faculty Emergency Medicine Residency Program
EMERUS- Craig Ranch Medical Director 2/2010- 9/2010
Full Time Clinical Staff

Education (include internships and residency information)
July 2006- June 2009 Texas Tech University/Thomason Hospital El Paso, TX Residency- Emergency Medicine
• Administrative Chief Resident 2008-2009
July 2005 – June 2006 UTMB- Children’s Hospital Galveston, TX Internship- Department of Pediatrics
2001-2005 TTUHSC School of Medicine Lubbock/El Paso, TX
Doctor of Medicine
1998- 2001 Southern Methodist University Dallas, TX Bachelor of Arts, Psychology
Degree: Doctor of Medicine (MD) 2005

Certifications
American Board of Emergency Medicine 11/2010

Professional Societies
ACEP
Texas ACEP
Texas Medical Association
• 2012-2014 Chair Young Physicians’ Section
• Current TMA Board of Trustees
Collin County Medical Society
• Board of Directors/ TMA Delegate 2010-Present
• Current Immediate Past President
TEXPAC
- Vice Chair 2014- Present
TAFEC- Texas Association of Freestanding Emergency Centers
NAFEC- National Association of Freestanding Emergency Centers
UCAOA- Urgent Care Association of America

American College of Emergency Physicians - Texas Chapter
- TCEP Board of Directors 2012- Present
- TCEP Board of Directors Secretary 2014-2015
- TCEP Board of Directors- YPS Member 2011- 2012
- TCEP Board of Directors – Candidate Member 2008-2009
- TCEP Leadership and Advocacy Fellow 2010-2011
- ACEP- Texas Councilor 2012- Present
- ACEP- Texas Alternate Councilor 2009-2012

National ACEP Activities – List your most significant accomplishments
- Current Chair- ACEP Freestanding Emergency Centers Section 2016- present
- Helped to push forward the advancement of the ACEP FSEC Accreditation Task Force
- Chair Elect ACEP Freestanding Emergency Centers Section 2014-2016
- Current Secretary American Association of Women Emergency Physicians
  - LEAP Mentor
- ACEP Federal Government Affairs Committee 2016-present
- ACEP National Chapter Relations Committee 2014-2015
- ACEP Council Reference Committee 2014
- ACEP Membership Committee 2012-2014
  - Sub-committee Co-Chair ACEP EM Futures
- ACEP Pediatrics Committee 2008-2012
- ACEP 911 Network
- ACEP YPS Steering Committee  2011-2015
  - Co-Authored 2013 Breastfeeding Resolution
- ACEP- Texas Councilor 2012- Present
- ACEP- Texas Alternate Councilor 2009-2012
- EMRA Region 5 Representative and Program Rep 2006-2009

ACEP Chapter Activities – List your most significant accomplishments
- TCEP Board of Directors Secretary 2014-2015
- TCEP Board of Directors 2012-2015
- TCEP Board of Directors- YPS Member 2011- 2012
- TCEP Board of Directors – Candidate Member 2008-2009
- TCEP Leadership and Advocacy Fellow 2010-2011
- TCEP Residency Visits Coordinator 2011- 2013
- TCEP 40th Anniversary Gala Committee Chair 2014

Practice Profile

Total hours devoted to emergency medicine practice per year: 2880 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
- Direct Patient Care 50%
- Research 5%
- Teaching 5%
- Administration 40%
- Other:

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I founded, work for, and lead an independent group of Emergency Medicine physicians. We own and operate our own Emergency Centers and Urgent Cares in both Texas and Nevada, in addition to providing outsourced emergency medicine physician staffing to hospitals and other freestanding emergency centers. Our group has over 120 independent emergency physicians with over 60 invested partners from all over the United States. We
currently operate 4 Freestanding Emergency Centers and 5 Urgent Care facilities, most of which are co-located. By the end of 2017, we will operate 6 Freestanding Emergency Centers and 7 Urgent Care facilities. Every facility is owned and managed by Board Certified Emergency Medicine physicians.

**Expert Witness Experience**

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defense Expert</td>
<td>0</td>
</tr>
<tr>
<td>Plaintiff Expert</td>
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<tr>
<td>Cases</td>
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</tr>
</tbody>
</table>
# CANDIDATE DISCLOSURE STATEMENT

## Carrie de Moor, MD, FACEP

### 1. Employment

- **Employment** – List current employers with addresses, position held and type of organization.

<table>
<thead>
<tr>
<th>Employer</th>
<th>Address</th>
<th>Position Held</th>
<th>Type of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 3 Emergency Partners, LLC</td>
<td>5300 Town and Country Blvd Suite 260, Frisco, TX 75034</td>
<td>Chief Executive Officer/President</td>
<td>Practice Management Service Organization/ FSER and UCC Operator</td>
</tr>
<tr>
<td>Code 3 Emergency Physicians, PA</td>
<td>5300 Town and Country Blvd Suite 260, Frisco, TX 75034</td>
<td>Chairman of the Board/Founder</td>
<td>Independent Physician Staffing Group</td>
</tr>
</tbody>
</table>

### 2. Board of Directors

- **Board of Directors Positions Held** – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Type of Organization</th>
<th>Duration on the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Medical Association</td>
<td>401 West 15th Street, Austin TX 78701</td>
<td>Texas Chapter of the AMA/ Organized Medicine- All Specialties</td>
<td>2 years Current until April 2018</td>
</tr>
<tr>
<td>Texas College of Emergency Physicians</td>
<td>2525 Wallingwood Dr., Bldg. 13-A, Austin, TX 78746</td>
<td>Texas Chapter of ACEP</td>
<td>6 years</td>
</tr>
<tr>
<td>Code 3 Emergency Partners, LLC &amp; Code 3 Emergency Physicians, PA</td>
<td>5300 Town and Country Blvd Suite 260, Frisco, TX 75034</td>
<td>Practice Management Service Organization/ FSER and UCC Operator/Physician Group</td>
<td>Chairman and Founder 4 years to present</td>
</tr>
</tbody>
</table>
Organization: Our World Water Foundation
Address: 25 Highland Park Village
Dallas, TX 75205
Type of Organization: Non-Profit foundation for clean water
Duration on the Board: 1 year 2016- present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE
☒ If YES, Please Describe: As below, my ownership and positions within my practice and facilities could be perceived as a conflict by competitors in the market.

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:
72% ownership of Code 3 Emergency Partners, LLC – CEO and President - MSO providing development and management to Freestanding ERs and Urgent Care Centers
5% Ownership- Blitz Medical Billing- Billing Company for Emergency Medicine practices
50% indirect ownership through my husband of Code 3 Construction- Construction company providing construction services to medical practices including Emergency Centers and Urgent Cares

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Carrie de Moor, MD, FACEP
Date 8/5/2017
Dear Colleagues,

On behalf of the membership of the ACEP Freestanding Emergency Centers Section, we enthusiastically nominate and endorse Dr. Carrie de Moor, MD, FACEP for ACEP Board of Directors.

The call for nominations listed that, first and foremost, candidates need to be highly motivated and committed to serving ACEP. Dr. de Moor’s exceptional degree of motivation, commitment, and passion for serving our Section, ACEP, and all Emergency Physicians are all at the heart of our nomination.

Dr. de Moor has served ACEP for over a decade in various leadership roles. Early on and throughout her residency, Dr. de Moor served as EMRA Region 5 Representative and on many EMRA committees. She also served as a member of the Texas College of Emergency Physicians Board of Directors for 5 years, including Secretary of the College. She recently completed a two-year term as President of her County Medical Society, and was elected in April of 2016 to the Texas Medical Association Board of Trustees, which speaks volumes to the respect that Dr. de Moor has earned from her peers across the House of Medicine.

While Dr. de Moor has served in many positions within Texas, she has shown commitment and leadership on a national level by serving as a Councillor for 8 years, a member of multiple national committees including Pediatrics, Membership, National Chapter Relations, and currently, Federal Government Affairs. She has served the Council as Reference Committee member, co-author of multiple successful resolutions, and even as National Anthem soloist on several occasions. Dr. de Moor has been trusted by her peers as a leader across several diverse sections. While simultaneously serving the College as Secretary of the American Association of Women Emergency Physicians, she is our current Chair of the ACEP Freestanding Emergency Centers Section, and was our inaugural Chair-Elect during the first few years of our Section’s existence.

Dr. de Moor is uniquely qualified to serve on the ACEP Board of Directors. The Freestanding Emergency Centers (FEC) movement has been a disruptive force in healthcare over the past few years. As more and more states look to legislate the existence of Freestanding Emergency Centers, it is crucial that the ACEP Board of Directors have a member that is an expert in this new and evolving model to represent the growing number of emergency physicians practicing in and owning FECs, as well as their patients. Dr. de Moor has served as both a Medical Director of an Academic Level 1 Trauma Center, a community emergency physician, and as a pioneering Administrator in FECs. Her breadth of experience gives her a unique skill set that the ACEP Board of Directors needs during this new evolutionary phase of Emergency Medicine into the Freestanding arena.

With the unanimous support of the Executive Committee of the FEC Section of ACEP, we nominate and endorse Dr. Carrie de Moor, MD, FACEP for the American College of Emergency Physician’s Board of Directors. She will serve all Emergency Physicians well, passionately and fiercely.

On behalf of the FEC Section,

John Dayton, MD, FACEP
Chair - Elect ACEP FEC Section
Friends and Colleagues,

“What lies behind us and what lies before us are tiny matters compared to what lies within us”- Ralph Waldo Emerson. I have been thinking about this quote a lot over the past week. As I write this, I look back on the events of the past week in Texas. One moment, my partners and I were celebrating the upcoming opening of our new Freestanding ER and Urgent Care facility in a rural underserved community in a town named Rockport, Texas. The next moment, we were facing mandatory evacuations as Harvey raged towards us becoming a Category 4 hurricane as it made landfall right at our doorstep. We feared the worst for our newly constructed facility that had been a dream for many independent emergency physicians that chose to make a difference in that rural community. When the sun rose, we found that we were still standing tall. Our facility is now the only access to emergency care within 30-40 miles each direction. Emergency Physicians from all over the State of Texas and from all over the Country jumped into action to assist us, some driving over 10 hours to deliver needed supplies and additional personnel to serve this community in need. We soon found ourselves surrounded by almost too much help. Even with near 60% burnout rate reported in our specialty, the disaster seemed to ignite a fire and a passion within all of them to make a difference and to save lives. I am honored and proud to be a member of this tribe we call ACEP.

I chose to accept the challenge of running for the ACEP Board of Directors because I saw a need to reignite the fire within our specialty. Many of our colleagues feel like someone is always trying to extinguish the flame that burns in us for our patients and for our specialty- insurance companies, large hospital systems, employers, and increasing regulations and requirements. My career in Emergency Medicine has been filled with a wide variety of practice environments. I have served as a Medical Director of a Level 1 Academic Trauma Center, practiced in suburban, urban, and rural environments, and several years ago started my own independent group. I have successfully negotiated the placement of the first Emergency Room at a US Airport and secured relationships with large employers throughout the country to ensure that my independent group of physicians would be paid fairly for the services we render. I have helped start a billing company and have become a subject matter expert on both in-network and out-of-network billing and contract negotiation. I understand facility and professional components to the practice of emergency medicine, and I know how to put emergency physicians back in the driver’s seat, as I have been doing this for the last 4 years.

Who am I as a candidate? I am an entrepreneur. I am a businesswoman. I am a Mom of 3. I am a full time practicing Independent Emergency Medicine Physician. I am a leader that is an unapologetically passionate advocate for EM Docs. I am a candidate that can bring a voice to the independent Emergency Physicians without influence of a large contract management group or a single academic institution. I am committed to the success of all Emergency Physicians and helping evolve our specialty into something more sustainable, healthy, and fulfilling no matter where you choose to practice.

I respectfully ask for your vote for the ACEP Board of Directors. If you have any questions or concerns, feel free to email me at cdemoor.md@code3er.com

Sincerely,

Carrie de Moor, MD, FACEP
TRUST IN CARRIE TO HELP LEAD ACEP INTO A BETTER TOMORROW FOR ALL EMERGENCY PHYSICIANS

As an Independent Emergency Physician, I have built my career on creating better, more sustainable practice environments for myself and my colleagues. My goal is to put my unique skill set to work on behalf of all EM Docs throughout the Country no matter what environment they choose to practice in. I am prepared to bring fresh ideas and an optimistic approach to the Board.

ELECT

Carrie de Moor, MD, FACEP

ACEP BOARD OF DIRECTORS

Proudly Endorsed by the ACEP Freestanding Emergency Centers Section

- Values independence & wellness of front line EM Docs
- Subject matter expert on both facility and professional billing In-Network and Out-of-Network
- A Respected Experienced Leader in Organized Medicine
- Successful Practice Manager and Business Woman
- Proven Effective Negotiator
- Committed, Hard-working, Invested
- Full Time Practicing Emergency Physician Mom of 3
Leadership Experience

- 2006-2009: EMRA Region 5 Representative
- 2008-2009: TCEP BOD Resident Member
- 2009-2014: Co-Director TCEP Residency Visit Program
- 2010: TCEP Leadership and Advocacy Fellow
- 2011-2012: TCEP BOD Young Physicians Member
- 2012-2015: TCEP Board of Directors
- 2013-2014: TCEP 40th Anniversary Gala Chair
- 2014-2015: TCEP Secretary
- 2008-2012: ACEP Pediatrics Committee
- 2010-Present: ACEP Councillor for Texas
- 2012-2014: ACEP Membership Committee
- 2014-2016: ACEP National Chapter Relations Committee
- 2016-Present: ACEP Federal Government Affairs Committee
- 2014: ACEP Council Reference Committee
- 2012-2014: Texas Medical Assoc. Young Physician’s Section Chair
- 2015-2017: President, Collin/Fannin County Medical Society
- 2014-2016: ACEP Freestanding Emergency Centers Section Chair Elect
- 2014-2015: TAFEC Public Affairs Committee Chair
- 2014-Present: TEXPAC Vice Chair
- 2014-Present: TMLT Business Development Committee
- 2014-2016: TMA Council on Practice Management
- 2015-Present: Secretary American Association of Women Emergency Physicians
- 2016-Present: Texas Medical Association Board of Trustees
- 2016-Present: ACEP Freestanding Emergency Centers Section Chair

Passionate Emergency Physician Advocate for Practicing Emergency Physicians
2017 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

John T. Finnell, MD, MSc, FACEP

**Question #1:** How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?

I am a practicing emergency physician and ACEP member for over 22 years. I work in Indianapolis at Eskenazi Health. Our hospital is a level I trauma center and one of the teaching facilities for Indiana University’s Emergency Medicine Residency Program. My primary role is to lead the clinical informatics fellowship program. I am also a research scientist at the Regenstrief Institute. There are three major issues that currently impact the practice of emergency medicine include: psychiatric boarding, the opiate epidemic, and reimbursement.

As a Research Scientist, I will bring wisdom and analytic skills to help your board provide solutions for these problems. Regarding psychiatric boarding; how is this defined? Each of us, in our own facilities uses different terminology to define this common problem. We should aim to find a common definition. Regarding opiates; while we are often able to identify patients, we have few treatment options. Resources should be pooled and patients prioritized. As a research scientist, I’ve led many similar projects and have made critical decisions to help us think strategically about our future.

As an Educator, with a sub-specialization in informatics, I will provide your board with the relevant expertise it needs to help lead us forward. Data is the cornerstone in providing relevant clinical care. We need data to help us make more informed treatment decisions at the bedside. This same clinical data, when aggregated, can be used to help inform others the value of emergency medicine. These types of data will allow us to better demonstrate how minor complaints can be true emergencies. We have a duty to educate payers of a patient’s fundamental right to access care.

As a Mentor, I’ve been fortunate to have great mentors that have allowed me to grow. A great mentor doesn’t tell you what needs to be done or how to do it; he or she is a good listener. A great mentor asks you questions and poses challenges designed to help you see problems that you may have not identified, to look further ahead than you may be currently looking, or to encourage a different perspective. I will draw upon my unique skills as a research scientist and informatician to help lead your ACEP board and offer a sounding board to test your ideas and your concerns.

**Question #2:** What strategies would you implement to address burnout and resiliency for emergency physicians?

There is no doubt that practicing emergency medicine brings unique stresses into our lives. We see 150 million patients annually. This is roughly 411,000 patients per day, five patients per second. If you expand the scope of emergency care to include EMS to the patient's final disposition, including laboratory and radiology, emergency medicine accounts for just 2% of our nation's health care expenditures.

Per shift: we make, on average, 10,000 decisions, with approximately 4000 “clicks” within the EHR. I don't need to point out to you double-sided impact electronic medical records have made upon our profession. When we went live with our own system last October, my heart literally sank as I saw physicians spending more time with the computer than with our patients. We need to find ways to work smarter, not harder.

Over the course of my career, I've seen the value that clinical data can provide. As a resident in California, we would often repeat the testing that was performed at an outside facility simply because we did not trust the ones that had already been done. As a new faculty member in Minnesota, the inpatient and outpatient systems were separate. We would often have to repeat the testing that was done on the outpatient side simply because we did not have access to the results. As an informatics fellow in Indianapolis, I learned the value of exchanging clinical data to order to provide care. In Indiana, we have a large health information exchange that shares clinical data from a number of sources across the state. This helps to cut down on the diagnostic burden that we all share when evaluating a new patient. We need to continue to work with vendors and ACEP's CEDR initiative to help realize the value of shared clinical data.
We can refine and build tools that will help us work smarter. For example, think of your last patient who presented with chest pain. Instead of digging through the electronic medical record for: old EKG, last stress test result, previous cardiology notes; why couldn't this information be pushed to us instead? These are the kind of tools that I've built at Regenstrief to help provide pathways for better care. As another example, there are systems that can help quantify the PDMP report (opiate dispensing data from the pharmacy) into a score. This score can then be used to help provide decision-support around opiate prescribing. In our clinical system, if you were to write for narcotic with a patient who has an elevated score, you would receive an alert to review the patient's PDMP report.

Your college knows that we are better able to meet the demands of our specialty through an active wellness program. ACEP has several print resources to help you stay healthy. In addition, I’ve personally found solace through the activities of the wellness section as well as participating in the Facebook group “EM Docs” started by our own KK Moody.

As your ACEP board candidate, I will bring the skills necessary to allow us to work smarter, not harder.

**Question #3:** How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?

The value of ACEP membership needs to be clear.

As an ACEP member, I am provided a community within which I can network and collaborate. ACEP works within our specialty and with other professional organizations to provide a singular voice to speak on our behalf. I find tremendous value in our educational meetings, *Annals* publication, and clinical policies that ACEP provides.

While, our membership continues to grow, we need to continue to advertise the value that ACEP membership provides. Did you know that ACEP offers exclusive, free access to LLSA articles, and summaries? Did you know that ACEP has a number of membership sections that can target your interests and expertise? Did you know that ACEP’s political action committee, NEMPAC, is one of the largest and most influential PACs in organized medicine?

In order to retain members, we need to start work with our candidate members. We should develop “best practice” to help inform state chapters to work with our student members. Some states, i.e. Texas, have a robust infrastructure to encourage engagement and membership at this level. With EMRA and the Young Physician Section (YPS) leadership, we can continue to educate our younger members of the value belonging to ACEP and the community it provides.

I am humbled to be re-nominated as a candidate for your board of directors, along with my distinguished colleagues. It would be an honor to serve our college and I respectfully ask for your vote.
CANDIDATE DATA SHEET

John T. Finnell, MD, MSc, FACEP

Contact Information
505 South 5th Street, Zionsville, IN 46077
Phone: 317-454-1089
E-Mail: jtfinnell@gmail.com

Current and Past Professional Position(s)
Fellowship Program Director, Clinical Informatics
President AMIA Academic Forum
Member AMIA Board of Directors
Member AMIA Education Committee
ABEM Senior Case Examiner Reviewer
ABEM Item Writer
ABEM Oral Examiner
ABEM Case Development Panel

Education (include internships and residency information)
B.S., Biology, University of Vermont 1983-1987
M.D., University of Vermont 1987-1991
Residency: Emergency Medicine, UCSF-Fresno 1991-1995

EMF/ACEP Teaching Fellowship, Dallas Tx 1997-1998
Evidence Based Medicine, McMaster University 2001
M.Sc., Clinical Research, Indiana University 2002-2004
Informatics Fellow, National Library of Medicine 2002-2005

Certifications
Diplomate, American Board of Emergency Medicine 1996-Present
Diplomate, American Board of Preventive Medicine in Clinical Informatics 2013-Present

Professional Societies
ACEP
Indiana ACEP
SAEM
AMA
AMIA (American Medical Informatics Association)
National ACEP Activities – List your most significant accomplishments

Council Steering Committee 2013-2015
Chairman Reference Committee 2014
Education Committee 2014-Present
Indiana Counselor 2010-Present
Tellers, Credentials Committee Member 2010-2013
State Leader 911 Network 2010-Present
Reference Committee Member 2010-2013
Clinical Policies Committee – Informatics Liaison 2004-2007
Academic Affairs Committee 1999-2003
Secretary Informatics Section 2002-2003

ACEP Chapter Activities – List your most significant accomplishments

Past-President INACEP 2014
President INACEP 2013-2014
Board of Directors 2009-Present

Practice Profile

Total hours devoted to emergency medicine practice per year: 1864 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 25 % Research 5 % Teaching 50 % Administration 20 %

Other: %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Eskenazi Health (formerly Wishard Memorial) is a county, level 1 trauma and burn center. It is one of the major teaching hospitals for central Indiana. The academic faculty are employed by Indiana Health, an affiliate of Indiana University.

Expert Witness Experience – N/A

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

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CANDIDATE DISCLOSURE STATEMENT

John T. Finnell, MD, MSc, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Indiana University

   Address: Indianapolis, IN

   Position Held: Physician

   Type of Organization: Health Care

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

   Organization: AMIA (American Medical Informatics Association)

   Address: Washington, DC

   Type of Organization: Informatics Society

   Duration on the Board: Current (1 year)

   Organization: Outrun the Sun

   Address: Indianapolis, IN

   Type of Organization: Non-Profit

   Duration on the Board: 5 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE

☒ If YES, Please Describe Below: My wife is currently employed by Anthem Medicaid. As part of their conflict of interest, she does not review cases relevant to emergency care.
3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☐ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John T. Finnell            Date       8/5/2017
March 24, 2017

Sonja Montgomery
National ACEP
PO Box 619911
Dallas, TX 75261-9911

Dear Ms. Montgomery,

The ACEP Informatics section highly recommends John Thomas Finnell MD, FACEP as a candidate for the national ACEP Board of Directors. As you can see from his Curriculum Vitae, Dr. Finnell has not only spent many years in leadership positions with the Indiana Chapter, but has also been very involved with numerous national ACEP committees, as well as ABEM and the national ACEP Council.

His energy and commitment to ACEP's interests are outstanding and his leadership skills are impeccable. He has formal training in BioMedical Informatics, and he is board certified in Clinical Informatics and is the program director for one of the only EM based Clinical Informatics programs in the country. This specific skillset would help ACEP realize it's goals with CEDR and other data registries.

The ACEP Informatics section wholeheartedly supports John Thomas Finnell MD, FACEP for candidacy to the national ACEP Board of Directors.

Sincerely,

Jason Shapiro, MD, FACEP
Professor, Department of Emergency Medicine
Program Co-director, MS in Biomedical Informatics, Graduate School of Biomedical Sciences
Icahn School of Medicine at Mount Sinai

Chair, ACEP Informatics Section
Dear Colleagues,

It is an honor and privilege to have been selected to be a candidate for your Board of Directors.

As you review the qualities of each of the exceptional candidates, I’d like for you to consider some of my core values that will give you a sense of who am I am, and the type of Board member I will be, if elected.

**Service.** Service is the ability to put aside your needs for the greater good of the group. For physicians specializing in Emergency Medicine - our schedules are 365/24/7. We work nights, weekends, and holidays. We work during major sporting events (Super Bowl in Indy) that we’d rather be attending. I value the commitment I’ve made to our specialty and I will work tirelessly for you to ensure your needs are being met in order to make the best decisions in the interest of our specialty.

**Health.** Wellness matters. We must do things outside of our work lives to keep us whole. For me, I’m a runner. I find the time I use running helps to clear my head and helps me to prepare for the challenges that lie in the days/weeks ahead. I’m very fortunate that my family can join me on these activities so we can spend these precious hours together.

**Innovation.** I like to explore new ways to do things and I think outside of the box. As a child, I would take things apart to better understand how it worked. I have been fortunate at IU to have worked with other schools on campus and have been awarded patents based upon our work together. I find that innovation comes not from one person, but from a group of individuals who wish to make something unique and better. I promise to bring these talents to your board to help make your job and our specialty better.

**Informatics.** I tire of doing things repeatedly over and over – reinventing the wheel each time. I want to be efficient with my time and use tools that can allow me to be more productive. We need to use IT to work smarter, not harder.

I look forward to getting to know more of you. For those that do not yet know me – here are some words that others I work with have used to describe the type of person I am.

“Calm, caring, creative, collaborative, driven, engaged, enthusiastic, experienced, fair, focused, knowledgeable, honest, insightful, open minded, personable, relaxed, thoughtful.”

I ask for the honor and privilege to serve you, and for your vote for the ACEP Board of Directors.

Sincerely,

JT
ACEP needs to be able to navigate the world of informatics because knowledge comes from clinical data. As a data scientist, I respectfully ask for your vote to help ACEP achieve this goal.

WHO I AM:
- Associate Professor of Clinical Emergency Medicine
- Associate Professor of Informatics
- Current INACEP Board Member
- Fellowship director of the first EM Clinical Informatics fellowship
- 20+ Years practicing physician in a Level 1 Trauma Center in an Urban Environment

PROVEN LEADERSHIP:
- Department Chair Health Informatics, Indiana University
- Fellowship Program Director, Clinical Informatics

MY GOALS AS A BOARD MEMBER:
- Advance the Clinical Emergency Data Registry
- Advance Emergency Medicine through regulatory reform
- Enhance knowledge that is derived from clinical data
JOHN T. (JT) FINNELL MD, MSc, FACEP

• ACEP Board of Directors Candidate •

National / Chapter Service:

• ACEP Council Steering Committee 2013 - 2015
• ACEP Chairman Reference Committee 2014
• ACEP Education Committee 2014 - Present
• ACEP Indiana Councillor 2010 - Present
• ACEP Tellers, Credentials Committee 2010-2013
• ACEP State Leader 911 Network - Present
• ACEP Reference Committee 2010-2013
• ACEP Clinical Policies Committee Informatics Liaison 2004 - 2007
• ACEP Academics Affairs Committee 1999 - 2003
• INACEP Past-President 2014
• INACEP President 2013 - 2014
• INACEP Board of Directors 2009 - Present

SERVICE:

• ABEM Oral Board Examiner
• ABEM Item Writing Committee
• ABEM Case Reviewer
• American Medical Informatics Association
  Board of Directors

LEADERSHIP

SERVICE

DATA SCIENTIST

Endorsed by Indiana ACEP & ACEP Informatics Section
Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?

The biggest issues that emergency medicine will face in the coming years are policy and reimbursement issues. For the past several years, emergency medicine has faced an increasingly hostile environment in many states due to the actions of insurers, regulators and legislators. We must be prepared to defend our value as a specialty and our patients’ right to access emergency care. We have been challenged on prudent layperson, out-of-network billing, and our commitment to providing universal access to emergency care. My strongest skillset is in this policy world. On the national level, I have many years of experience with the Federal Governmental Affairs Committee and am serving my second term on the NEMPAC Board. As of late, we have seen our biggest challenges on the state level, and having spent the past several years serving as Chair of the State Legislative and Regulatory Committee, I have been engaged with leaders from states around the country as they have fought to defend their patients right to access emergency care. I have developed relationships with EDPMA leaders by serving on the ACEP-EDPMA Joint Task Force. As we continue our legislative and regulatory work around the country, my knowledge and experience can help us gather the data and choose the tactics that we need to protect patients and demonstrate the value of emergency care.

Additionally, I have lived and worked in different states – from Michigan to Washington to California to Texas – and practiced in different environments – from working single-coverage for a small democratic group to large community sites for a big group to an academic urban county hospital. This breadth of experience helps me to understand the challenges that our members face wherever they may work.

I would bring generational diversity to the board as a current member of the Young Physicians Section, which is a perspective not currently represented on the ACEP Board. Earlier in our careers, emergency physicians often have different outlook and emphasis, and I am excited to bring that fresh perspective to the Board.

I also have a solid breadth of experience with different aspects of the College. I have been involved in the activities of three different Chapters and am currently serving on the Board of Directors of TCEP. Within the national organization, I not only have policy experience, but I have served on the EMRA Board of Directors, have completed a term on the Steering Committee, and have served several times on Council Reference Committees. My time on the Education Committee gave me an inside look at our annual meeting, a large event which has a huge impact on our membership and our budget. My varied experience within ACEP has developed my leadership skills, and I am now ready to be a focused, passionate, collaborative board member in service of all aspects of our College.

Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?

The first step in addressing burnout is to improve our practice environment. With the combination of our regulatory and reimbursement challenges and increasingly unmanageable EMRs, it is no wonder that our best emergency physicians are feeling stressed. Our college needs to act as a constant advocate for the individual emergency physician. We need to ensure that fair reimbursement from payers means fair reimbursement for individual physicians. We need more physician-friendly EMRs that are tailored to our specialty. We need to pressure hospitals to take action to solve the boarding crises in many of our busiest practice locations. In order to address burnout, our legislative and regulatory advocacy must be focused on these critical issues.

In addition, ACEP should support the individual physician trying to build resiliency in their career. Physicians will have different needs in different phases of their practice. ACEP must support everyone, including medical students worried about
matching in EM, residents struggling with long hours, young physicians uncertain about their first job, mid-career physicians building their leadership, and late-career physicians starting to plan their career transition. Increasing attention on the issue of resiliency will help individuals develop their own approach to preserve their joy for the practice of medicine. As an individual, I ask my residents at the end of every shift to think of one thing from the shift that they can be grateful for – whether it is a helpful consultant, a procedure they just learned, a patient who was particularly assisted by their care – so that they can end their shift on a high note and build their appreciation for the good work they do every day. Evidence from the positive psychology literature shows that cultivating gratitude is one of the best strategies for improving daily happiness and life satisfaction. Events like ACEP’s Wellness Week and Wellness & Resiliency Summit allow members to share strategies and build programs that can have a lasting impact on emergency physicians in all phases of their career. We must continue and strengthen these efforts to create a brighter future for our specialty.

Question #3: How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?

As a young physician myself, I am well connected with this crucial group of emergency physicians. Our best way to retain our graduating residents is to explain how ACEP’s advocacy will improve their practice. Our organization is constantly taking action to minimize the administrative burdens on emergency physicians by ensuring fair payment and protecting members from unreasonable regulations such as those restricting the use of propofol in the ED and the requirement to check the state PDMP for every opioid prescription. Membership in ACEP allows us to strengthen our collective voice as emergency physicians.

We already decrease dues for members in their first three years of practice, and should consider providing even more generous subsidies for our less seasoned members, particularly in the first year of practice. Freshly minted attendings face an incredible burden of costs in their first year, including the costs of licensing, board certification, moving and often aggressive requirements to pay off loans. In exchange for securing their ongoing contact information, we should consider making the cost of membership nominal in the first year, including the cost of Chapter membership.

While working on these retention programs, we must remember that for a majority of our members, their only interaction with the organization may be through ACEP.org. I have been a part of the current ACEP Website Redesign Workgroup and am looking forward to seeing the improvements made through this process. After that phase has been completed, it will be an ongoing effort to make sure that we reach all of our members with dynamic, up-to-date information about the latest actions taken by the college and the opportunities to be more involved.

For those members with a desire to participate, we need them to know that involvement in ACEP may be a key to developing career resiliency. Some young physicians already know this, as they have participated in the organization through EMRA. We need to continue to strengthen that bridge to leadership and involvement while reaching out to others who are not yet deeply engaged. For those new to our organization who can identify a special interest within our field, they will find improved career satisfaction by building that interest and networking with like-minded colleagues through our Sections and Committees.

Chapter participation provides an additional opportunity to find a sense of community within the specialty, and build relationships that will last young physicians for the rest of their careers. Several Chapters have implemented Leadership Development programs, which specifically target young physicians to increase chapter involvement, and all Chapters have opportunities for involvement in Chapter activities. An interested young physician can easily find a way to help plan an annual meeting, become more involved in state legislative advocacy or participate in a Committee within their Chapter. Many new advocates are pleased to discover that state-level advocacy is more accessible and has a greater impact on their practice than any efforts in DC. These young physicians will have their resiliency strengthened by participating in a process that improves their practice environment and increases their sense of influence over their practice, while building camaraderie with fellow emergency physicians in their state. Our College should work nationally to help strengthen Chapter leadership development and advocacy programs to achieve multiple goals simultaneously – increasing member engagement, building a diverse leadership pipeline, improving young physician retention, and strengthening our state-level advocacy efforts.
CANDIDATE DATA SHEET

Alison Haddock, MD, FACEP

Contact Information
8518 Hatton St; Houston, TX; 77025
Phone: (425) 246-6310
E-Mail: ajh2003@gmail.com

Current and Past Professional Position(s)

Current:
Assistant Professor of Emergency Medicine
Director of Health Policy: Advocacy
Department of Emergency Medicine at Baylor College of Medicine in Houston, TX

Former: Attending Emergency Physician at Tacoma Emergency Care Physicians (small democratic group in Washington State) and Attending Emergency Physician with CEP America (primarily at Edmonds, WA site)

Education (include internships and residency information)
Medical School: Cornell Medical College, MD, 2007
Undergraduate: Duke University, BS, 2003

Certifications
American Board of Emergency Medicine, Board Certified, 2012

Professional Societies
ACEP, TCEP, TMA, AMA, CORD, EMRA (Alumni Member)

National ACEP Activities – List your most significant accomplishments

Awards
Council Horizon Award, 2016
ACEP 9-1-1 Network Member of the Year, 2011

Board Service
NEMPAC Board of Trustees: 2 terms (2012-2015, 2015-2018)
EMRA Board of Directors: Legislative Advisor (2010-2012)

Committee / Section Involvement:
ACEP State Legislative & Regulatory Committee: Member 2012-present; Chair 2015-present
ACEP Federal Governemental Affairs Committee 2010-present
ACEP Education Committee, Educational Meetings Subcommittee: 2013-present
Member of the AAWEP, Palliative Medicine and Young Physicians Sections

Invited Speaking Experiences
Co-Star of ACEP Cigna parody video on Fair Coverage with over 150,000 views
Leadership and Advocacy Conference
“Out of Network / Balance Billing – Where Are We?” March 2017
“State Strategies to Deal With Out of Network / Balance Billing” May 2016
“Current Issues in Health Policy” May 2013
Minnesota ACEP Annual Meeting “Emergency Care and the New Political Landscape” November 2016
Council Participation & Leadership
2010: resolution author (brought by EMRA delegation)
2011 - 2012: Alternate Councilor for EMRA delegation
2013: Alternate Councilor for Washington Chapter
2015 - present: Councilor for TX Chapter delegation
2013 & 2015: Served on Reference Committee B (policy issues)
2015-2017: Steering Committee

ACEP Task Forces
ACEP Advisory Group: 2012-2014
Delivery System Reform Task Force: 2011-2012
Alternative Payment Models Task Force: 2015-present
ACEP-EDPMA Joint Task Force on Reimbursement: 2016-present

ACEP Chapter Activities – List your most significant accomplishments
Texas College of Emergency Physicians Board Member: 2016-present
TCEP Board Liaison to TCEP Government Relations Committee: 2016-present
TCEP Leadership and Advocacy Fellow: 2015-2016
TCEP Leadership and Advocacy Fellowship Co-Director: 2016-2017

Practice Profile
Total hours devoted to emergency medicine practice per year: ~2000 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care 50 % Research 10 % Teaching 25 % Administration 15 %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)
I work for Baylor College of Medicine at Ben Taub Hospital, a busy safety-net county hospital and Level One trauma center in Houston, TX. My primary responsibilities include direct patient care and bedside teaching, and I also teach several pre-clinical medical student courses within the medical school.

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.
Defense Expert 0 Cases Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Alison Haddock, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Baylor College of Medicine
   Address: 1 Baylor Plaza
           Houston, TX  77030
   Position Held: Assistant Professor of Emergency Medicine
   Type of Organization: Medical School

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

   Organization: Texas College of Emergency Physicians
   Address: 2525 Wallingwood Dr., Bldg. 13-A
           Austin, Texas 78746
   Type of Organization: State Medical Specialty Society
   Duration on the Board: 2016 - present

   Organization: National Emergency Medicine Political Action Committee
   Address: 4950 W Royal Lane
           Irving, TX  75063
   Type of Organization: Political Action Committee
   Duration on the Board: 2012 – present

   Organization: Emergency Medicine Residents Association
   Address: 4950 W Royal Lane
           Irving, TX  75063
   Type of Organization: Medical Specialty Society
   Duration on the Board: 2010 – 2012
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☑ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Alison Haddock          Date          August 5th, 2017
Alison Haddock, MD, FACEP  
Candidate for ACEP Board of Directors

Dear Councillors:

The Texas Chapter and the Young Physician Section of ACEP proudly and enthusiastically endorse Alison Haddock, MD, FACEP as a candidate for the ACEP Board of Directors.

Alison has demonstrated a long-term commitment to local ACEP chapters, and been selected to serve as a member of the ACEP Council from EMRA, Washington and Texas. She is currently serving on the Texas Chapter Board of Directors.

Her accomplishments far exceed those of a typical young physician, and she is a rare candidate who would qualify as a young physician for her entire first term if elected. This, in addition to her dedication to patients, residents and advocacy, is why the Young Physician Section, the largest in ACEP, is proud to stand behind Alison as a candidate.

Alison's qualifications are considerable, and she has been active in ACEP since her earliest EM training. She was elected as an EMRA Board Member in 2010. She has also been a member of numerous EMRA and ACEP committees and task forces, including the State Legislative Committee, serving as chair since 2015. She is likely the youngest chair ever of that committee, which has led ACEP’s efforts to fight the Balanced Billing issues state by state. Alison has stepped up with time, energy, and insight to support those efforts. She has also been a speaker on advocacy and legislative affairs at both state and national meetings.

While still early in her career, Alison has dedicated extensive time and efforts toward the American College of Emergency Physicians. She is ready to bring her boundless energy and enthusiasm to the ACEP Board of Directors. Together, the Texas Chapter and the Young Physician Section are honored to endorse her for this position.

Sincerely,

Heidi Knowles MD, FACEP  
President, Texas Chapter of Emergency Physicians

Sandra Williams DO, MPH, FACEP  
Chair, Young Physician Section, American College of Emergency Physicians
Dear Colleagues:

Thank you for your service to our specialty through Council activities, your involvement in your Chapter, and likely in several Sections and Committees as well. Our Councillors are the engaged heart of our college and I am honored to have been selected by the Council Nominating Committee as a candidate for the ACEP Board of Directors.

I am well prepared to take on the biggest challenges emergency medicine will face in the coming years: legislative and regulatory policy challenges. My policy expertise comes through my years of involvement with EMRA, ACEP and NEMPAC. I am ready to stand up to the legislators, regulators and insurers who seek to reduce our patients’ access to care. Over the past years, our specialty and our patients have been threatened in many states over out-of-network billing and attempts to violate the prudent layperson standard. I believe our future issues will continue to be largely state issues, and we must continue to build our capabilities to support our chapters in these battles.

As we take on these challenges, we can’t forget the daily challenges of being an emergency physician. We need to ensure that we support each other and develop our sense of community as we modernize our college website and develop wellness initiatives. However, our wellness at work ultimately comes through having an optimized practice environment, and we can and will create a better practice environment through our legislative and regulatory efforts.

I am ready to bring my diversity of experience – in different states, in different practice types, in different parts of the college – to the ACEP Board of Directors. I am also ready to bring a fresh perspective as a Young Physician, as I would be a Young Physician for the entirety of my first term on the ACEP Board.

I would be honored to be your choice to serve on the ACEP Board of Directors.

Alison Haddock, MD, FACEP
Chair, ACEP State Legislative and Regulatory Committee
Nominee of Texas Chapter and Young Physicians Section
ALISON HADDOCK FOR ACEP BOARD

RECOGNIZED LEADER
2016 ACEP Council Horizon Award winner
ACEP State Legislative Committee Chair
TCEP Board of Directors
EMRA Advocacy Handbook Co-Editor
EMRA Board of Directors Alum
NEMPAC Board of Trustees
Past ACEP 9-1-1 Network Member of the Year

- Eager to serve
- Dedicated worker
- Community and academic experience
- Background in policy and reimbursement
- Ready to advocate!
ALISON HADDOCK, MD, FACEP
FOR ACEP BOARD OF DIRECTORS

RECOGNIZED LEADER

National Board Service
- EMRA Board of Directors, Legislative Advisor: 2010-2012
- NEMPAC Board of Trustees: 2012-2015, 2015-2018

National Committees
- ACEP State Legislative Committee: current chair, member 2012-present
- ACEP Federal Governmental Affairs Committee: 2010-present
- ACEP Education Committee, Educational Meetings Subcommittee: 2013-present
- EMRA Health Policy Committee: 2008-2012

ACEP Council
- Councillor for TX State Chapter (2015, 2016)
- ACEP Council Reference Committee: 2013 and 2015 (Committee B on policy issues)
- ACEP Council Steering Committee: 2015-2017

National Task Forces
- ACEP Alternative Payment Models Task Force: 2015-present
- ACEP-EDPMA Joint Task Force on Reimbursement Issues, OON/Balance Billing: 2016-present
- ACEP Advisory Group: 2012-2014
- ACEP Delivery System Reform Task Force: 2011-2012

National ACEP Sections
- Member of the AAWEP, Palliative Medicine and Young Physicians Sections

Chapter Committees and Leadership
- Texas Chapter Board of Directors: 2016-present
- Co-Director, TCEP Leadership and Advocacy Fellowship Program: 2016-present
- Texas Chapter Government Relations Committee and Education Committee: 2015-present
- Washington Chapter Legislative Affairs Committee: 2011-2014

TMA/AMA Leadership
- Alternate Delegate, Texas Medical Association to AMA House of Delegates: 2017
- Delegate, Texas Medical Association to YPS Assembly: 2017
- Texas Medical Association Leadership College: 2015-2016
- Texas Medical Association Council on Health Promotion: 2016-present
- Harris County Medical Society Quality Committee: 2016
- Harris County Medical Society Board on Medical Legislation: 2017-present
- Delegation Member, Harris County Medical Society to TMA Council: 2016-present

PASSION FOR THE SPECIALTY
Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?

Board service isn’t a hobby; it is a serious commitment of thought, energy, time and passion. ACEP’s mission is to promote the highest quality of emergency care. We are the leading advocate for emergency physicians, our patients and the public. As a Member of the ACEP Board of Directors for the past 3 years, I have been and remain passionately dedicated to improving access to high quality emergency care in the United States and globally for you, our colleagues and our patients.

For over 25 years, I have been a clinician, an educator and a physician leader. Whether treating a patient with a STEMI, teaching wide-eyed interns the finer points of a lung exam, or speaking to unseen thousands through the television, I tirelessly advocate for our specialty. The key traits of an outstanding emergency physician - the abilities to work together as a team leader, communicate clearly and effectively, and to make thoughtful decisions based upon the available data - are all necessary aspects to being a valuable member of ACEP’s Board.

As a physician board certified in both Emergency Medicine and Preventive Medicine, as well as having a Doctorate in Epidemiology, I bring an exceptionally strong background in understanding data and the impact of data driven policy on populations. My background, rich in data analysis and interpretation, is an incredibly important asset to the Board, as it will assure that we can have strong, effective public policy based upon high quality science.

In our current environment of health policy uncertainty, my passion shines through, whether at the bedside, in the board room or in front of policy makers and the public. I will continue to thoughtfully, passionately and untiringly advocate for you, and our profession as I continue to advocate for my patients to address the many challenges we face.

Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?

Being an emergency physician remains an exciting, thought-provoking, stimulating and incredibly soul satisfying profession. Whether delivering a baby or helping a family as their loved one passes away, we are blessed to be at the bedsides of our patients, often in the time of their greatest need. However, it is also an incredibly stressful profession - one in which we are constantly being challenged from multiple directions. Whether it is a new, potentially inadequate electronic medical record (EMR), our biorhythmically challenging schedules, or the demands of an administrator (with Press-Ganey scores in hand), we are constantly bombarded with requests, demands and ever-increasing burdens. According to one recent survey of physicians, the specialty with the greatest degree of burnout is emergency medicine.

We need to address burnout and help create resiliency for emergency physicians; this is true both for newly minted doctors just starting or old gray hairs still working clinically and administratively. Burnout includes the feeling of physical and emotional exhaustion, a sense of depersonalization, and a reduced sense of personal accomplishment. It is critically important that we take care of ourselves, just like we take care of our patients. First, are we listening, and I mean truly and actively listening, to our bodies, our families and our friends? Do we take time out to smell the roses and not just smell the coffee?

On an individual level, do you take time out during a busy clinical shift to briefly decompress? I’ve started having my residents take a 5-minute break, a true break away from clinical chores, a couple of times a shift. It is not much, but it is a start and it allows for a moment of reflection or relaxation. I wish I could get them to take a little more time, but some strongly resist because of the concern that they will miss something important while they are gone. Additionally, after a stressful event such as a prolonged code or an unexpected death, I try to have a short debrief with the whole team. We need time to discuss the events and to learn from them, both intellectually and emotionally. These little steps are important because they acknowledge our humanity while trying to create new, more healthy habits.

On a larger level, when was the last time you took a vacation- I mean a real vacation when you unplugged? My family and I went to Ireland this summer for 8 days- it was awesome! Enjoy your family and friends while you can; take a moment or two
to spend some quality time together. At your hospital or in your group is there a wellness committee or a wellness champion? Are there wellness indicators that you discuss, like many groups discuss quality and clinical indicators?

On a macro level, we must address the ever-increasing burden placed on us. This burden is not more and more patients, but rather ever more complex EMRs, increased expectations to reduce readmissions, additional responsibilities and constant demands to quickly adapt to our ever-changing clinical and health policy environment. We must strongly and passionately advocate for policies and procedures that recognize our humanity and work to decrease clerical and regulatory burden, allowing us more time for our patients and for ourselves.

**Question #3:** How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?

There are a multitude of benefits to being an ACEP member, but what many members find as the most valuable aspect is the worldwide network of emergency physicians. For me, ACEP is my professional family- an incredible and wonderful group of colleagues and friends who I see annually at our Scientific Assembly and at our Leadership and Advocacy Conference. After the trials and tribulations of a busy professional life with the constant pressures of clinical, administrative and educational demands, I come to Scientific Assembly and to Leadership and Advocacy Conference to recharge my batteries. It is great to see many friends and colleagues who I have grown to know over the years.

Of course, there are many other programs and benefits for members. These include ACEP-sponsored meetings and educational products, such as the ACEP Teaching Fellowship, practice resources such as clinical policies and reimbursement frequently asked questions, and the most respected and influential journal in emergency medicine- Annals of Emergency Medicine. For young emergency physicians, there are great opportunities for job searches; additionally, ACEP can serve as a personal concierge for many emergency medicine practice needs. There is the Emergency Medicine Residents’ Association (EMRA), which is an independent resident organization who works closely together with ACEP. The benefits of EMRA are numerous, including EMRA’s antibiotic guide and discounts to many great educational programs.

A key to a successful, long-term career in medicine is finding your niche populated with like-minded individuals. Interested in International Emergency Medicine, Critical Care Medicine or Emergency Medicine Informatics? ACEP has sections in each of these fields and dozens of other focus areas; in these sections you will meet leaders, many who helped develop these subspecialties. Do you have a passion for health policy, reimbursement or ethics? ACEP has committees on each of these and many other areas; your volunteer commitment, experience and expertise would be whole-heartedly welcomed.

ACEP is dedicated to diversity and inclusion. We can always do a better job of embracing our talented and diverse membership. We need to work together to consciously build a professional culture that both understands and values differences. Engaging our diverse membership is something the Board of Directors cares about passionately; we are working hard to identify and address obstacles to advancement for members within the profession of emergency medicine. ACEP provides an environment of mutual respect and support for colleagues who want to collaborate and grow.

In the end, to engage our members young and old, ACEP needs to be personal and meaningful for each of us. What works for one member or potential member may not work for another. As ACEP leaders and members, it is important that we continually listen to each other, find ways to work together and look for solutions that engage and support each other. ACEP is a vibrant, dynamic, committed organization made up of hard-working, dedicated and caring members and staff. For emergency physicians, it is an awesome professional organization and family.
CANDIDATE DATA SHEET

Jon Mark Hirshon, MD, PhD, MPH, FACEP

Contact Information
Department of Emergency Medicine
University of Maryland School of Medicine
110 S. Paca Street, 6th Floor, Suite 200
Baltimore, Maryland 21201
Phone: 410-328-8025
Cell: 410-271-4825
E-Mail: jhirshon@acep.org

Current and Past Professional Position(s)
My current position is as Professor, Department of Emergency Medicine and Department of Epidemiology and Public Health, University of Maryland, School of Medicine. I am also Senior Vice-Chair of the University of Maryland, Baltimore Institutional Review Board. Prior positions include assistant professor at University of Maryland School of Medicine and Johns Hopkins School of Medicine, as well as prior clinical employment in several emergency departments in Baltimore, Maryland.

Education (include internships and residency information)
1984 Bachelor of Arts, Biology and French Literature, University of California, Santa Cruz
1990 Doctor of Medicine, University of Southern California, School of Medicine
1990–1993 Emergency Medicine Residency, Johns Hopkins Hospital, Johns Hopkins University
1994–1995 Preventive Medicine Residency, Johns Hopkins Bloomberg School of Public Health,
1994 Master in Public Health, Johns Hopkins Bloomberg School of Public Health, Special Emphasis on International Health
2011 Doctor of Philosophy in Epidemiology, Department of Epidemiology and Public Health, University of Maryland School of Medicine

Certifications
1991–current Diplomate, National Board of Medical Examiners
1997–current Fellow, American College of Emergency Physicians
1998–current Fellow, American Academy of Emergency Medicine
2002, 2012 Diplomate, American Board of Preventive Medicine
2002–current Fellow, American College of Preventive Medicine

Professional Societies
1990–current Alpha Omega Alpha Medical Honor Society
1998–current American Academy of Emergency Medicine (fellow)
1997–current American College of Emergency Physicians (fellow)
2002–current American College of Preventive Medicine (fellow)
1994–current Delta Omega Public Health Honor Society
1993–current Society for Academic Emergency Medicine
2011–current African Federation of Emergency Medicine
2016–current American Medical Association
National ACEP Activities – List your most significant accomplishments

1996-2006 Member, then Chair, Public Health Committee
2001–2010 Liaison, American College of Emergency Physicians to the American Public Health Association
2002–2003 Terrorism Response Task Force
2003 Representative, American College of Emergency Physicians to the Institute of Medicine’s Meeting on Committee on Smallpox Vaccination Program Implementation
2004–2008 Tellers, Credentials and Elections Committee
2004–2008 Scientific Review Committee
2006–2008 Council Steering Committee
2006–2007 Finance Committee
2006–current International Ambassador to Egypt (starting 2006) and Sudan (starting 2016)
2006–2009 National Report Card Task Force, Chair, Data Subcommittee
2008–2009 Liaison, American College of Emergency Physicians to the Healthy People Consortium
2011-current Member, International Ambassador Program Committee
2011-2013 Chair, National Report Card Task Force
March 16th, 2014 Testified before the Subcommittee on Oversight and Investigations of the House of Representatives’ Energy and Commerce Committee concerning access to emergency care related to mental health and the shortage of psychiatric services.

2014-current National Board of Directors, multiple tasks and roles, including:
Liaison/member to the following committees and task forces: Clinical Policies Committee, Coding & Nomenclature Committee, ED Health Information Technology Safety Task Force, Epidemic Expert Panel, Finance Committee, Freestanding Emergency Centers Task Force, National/Chapter Relations Committee, Nominations Committee, Reimbursement Committee, ACEP/SAEM Research Work Group, State Legislative/Regulatory Committee
Liaison to the following sections: Air Medical Transport, Emergency Medicine Informatics, Emergency Medicine Practice Management and Health Policy, Wilderness Medicine
Chair, Emergency Department Sickle Cell Care Collaborative (EDSC3), a private/public partnership, which provides a national forum dedicated to the improvement of the emergency care of patients with SCD in the United States.

ACEP Chapter Activities – List your most significant accomplishments

2000–2001 Board of Directors
2000–current Education Committee
2001–2002 Treasurer
2001–2014 Representative or Alternate Representative from Maryland ACEP to the National ACEP Governing Council
2001–current Public Policy Committee
2002–2004 Vice-President
2004–2007 President
2007 Award in Appreciation for Outstanding Leadership, Dedication and Support of Emergency Medicine as President, Maryland Chapter, ACEP
2007–2009 Immediate Past President
2015 Physician of the Year, 2015. Maryland Chapter, ACEP

Practice Profile

Total hours devoted to emergency medicine practice per year: 2000 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 40 % Research 15 % Teaching 20 % Administration 25 %

Other: %
Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My primary clinical work is in a busy, academic emergency department with an approximate annual volume of 65,000. I work closely with residents, students and advance practice providers. In addition to the inner-city population that we serve, we are a tertiary referral center that receives many referrals from around the state.

**Expert Witness Experience**

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

| Defense Expert | 0 Cases | Plaintiff Expert | 0 Cases |
CANDIDATE DISCLOSURE STATEMENT

Jon Mark Hirshon, MD, PhD, MPH, FACEP

1. Employment – List current employers with addresses, position held and type of organization.

   Employer: University of Maryland School of Medicine
   Address: 110 S. Paca Street, 6th Floor, Suite 200
   Position Held: Professor, Senior Vice-Chair of the Institutional Review Board
   Type of Organization: University

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.

   Organization: Maryland Chapter, ACEP
   Address: 1211 Cathedral Street
   Baltimore, Maryland 21201
   Type of Organization: Professional Society
   Duration on the Board: 2000-2009

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☑ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☑ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☑ If YES, Please Describe:
I am a consultant and advisory board member to Pfizer, Inc. concerning the medical care and treatment of patients with sickle cell disease.
5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☑ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☑ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jon Mark Hirshon                Date                August 5, 2017
August 30, 2017

Dear Colleagues,

On behalf of Maryland ACEP, it is with pride that we enthusiastically support Dr. Jon Mark Hirshon’s candidacy for re-election to the ACEP’s Board of Directors. Our Chapter wholeheartedly endorses his candidacy because we know that his continued presence on the Board will immeasurably benefit our college for years to come. He is uniquely qualified because he is a dedicated and respected practicing clinician, an enthusiastic leader, a keen organizer, a master of the data concerning the emergency care environment. He is a man with the wisdom, knowledge and vision to help improve access to high quality emergency care in the U.S. and globally. He is the type of leader we need to continue moving ACEP forward.

It is important to list some of his accomplishments to demonstrate Dr. Hirshon’s solid and deep experiences in emergency medicine. For many years, he has been an integral and vital member of Maryland ACEP. He is a Past President of Maryland ACEP, having completed the executive offices of Secretary, Vice President and President. His passion for our patients, our colleagues and our organization is evidenced by his dedication to ACEP’s legislative efforts, both within Maryland and nationally. He was a national ACEP Councillor or Alternate Councillor for approximately 15 years prior to his election to the Board of Directors. Additional roles included service on ACEP’s Steering Committee and Task Force Chair for the 2014 ACEP Report Card. This second position not only demonstrated his keen intellect and knowledge of the multitude of forces impacting emergency care today, but also highlighted his skill and ability to promote ACEP to television, radio and print media.

Dr. Jon Mark Hirshon is a well-respected national and international leader in public health and emergency medicine. He is the Senior Vice Chair of the University of Maryland’s Institutional Review Board and is a former director of the Charles McC. Mathias, Jr. National Study Center for Trauma and EMS. He has been the principal investigator on over $8 million in federal research and training grants. He has taught emergency physicians, residents and medical students domestically and in the Middle East. Dr. Hirshon serves as a role model and mentor by practicing high quality clinical emergency medicine while broadening the frontiers of scientific knowledge through collaborative research efforts.
His vision, leadership and contributions of time as a volunteer while working to enhance the profession of emergency medicine, improve patient care and his extraordinary efforts toward optimal emergency medicine practices are inspiring. His career has been dedicated to delivery of the very finest quality of emergency care which has included not only his personal commitment to emergency medicine, but a greater calling to the education of others and himself, advocacy for patients, and support of organizations and causes beyond himself, all of which have benefited by his national and international efforts to further emergency medicine.

Maryland ACEP was also honored to select Dr. Hirshon as the “Physician of the Year 2015.” His career constantly and consistently demonstrates his passion for emergency medicine, his belief in life long education, his commitment to public health and, most importantly, his dedication to the delivery of the highest possible quality of emergency care to those in need.

Clearly, Dr. Hirshon has worked tirelessly to improve access to emergency care and to promote emergency medicine, both in the U.S. and globally. He is a superb candidate and Maryland ACEP is honored to passionately support his candidacy for re-election to the ACEP Board of Directors and urge you to vote for him.

Respectfully,

Drew White, MD, FACEP
Maryland ACEP President
Dear Friends, Colleagues, and Councillors:

Every day that you work in the emergency department, you make many decisions- often lifesaving. It can be challenging, exhilarating, exhausting. Earlier this week, I was working and running the department while my colleague spent several hours fully focused on trying to resuscitate a patient hemorrhaging from an aortic dissection. It was clear that ultimately lifesaving intervention required operative care, but we couldn’t get an OR in time. A death of a person, especially one who comes in talking, can be emotionally traumatic- especially for the family but also for the provider. While I was not the primary provider, what really vexed me was when the surgical PA started criticizing my colleague for delay in care, when it was clear that it was their service that needed to mobilize the operative resources. Criticizing a fellow health care provider in the middle of the clinical department is incredibly disrespectful and requires a strong and professional response.

Yet, it is not just in the clinical department that we as emergency physicians and our patients are being challenged. On a societal level, patients’ ability to access and pay for care is under siege! Increasing co-pays and deductibles, decreased insurance coverage, and inadequate physician networks are three ways that insurance companies are shifting costs to patients. At the same time, insurance companies are creating other policies to limit payments to providers, such as retrospective denial of care. We fought this battle a decade ago- it is called “the prudent layperson” standard! Yet, it is under attack again. When I had lunch with Senator Ben Cardin earlier this summer, the key proponent of prudent layperson on the federal level, he was astounded to find that this challenge to accessing emergency care was reoccurring.

Ultimately, whether it is in the emergency department, in the board room, on television, or in front of policy makers, we must persistently, passionately and effectively advocate for our patients, for our colleagues and for high quality emergency care.

For the past three years as a member of the Board of Directors, I have worked with thoughtful and caring colleagues on projects large and small to support emergency care. Through the many committees, task forces, meetings with federal agencies and legislators, and my international ambassador work, I have represented ACEP and our profession with integrity and passion. Serving on the ACEP Board of Directors has allowed me to more powerfully advocate for you and our patients.

It has been both an honor and a privilege to serve you as a member of the ACEP Board of Directors and to passionately advocate for assuring access to high quality acute care. You have an important decision to make during the upcoming election for the ACEP Board of Directors. We have come a long way in the almost 50 years since ACEP was created, but we still have a long way to go. My track record is proven, as is my passion, dedication and integrity.

I respectfully ask for your vote to allow me to continue to serve you for another three years.

Sincerely,

Jon Mark Hirshon, MD, PhD, MPH

Jon Mark Hirshon, MD, PhD, MPH
Cell: 410-271-4825
Email: jhirshon@acep.org
JON MARK HIRSHON, MD, PHD, MPH, FACEP

Board of Directors Candidate for Re-election

SELECTED LIST OF ACEP SERVICE
- ACEP Board of Directors, 2014-2017
- Past President of Maryland ACEP
- Chair, National Report Card Task Force 2014
- Past Chair of ACEP’s Public Health Committee
- Board Liaison to multiple National Committees and Sections, including:
  - Emergency Medicine Informatics
  - Clinical Policies
  - State Legislative
  - Reimbursement
  - National/Chapter Relations
- Testified before Congress on the national crisis related to psychiatric boarding
- Member of multiple ACEP Task Forces, including:
  - Epidemic Expert Panel
  - Freestanding Emergency Center Accreditation TF
  - ED Health Information Systems Safety TF
- ACEP International Ambassador to Egypt and Sudan
**Personal Statement:** ACEP’s mission is to promote the highest quality of emergency care and be the leading advocate for emergency physicians, our patients, and the public. It has been my honor and privilege to serve as your representative and voice on the ACEP Board of Directors for the past three years, to strive to achieve our mission, and for the vision of access to emergency care for our patients in need regardless of time of day, ability to pay, disease status or social circumstances. Over the past 25 years, I have been passionately dedicated to improving access to the highest quality emergency care. Whether at the bedside, in the board room, meeting with my Senator or standing in front of policy makers and the public, I continue to passionately, thoughtfully and tirelessly advocate for you, our profession, and our patients.

Healthcare is rapidly changing in these times of economic and political turbulence. Specific challenges facing us and our patients include the shifting of the cost of medical care from insurance companies to patients and providers through increased co-pays, deductibles, inadequate physician networks and limited medical coverage. Our patients’ ability to access and pay for care is under siege! From a provider perspective, we are under increasing pressure to find less costly means than hospital admissions to care for out patients. While this sounds great, there is a critical need for the right outpatient resources and the care coordination required for appropriate, safe and effective care.

As a member of the Board of Directors for the past three years, I and my colleagues have tirelessly fought for you and our patients in order to assure support for high quality emergency care.

*I ask for your vote for re-election in order to continue to serve as your advocate.*

**Background:** Jon Mark Hirshon, MD, MPH, PhD, FACEP

- **Professor,** Department of Emergency Medicine and the Department of Epidemiology and Public Health at the University of Maryland School of Medicine.
- **Mentor and Teacher,** both domestically and internationally
- **Senior Vice-Chairman,** Institutional Review Board, U. of Maryland, Baltimore
- **Federally funded researcher and teacher** with specific interest in improving access to acute care and in developing emergency departments as sites for surveillance and hypothesis driven research in public health and emergency department operations
- **Prolific Author** of over 100 articles and chapters on emergency care topics, including placing emergency care on the global health agenda.
- Honored by his peers and the American College of Emergency Physicians as a “**Hero of Emergency Medicine**”.

**CONTACT INFORMATION:**
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University of Maryland School of Medicine
110 South Paca Street, 6th Floor, Suite 200
Baltimore, Maryland 21201
Cell: 410-271-4825
Email: jhirshon@umaryland.edu
2017 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Aisha Liferidge MD, MPH, FACEP

**Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?**

Driven by purpose and passion, I have a proven track record of leadership which results in organizational growth and the advancement of landmark issues. While EMRA President, its budget hit the $1 million mark which was unprecedented at the time. As President of the District of Columbia Chapter of Emergency Physicians, I led revitalization efforts which resulted in doubled revenue and a 50% increase in membership. As Chair of the ACEP Associate Membership Task Force, significant progress was made on the delicate topic of membership for non-board certified providers. Currently, I serve as the Chair of the trailblazing Diversity and Inclusion Task Force which sets ACEP apart as a courageous champion of this important initiative. Additionally, I’ve served on ACEP’s Public Health and Injury Prevention, CEDR, and Steering Committees.

The challenges that we face are far more complex than our founders could have ever imagined. Crucial issues such as the devaluation of emergency care as an essential service, the devastating opioid crisis, and the daunting challenge of sustainable healthcare financing beg our immediate attention and creativity. The approach must be strategic and skilled through effective health policy. As a senior leader in health policy at George Washington University in Washington, DC, I have been uniquely prepared to do just this. I understand how the federal government, agencies, private entities and think tanks operate, and how they are most effectively influenced. I also understand the implementation of change through policy. Having forged beneficial relations with key stakeholders, my skillset additionally includes the ability to effectively employ health policy strategy that utilizes a myriad of collaborative approaches.

As ACEP charts crucial territory, now is the time to promote experienced leadership that is purposeful, passionate, and policy-minded, to ensure that our voice is not only heard, but also respected and heeded.

**Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?**

At nearly 60%, emergency physicians have the highest rate of burnout of any specialty. Burnout is a symptom of a systemic illness which is best combatted with a systemic treatment plan. Studies have shown that most emergency physicians feel that burnout is primarily related to feeling burdened by having to perform excessive logistical and technical tasks during clinical shifts and due to challenging patient encounters.

One high-yield solution to overly stressful clinical practice is the development of an emergency physician-inspired electronic medical record (EMR) system which replaces the typical, often technically inefficient EMR systems which require the use of multiple clicks and has convoluted steps. An emphasis should be placed on creating EMR’s with automated processes tailored to specific patient, chief complaint, and final diagnosis types. Further, capacity for improved interoperability of electronic health records must be realized. As a key stakeholder on the issue of EMR/EHR optimization, the College should collaboratively lead this charge, particularly given the integral role that ACEP’s new Clinical Emergency Data Registry (CEDR) will play in the future of our nation’s emergency health records as related to quality measures, data collection, and billing.

In order to combat the ill effects of challenging patient encounters, one approach is to address the mental health crisis in a meaningful way. The problem of prolonged boarding of psychiatric patients in the emergency department (ED) should be branded as a significant patient and provider safety concern, as evidenced by the numerous data on related injury, anxiety, and disruption in the ED. This effort will require that ACEP join our psychiatry colleagues to align incentives, and then target
private psychiatric facilities and related insurance companies through advocacy efforts which determine commonality amongst stakeholders and insist on improved ethical accountability.

Additionally, wellness initiatives that equip individuals with the tools needed to avoid and manage burnout have been found to be effective. For example, I teach a professional development course that provides medical students with the skills needed to become reflective and introspective physicians who enjoy healthy, long careers. Reflection is a metacognitive process that creates improved understanding of both the self and the situation, such that future actions might be better informed by this understanding (Sandars). Effective reflection improves the process of patient care and provides for therapeutic enlightenment. In an effort to create a workforce that is equipped to successfully weather the inherent emotionally charged complexities of the practice of emergency medicine, teaching the art of reflection as a standard part of medical and resident education would effectively re-define wellness as a requirement, lending to less burnout. Using concepts from medical education curriculum, I could share my experiences in this area to help the Wellness Committee and other vested ACEP groups promote a College-wide “War on Burnout” initiative.

**Question #3: How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?**

Within the context of member organizations, value is a bi-directional process wherein the organization must successfully communicate how much they value the member, and in turn, the member must find value in the organization. As the responsible party providing a service, however, the primary onus is on the organization to ensure that the member feels valued. Value naturally evolves once the member has a sense of belonging, perceives that they are receiving genuine benefit, and feels connected through shared priorities.

It is important that members have a sense of true belonging on a level that surpasses the technical formality of renewing one’s membership online each year. In order to belong, one must first understand their role within the organization and how they fit into its culture and mission. Thus, organizations whose members feel as though they belong, not only implement initiatives which boost their membership rolls, but also commit to activities which promote inclusivity and acceptance.

Membership without *perceived* benefit lacks value. ACEP must continue to provide its members with highly visible, state-of-the-art products that enhance clinical practice, provide advocacy support, promote wellness, and provide means for emotional connection. Additionally, less tangible benefits such as networking, mentorship, and social opportunities should be emphasized and branded as an exclusive member advantage.

Finally, membership is valued when one feels that there is commonality with the organization and other members due to shared commitment to the realization of the same priorities. There is something very special about being with thousands of people who you don’t personally know, but with whom you speak the same emergency department (ED)-specific clinical language, have shared the same classic ED experiences, understand the needs of the same ED patient populations, and seek the same lifestyle fulfillment and happiness. Once that connection is consciously realized, a degree of trust, accountability, and fellow benevolence develops, which results in an understanding of the value of that relationship; it’s called community.

Thus, when explaining to a young physician why they should value ACEP membership, I would share with them my personal journey within the College; I feel a true sense of belonging. I perceive that I’m receiving genuine benefit, and I feel connected through commonality. I would explain how, even as a young resident physician who became EMRA’s first African American President, rather than feeling marginalized, I felt like I belonged because my contribution was recognized and valued. I would explain how the benefit of mentorship from ACEP’s inspiring leaders changed the trajectory of my career in positive ways that I never imagined. I would tell them how I always feel safe and at home when attending ACEP functions, because relationships based on respect and shared priorities have grown over the years, providing me with tremendous value. Finally, I would remind the young physician of the fact that they, too, can experience the same value that I have, and I would offer to mentor them along the way.
CANDIDATE DATA SHEET

Aisha Liferidge MD, MPH, FACEP

Contact Information
3001 26th Street, NE
Washington, DC 20018

Phone: 443-801-8459
E-Mail: aisha.t.liferidge@gmail.com

Current and Past Professional Position(s)
2012-present  Assistant Professor, Department of Emergency Medicine
              Director, Emergency Medicine Health Policy Fellowship
              George Washington University School of Medicine

2013-present  Assistant Professor, Department of Health Policy
              Milken Institute of Public Health, George Washington University

2007-2011   Assistant Professor, Department of Emergency Medicine
              University of Maryland School of Medicine

Education (include internships and residency information)
1999         Duke University
            Durham, North Carolina
            Bachelor of Science (BS) in Biology, Chemistry and Spanish Minor

2003         University of North Carolina School of Medicine
            Chapel Hill, North Carolina
            Doctor of Medicine (MD)

2011         Columbia University Mailman School of Public Health
            New York, New York
            Executive Master of Public Health (MPH), Health Policy and Management Focus

2003-2006    University of Maryland Medical System, Department of Emergency Medicine
              Emergency Medicine Residency Program

Certifications
2008         Board Certified (ABEM) in Emergency Medicine
2006         Maryland, medical license
2011         Washington, DC, medical license (active)

Professional Societies
2001 - 2006   Society for Academic Emergency Medicine (SAEM)
2003 - 2011   Maryland American College of Emergency Physicians (MD ACEP)
2002 – present American College of Emergency Physicians (ACEP)
2003 – present Emergency Medicine Residents’ Association (EMRA)
2008 – present American Medical Association (AMA)
2012 – present District of Columbia College of Emergency Medicine
National ACEP Activities – List your most significant accomplishments

2004-2006  Emergency Medicine Practice Management and Health Policy Section member
2005-present 911 Legislative Network member
2005-present Public Health and Injury Prevention Committee member
   -- Disparities in Health Care Subcommittee, chair (2009-2012)
   -- Healthy People 2020 Subcommittee, member (2009-2011)
   -- Sobering Centers Subcommittee, chair (2012-2014)
2006  EMRA/ACEP Mini-Health Policy Mini-fellowship, ACEP Office in Washington, DC
2007-present Young Physicians Section, member
2008-2009 Associate Membership Task Force, appointed Chair
2008  Hero in Emergency Medicine Award
2009  ACEP Council Teamwork Award
2016-present Diversity and Inclusion Task Force, appointed Chair
2017-present Diversity in Leadership Task Force, appointed member

ACEP Chapter Activities – List your most significant accomplishments

District of Columbia Chapter of the College of Emergency Medicine
2013-2015 Board of Directors member, President and Councilor
   As President, led Chapter revitalization efforts; revenue doubled and membership increased by 50% during term.
2015-2016 Board of Directors member, Immediate Past President and Councilor
2016-present Board of Directors member and Councilor

Maryland American College of Emergency Physicians (ACEP)
2005-2006 Public Relations Committee member
2005-2012 Public Policy Committee member
2007-2012 Board of Directors member

Practice Profile

Total hours devoted to emergency medicine practice per year: 900 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
   Direct Patient Care 50 %  Research 10 %  Teaching 30 %  Administration 10 %
   Other: ________________________________ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

University hospital in urban city; employed by multi-specialty contract group.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. N/A

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CANDIDATE DISCLOSURE STATEMENT

Aisha Liferidge MD, MPH, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

   Employer: Medical Faculty Associates / George Washington University Department of Emergency Medicine
   Address: 2150 Pennsylvania Avenue, NW, Washington, DC 20037
   Position Held: Attending physician
   Type of Organization: University Hospital

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

   Organization: Emergency Medicine Residents’ Association
   Address: 4950 West Royal Lane, Irving, TX 75063
   Type of Organization: Non-profit resident specialty association
   Duration on the Board: October 2006 to October 2009

   Organization: Maryland College of Emergency Physicians
   Address: 1211 Cathedral Street, Baltimore, MD 21201
   Type of Organization: Non-profit state chapter specialty organization
   Duration on the Board: 2007 to 2012

   Organization: District of Columbia Chapter, American College of Emergency Physicians
   Address: 4950 West Royal Lane, Irving, TX 75063
   Type of Organization: Non-profit state chapter specialty organization
   Duration on the Board: 2013 to present
I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☐ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Aisha Liferidge            Date    08/05/2017
Dear Dr. Cusick,

As President of the District of Columbia Chapter it is my pleasure to write to you on behalf of our three hundred and twenty-six emergency medicine physician members, to proudly endorse Aisha T. Liferidge, MD, MPH, FACEP for election to the ACEP Board of Directors.

During her presidential leadership with the District of Columbia Chapter from 2013 to 2016, the Chapter’s activity soared and its revenue more than doubled. Dr. Liferidge continues to be an active member of the Board of the District of Columbia Chapter. She serves as a voting ACEP Councilor and is a member of the chapters Public Health and Injury Prevention Committee.

Since 2004, Dr. Liferidge has been a member of multiple sections and committees such as the EM Practice Management and Health Policy Section, 911 Legislative Network, Public Health and Injury Prevention Committee, Young Physicians Section, just to name a few.

During her residency in Fall 2005, Dr. Liferidge was elected President of the national Emergency Medicine Residents’ Association (EMRA). Under her leadership, EMRA’s budget reached an all-time high of $1 million and she spearheaded the implementation of the ACEP/EMRA Mini-Health Policy Fellowship in Washington, DC, which successfully continues today. She has been and continues to be a mentor to so many of our young ACEP members and Residents.

In 2008, she received a prestigious award from The College, Hero in Emergency Medicine, and in 2009 she received The ACEP Council Teamwork Award.

Dr. Liferidge has also been a huge champion of diversity within our organization. She currently chairs ACEP’s Diversity and Inclusion Task Force, which seeks to increase awareness on the topic, identify barriers and solutions to diversifying the physician workforce, and link patient outcomes with workforce diversity.

Dr. Liferidge has participated in collaborative research on many topics and published a number of peer reviewed publications. She has given numerous local, state, national and international lectures and speeches on topics such as the triage of emergency department patients to a medical home, sustained growth formula (SGR) reform, coordinated and integrated health care, physician reimbursement, and innovative physician health policy education. Dr. Liferidge also leads health policy and stroke research efforts, partially through grant funding from the National Institute of Health (NIH).  

At present, Dr. Liferidge works at the George Washington University School of Medicine in Washington, DC, where she fulfills her true passion for clinical practice, teaching, and mentoring as an assistant professor of Emergency Medicine and Health Policy at the Milken Institute School of Public Health. She directs the Health Policy Fellowship at this institution and serves as Co-director of the Clinical Skills and Reasoning Theme Curriculum for medical students. She also serves as a Professional Development Mentor which requires her to teach professionalism skills to medical students through small group sessions focused personal reflection and team-building exercises.

She is the chief executive officer of the Dr. Aisha Liferidge Minority Women in Science Foundation (MWSF), a non-profit organization that empowers the dreams of future leaders with interest in science careers. The MWSF provides mentorship, tangible resources, networking opportunities, and career-long support to its beneficiaries. In 2013, the Foundation provided 13 scholarships ($8,000) to aspiring youth and funded SAT preparatory courses for 10 high school juniors in 2015. In 2016,
the MWSF provided academic and merit based scholarships to 10 rising college freshmen totaling approximately $25,000.

Dr. Liferidge has the courage and vision to lead ACEP toward a better future. She has demonstrated the highest level of commitment to Emergency Medicine, our Chapter and the College. She is a skillful communicator, excellent clinician, and exemplary community member committed to the cause and mission of emergency medicine. She is well prepared to serve as a member of ACEP Board of Directors.

The DC Chapter is proud and fortunate to have a dedicated advocate to represent emergency medicine. We hope you accept this letter of endorsement and vote to choose Dr. Liferidge as an ACEP Board member.

Sincerely,

Guenevere Burke, MD
DC ACEP Chapter President
Aisha T. Liferidge, MD, MPH, FACEP

Dear esteemed fellow Councillors,

It is honorable and exciting to have been nominated as a candidate for the ACEP Board of Directors. It has been a pleasure to serve alongside you for the past 12 years, and it would be a humbling distinction to now serve you and the College as a Board member.

From my term as President of EMRA during its formative years over a decade ago, to my current appointment as Chair of ACEP’s trailblazing Diversity and Inclusion Task Force, I am sincerely grateful for having served the College in several capacities over the years. My passion for our specialty is founded in a clear purpose to advocate for patients, as well as vulnerable populations, and has afforded me the opportunity to amass a wealth of experience in organized medicine.

I realize, however, that purpose and passion alone are not enough to carry ACEP and our specialty to the next frontier of advocacy and clinical practice. The unprecedented challenges that we now face in health care are far more complex than our founders could have ever imagined. From the devastating opioid crisis to the daunting concept of sustainable health care financing, there are many key issues that beg our immediate attention and creativity.

Perhaps the most pressing issue faced by emergency medicine (EM) is the current attacks which devalue our practice as being a non-essential service. These efforts are disheartening at best, as they are incongruent with the federal mandate to provide care for all and erode the essence of why many of us chose emergency medicine practice in the first place – that is, to serve all patients in their time of greatest need. Should these efforts go unchallenged, our patients are at risk of losing access to quality emergency care, and we, the joy of our livelihood.

Thus, in addition to purpose and passion, today’s challenges must be met with strategy and skill by way of effective and perpetual health policy. My experience as assistant professor and fellowship director of health policy at the George Washington University and Milken Institute School of Public Health in Washington, DC has uniquely prepared me to lead such a charge. In this capacity, I’ve gained a wealth of knowledge about effective change through policy at the federal, state, and regional levels, while having been exposed to numerous influential stakeholders. I understand how the government and its agencies, as well as private entities and think tanks operate, what they manage, how they are incentivized, and how they are most effectively influenced. I have learned the tremendous value of true bipartisan, often state-centered, multi-agency, and multi-modality collaboration and integration of resources and thought. For ACEP, a similar model would promote a unified approach inclusive of other EM organizations, other specialties, and applicable agencies, while acknowledging the important role of Chapter support and innovation.

As ACEP charts challenging and crucial territory during this pivotal period in the history of health care, now is the time to promote experienced leadership that is purposeful, passionate, and policy-minded; we must ensure that our voice is not only heard, but also respected and heeded. Qualified and ready, now is the time for me to lead and serve as your faithful Board of Directors member. I humbly ask for your vote and support. Thank you for your thoughtful consideration.

Sincerely,

Aisha T. Liferidge MD, MPH, FACEP
Aisha T. Liferidge MD, MPH, FACEP
Candidate for Board of Directors
American College of Emergency Physicians
“Qualified and Ready to Lead”

Platform Focus Areas:
• Health Care Reform / Ensuring EM Remains an Essential Service
• Enhanced Clinical Practice of EM
• Optimized State Chapter and National Relations and Synergy

EXPERIENCE

Organized Medicine
EMRA President 2005 - 2008
> $1 million budget mark reached
> Major EM Resident overhaul
> Developed EMRA/ACEP Health Policy Mini-fellowship

Business Management
> 501c3 for young women with science interest, Founder and CEO

Awards
> ACEP Heroes in EM Award (2008)
> ACEP Council Teamwork Award (2009)

ACEP
> 12+ years as Councilor
> Task Force Leadership
- Diversity and Inclusion TF, Chair
- Associate Membership TF, Chair
> Committees
- Steering Committee
- CEDR Committee
- Public Health and Injury Prevention Committee
- Disparities in EM Subcommittee, Chair
- Sobering Centers Subcommittee, Chair
> Chapters
- DC ACEP Chapter, Past President, Board Member
- Led revitalization; revenue doubled,
  50% increase in membership
- Maryland ACEP
- Served 2 Terms on Board of Directors
- Public Policy Committee

Health Policy and Advocacy
> Public Health and Health Policy Trained
> George Washington University, Health Policy Fellowship, Director
> Federal government experience
> Emergency Medicine Foundation,
  Past Board of Trustees Member

Academician
> Assistant Professor of Emergency Medicine and Health Policy
> Medical school course director

Proudly Endorsed by the
District of Columbia
College of Emergency Physicians
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Thank you for your thoughtful consideration.

Sincerely,

Aisha T. Liferidge MD, MPH, FACEP

Proudly Endorsed by
the District of Columbia
College of Emergency Physicians

DR. AISHA T. LIFERIDGE

Aisha T. Liferidge MD, MPH, FACEP
2017 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Virgil W. Smaltz, MD, MPA, FACEP

**Question #1: How will your skills, background, knowledge, or unique abilities help you as a member of the Board to address the major issues facing emergency medicine in the next three years?**

Insurance companies, the government, and others are affecting our ability to care for patients. My experience in small (WV) and large (NY) chapters allows me to have a broad perspective on the issues. I was involved in passing the prudent layperson standard in West Virginia and continue to be involved fighting for patient protections in New York. I will bring to the ACEP Board of Directors someone who has worked in many aspects of Emergency Medicine. I started my career as a clerk and then as a manager in the emergency department. I have volunteered as an EMT, firefighter, paramedic, and flight medic. I have worked as a staff physician and as a director. My work background has been as a hospital employee, small and large contract group employee, and now as a locum tenem. This varied employer background gives me insight into how issues affect the delivery of care in varied situations. I am currently working with residents in a community based Emergency Medicine residency and my daughter is a second year medical student. I have definitely become more aware of the issues facing our residents and students and how we must address them to ensure their success in their future careers. I have an excellent perspective on the issues that we are faced with. It would be easy to say I have all of the answers, or even some of them. In reality, these issues are complex and only through collaboration will ACEP be able to effectively address them. Among my ACEP accomplishments I have been a Reference Committee Chair and Chair of the Bylaws Committee. This allowed me to polish the skills necessary to work with other like minded and strong willed individuals. My ability to work collaboratively with other team members will be an important asset.

**Question #2: What strategies would you implement to address burnout and resiliency for emergency physicians?**

During my career I have seen different approaches to the burnout epidemic that is plaguing emergency physicians. What I have seen be effective is that when a suitable work environment is provided for an emergency physician, then increased work satisfaction leads to decreased burnout and stress. That can be accomplished by having the tools needed available and easily accessible to accomplish establishment of a better work environment. We need to make sure that emergency physician wellness is at the forefront of the discussion when we are designing new or refurbished departments. I feel strongly that the all glass “fishbowl” work areas of old are outdated and only lead to increased stress for our physicians. A quieter work environment where physicians can document, review, collaborate and yes, even eat and drink in peace are mandatory for our future. The stories of physicians not taking a 5 minute break to use the restroom need to be history lessons and not current practice. To further decrease burnout ACEP needs to increase how we reach out to our members. We need to not only poll our members, we need to contact at-risk individuals to directly offer help. Identification of at risk individuals will be difficult, as most physicians don't like admitting that we need help. However, almost every physician will experience some form of burnout in their career. Therefore, we need to make physician families a part of the solution. They sometimes are the only ones who notice a problem, but may not realize the tools and support that are available for help. Increased educational materials would hopefully provide our members and their families some measure of increased awareness on this issue. Aggressive marketing of these will increase their availability. Losing one colleague to suicide is unacceptable and we must do everything in our power to prevent another loss of life. While this won't be an inexpensive measure, we need to devise an aggressive plan to help our members. Implementing a toll free number that our members can call for help is one solution that needs to be investigated. An intervention such as this would allow us to provide individualized support and referrals for our members. Anonymous referral could be another important mechanism to help our fellow physicians. While privacy laws would need to be respected, there should be mechanisms where physicians could identify a colleague who is at risk and refer them for some form of third party assistance to help resolve their issues. Wellness retreats and increased socialization efforts are other aspects that would help us address this issue. The EMDocs Facebook group is one effort that I believe has shown promise in this area. I have seen fellow Emergency Physicians post on the EMDocs Facebook group and immediately receive feedback. Whether it is on a “hypothetical” case that they are thinking about, or work or career advice. The group has become an important part of
the daily routine for those who are involved with it. ACEP needs to continue to support current efforts that attempt to address burnout. We need to give our members the tools and support that they need to identify potential burnout in them or their colleagues. Increasing resiliency through better practice environment, healthier sleep patterns, better nutrition and exercise will all lead to increased satisfaction. We need to engage our medical students and residents to provide them with these interventions. We also need to provide them tools for self-regulation of their own cognitive, somatic and emotional reactions to the stressful environment in which they have chosen a career. Starting early in their careers will allow them to lead a long healthy career in Emergency Medicine.

**Question #3:** How would you explain the value of membership to a young emergency physician to encourage their continuing membership in ACEP? What programs or incentives would you recommend to retain members following residency?

I have some recent experience in this area as the residents that I am currently working with have been quite interested in my role within ACEP and why I think ACEP is important in their careers. The answer I give is that ACEP membership is one of the most important professional activities that you can participate in. Having a voice of more than 37,000 members fighting for you in Congress, against the insurance companies and for the protection of our patients is well worth the money spent. I explain that the graduated ACEP dues allow the increased cost of membership to be slowly integrated in to their post residency financial environment. I tell them that the additional benefits of CME, practice resources, tools to combat burnout, increase resiliency, along with the camaraderie of interactions at meetings make it an absolute winning proposition. I also encouraged my daughter, who is a second year medical student, to join EMRA/ACEP. I feel that it is important for her to understand the career path she is interested in and I want her to have access to the information and resources we currently have available. I do receive many questions regarding the cost of being a member. This cost should be better defined for the newer members. The questions of “what exactly do I get and where does my money go” are important and we need to be more specific in answering them. We need to emphasize the importance of being a part of the ACEP community and how increased membership numbers gives us a larger voice. Increased communication with newly graduated residents, both directly and through social media will increase their sense of belonging which should hopefully increase their willingness to stay as members. Increasing ACEP’s presence on social media is important. Residents communicate not only on Facebook and Twitter but on Instagram and Snapchat. We need to make sure that we are speaking to them where they are listening. The ACEP Scientific Assembly is one area where the value of ACEP is demonstrated. We need to continue to ensure that the offerings are not only state of the art medicine but also topics that are fun and interesting to the younger physicians. ACEP should be reaching out directly to those young physicians who choose not to renew. This will not only allow us to answer any questions this physician might have but it will also allow us to identify areas in which our efforts might be falling short. Most young physicians struggle with their finances. The creation of a program that would provide easy access to financial and estate planning for our young physicians would be quite beneficial. I feel that this type of benefit would not only show that ACEP listens to their concerns but also ACEP cares about their future.
CANDIDATE DATA SHEET

Virgil W. Smaltz, MD, MPA, FACEP

Contact Information
24 Bay View Ter, Geneva, NY 14456
Phone: 304-389-0595 (C) 315-325-4017 (H)
E-Mail: vws maltz@gmail.com

Current and Past Professional Position(s)
Self Employed Emergency Medicine Physician (2016-present)
Director of Emergency Medicine (Finger Lakes Health 2011-2016)
Medical Director Emergency Medicine (Wheeling Hospital 2007-2011)
Medical Director Emergency Medicine (Thomas Memorial Hospital 2002-2007)
Emergency Medicine Physician (Wheeling Hospital 1996-2002)

Education (include internships and residency information)
WVU Emergency Medicine Residency 1993-1996
MD 1993 Marshall University School of Medicine

Certifications
ABEM 2008-present

Professional Societies
ACEP, AMA, NYACEP, SMA

National ACEP Activities – List your most significant accomplishments
Chairman, ACEP Bylaws Committee 2014-2016
Reference Committee Chair ACEP Council
Member ACEP Section Affairs Committee 2000-2001
Member ACEP Finance Committee 2001-2006
Member ACEP Audit Committee 2005-2006
Member ACEP Council Steering Committee 2003-2005
Member ACEP Bylaws Committee 2007 – present
911 Network Member

ACEP Chapter Activities – List your most significant accomplishments
President, WVACEP
Councilor WVACEP and NYACEP
Committee member (various committees) WVACEP and NYACEP
Practice Profile

Total hours devoted to emergency medicine practice per year: 2080 Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care 100 %  Research 0 %  Teaching 0 %  Administration 0 %

Other: ____________________________ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Locum Tenem Emergency Medicine Physician. Currently working as an Independent Contractor at Arnot Ogden Hospital in Elmira, NY and Oswego Hospital in Oswego, NY.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases  Plaintiff Expert 0 Cases
CANDIDATE DISCLOSURE STATEMENT

Virgil W. Smaltz, MD, MPA, FACEP

1. Employment – List current employers with addresses, position held and type of organization.
   
   Employer: Self employed
   
   Address: 24 Bay View Ter
   
   Geneva, NY 14456
   
   Position Held: Emergency Medicine Physician
   
   Type of Organization: Emergency Medicine

2. Board of Directors Positions Held – List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.
   
   Organization: WV ACEP
   
   Address: 2000 Eoff Street
   
   Wheeling, WV 26003
   
   Type of Organization: Professional/Membership organization
   
   Duration on the Board: 1997-2011

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☐ If YES, Please Describe:
5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Virgil W. Smaltz, MD, MPA, FACEP        Date        August 4, 2017
Virgil W. Smaltz, MD, MPA, FACEP

Dear Fellow Councillors,

I am honored to be a candidate for the ACEP Board of Directors. The candidates this year are an amazing group of leaders and I feel fortunate to be included. ACEP has been an important part of my career. I joined as a medical student over 25 years ago and it has been a decision I have never regretted. I am especially excited for the opportunity serve on the ACEP BOD at this time as we are facing many challenges to our practice. Insurance companies and legislatures are trying to alter the way Emergency Medicine is practiced and I want to be able to be part of the leadership in the forefront of the fight. My experience on the Finance Committee and as Chair of both a Council Reference Committee and the Bylaws Committee has prepared me well to work with the leaders of our College.

Over the past 18 months I have been working as a self employed Locum Tenens. This has given me added perspective on both the issues and the different work environments that Emergency Physicians deal with. I am a strong proponent of physician wellness and believe that ACEP can continue to offer ideas and suggestions to improve our work environment. Emergency Medicine has many different practices. I will be a strong voice for my fellow members and support whatever type of practice that they chose.

Burnout and physician well being are a strong area of interest for me. I have been there. I will work to help ACEP provide the resources necessary to combat burnout and to ensure that we all know the benefits of physician wellness and how to achieve an appropriate state of mind.

I am concerned about what the future holds for our residents and students. My daughter is a second year medical student and is interested in pursuing a career in Emergency Medicine. This only reinforces my concern about the future for our young physicians. I will work diligently to ensure that ACEP continues to be a strong voice for the residents and students pursuing a career in Emergency Medicine. This not only includes the support for EMRA, but also being a continued proponent of ensuring appropriate transitions of contracts where residency training is involved.

I grew up and practiced most of my career in West Virginia. I was privileged to serve as President of WVACEP and value my experience in a small chapter. Moving to New York in 2011 and joining NYACEP has giving me a completely new perspective on involvement in a large chapter. This experience will be invaluable to me as member of ACEP's Board of Directors. I am thankful that I received nominations from both West Virginia and New York and will work hard to live up to the expectations of both of these great chapters.

ACEP needs to continue to be involved in the evaluation of the utility and appropriateness of the ABEM MOC. I will work with the BOD to make sure that the voices of our members are heard by ABEM as the future of the MOC is debated.

Emergency Medicine needs a strong and unified presence. I will work to ensure that ACEP continues to be the premier voice for Emergency Medicine.

Virgil W. Smaltz, MD, MPA, FACEP
304-389-0595
vwsmaltz@gmail.com
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I will bring to the ACEP Board of Directors someone who has worked in many aspects of Emergency Medicine. I started my career as a clerk and then as a manager in the emergency department. I have volunteered as an EMT, firefighter, paramedic, and flight medic. I have worked as a staff physician and as a director. I have worked as a hospital employee, small and large contract group employee, and now as a locum tenens. This varied employer background gives me insight into how issues affect the delivery of care in different situations.

Over the past 18 months I have been working as a self employed locum tenens. This has given me added perspective on both the issues and the different work environments that Emergency Physicians deal with. I am a strong proponent of physician wellness and believe that ACEP can continue to offer ideas and suggestions to improve our work environment. Emergency Medicine has many different practices. I will be a strong voice for my fellow members and support whatever type of practice that they chose.

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This item will be provided as soon as it is available.
The 2017 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the following awards:

**Brian F. Keaton, MD, FACEP**

**John G. Wiegenstein Leadership Award**

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

**Wesley A. Curry, MD, FACEP**

**James D. Mills Outstanding Contribution to Emergency Medicine Award**

Presented to an active, life, or honorary member for significant contributions to emergency medicine. The award honors the late James D. Mills Jr., MD, second president of the College.

**Nathaniel R. Schlicher, MD, JD, MBA, FACEP**

**Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy**

Presented to a member who has made a significant contribution to achieving the College’s health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP’s Executive Director from 1982 to 2003.

**Francis L. Counselman, MD, FACEP**

**Award for Outstanding Contribution in Education**

Recognizes a member who has made a significant contribution to the educational aspects of emergency medicine.
ACEP HONORS 2017 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Edward C. Jauch, MD, FACEP
Award for Outstanding Contribution in Research
Presented to a member who has made a significant contribution to research in emergency medicine.

Salvatore Silvestri, MD
Award for Outstanding Contribution in EMS
Presented to an individual who has made an outstanding contribution of national significance or application in Emergency Medical Services. The award is not limited to ACEP members.

Kelly Gray-Eurom, MD, MMM, FACEP
Council Meritorious Service Award
Recognizes consistent contributions to the growth and maturation of the ACEP Council.

A. Compton Broders III, MD, FACEP
John A. Rupke Legacy Award
Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.
ACEP HONORS 2017 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Patty Stowe, CAE
Honorary Membership Award

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Laura Tiberi, MA, CAE
Honorary Membership Award

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Gordon Wheeler
Honorary Membership Award

Presented to individuals who have rendered outstanding service to the College or the medical profession.
2017 ACEP COUNCIL AWARDS

Staff will identify all who qualify
Council Service Milestone Award

Purpose: To commemorate accumulated years of service as a Councillor or Alternate Councillor.

Award: The Award is a pin indicating years of service given at 5-year service intervals.
Criteria: Any member who has served as a Councillor or Alternate councillor. Recipients will be automatically recognized by ACEP staff via the Councillor database.
Presentation: The award is given to individuals at council registration. Recipients will be briefly recognized at the Council luncheon.

Kelly Gray-Eurom, MD, MMM, FACEP
Council Meritorious Service Award

Purpose: presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.
Criteria: The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. The nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

Laura N. Medford-Davis, MD
Council Horizon Award

Purpose: Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.
Criteria: The nominee should have made an outstanding contribution to the Council of important resolutions, significant contributions to Council discussions, etc.
Government Services Chapter

Council Teamwork Award
*Purpose:* Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

*Criteria:* Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

Pamela P. Bensen, MD, MS, FACEP

Council Curmudgeon Award
*Purpose:* To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.
ACEP Strategic Plan for 2017-2020

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective A – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective D – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Objective E – Achieve meaningful liability reform at the state and federal levels.

Objective F – Position ACEP as a leader in emergency preparedness and response.

Objective G – Establish the value of emergency medicine as an important component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Increase total membership and transitioning resident retention.

Objective B – Provide robust communications and educational offerings, including novel delivery methods.

Objective C – Promote member well-being and improve resiliency.

Objective D – Ensure adequate infrastructure to support growth.

Objective E – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Objective F – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.
STATEMENT OF DIRECTION

Mission Statement

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

Values

The Board of Directors has identified values that serve as the guiding principles for the specialty of emergency medicine. These values, and the objectives that follow, are the foundation of ACEP's planning processes and Council and Board actions.

The values of the American College of Emergency Physicians are:

- Quality emergency care is a fundamental right and unobstructed access to emergency services should be available to all patients who perceive the need for emergency services.

- There is a body of knowledge unique to emergency medicine that requires continuing refinement and development.

- Physicians entering the practice of emergency medicine should be residency trained in emergency medicine.

- Quality emergency medicine is best practiced by qualified, credentialed emergency physicians.

- The best interests of patients are served when emergency physicians practice in a fair, equitable, and supportive environment.

- Emergency physicians have the responsibility to play the lead roles in the definition, management, evaluation, and improvement of quality emergency care.

Approved by the Board of Directors
August 16, 2000
Vision Statement

- Emergency medicine is recognized and valued as an essential public service.
- Patients seeking emergency care are treated by board certified emergency physicians who are supported in their practices with all resources necessary to provide the highest quality medical care.
- Emergency physicians practice in an environment in which their rights, safety, and wellness are assured.
- All patients have health care coverage that ensures access to emergency services. Legally mandated health care services are fully funded.
- Resources for education and training of emergency physicians are sufficient to meet the workforce needs of the specialty.
- Emergency physicians are recognized and valued for their commitment to high quality patient care, teaching, leadership, research, and innovation.
- All emergency physicians are members of the American College of Emergency Physicians.

Approved by the Board of Directors
February 18, 2003
Fiscal Year 2016-2017 Highlights

Foundation Revenue
- Total revenue for FY 2016-2017 totaled more than $2 million.

Grant Awards & Administration
- Awarded more than $1.7 million in research grants in FY16-17.
- Currently slated to award $875,351 in grants in FY17-18.
- Raised $619,264 to support directed grants and special projects.
- Hosted successful EMF Grantee Workshop January 10-12 in Bethesda and provided grantees training and networking opportunities with NIH Program Officers.
- Hosted Scientific Review Subcommittee meeting March 8-9 in Dallas to review and score 2017-2018 EMF grants applications.
- Currently working to develop or finalize new research initiatives, including:
  - GE Healthcare directed grants for Point of Care Ultrasound
  - Veterans’ Administration Fellowship grant partnership
  - American Foundation for Suicide Prevention grant partnership
  - Center for Deployment Psychology grant partnership

Fundraising Activities
- Completed Pave the Way Campaign on December 30, 2016 with a total of $511,500 raised.
  - 403 bricks
  - 150% of goal met
  - EMF Plaza signage installed in April and final brick installation scheduled for June
- Wiegenstein Legacy Society grown to 77 members (estimated value of $2,320,500).
- Launched new Physician Group Giving Society (formerly Honor Roll).
- Currently developing a $500,000 Endowment Campaign in acknowledgment of ACEP’s 50th anniversary.
- Currently developing a Women’s Giving Society.
- EMF Staff Campaign raised $18,892 – 62% staff participation. A record breaking year!
**Donor Acknowledgement**

- Installation of two, beautifully designed donor walls located inside ACEP’s new headquarters:
  - Pave the Way plaques recognize campaign gifts over $2,500
  - WLS donor wall acknowledges members of the Wiegenstein Legacy Society who have listed EMF in their estate plans.

**EMF 4 Star Rating**

For the third year in a row EMF received the Charity Navigator 4-star rating. Charity Navigator is the largest and most-utilized independent evaluator of charities.

**EMF Activities at ACEP17**

**Thursday, October 26**
3:00pm – 8:00pm  
EMF Council Challenge, Marriott, Marquis Ballroom Foyer, Level M2

**Friday, October 27**
7:00am – 5:00pm  
EMF Council Challenge, Marriott, Marquis Ballroom Foyer, Level M2

**Saturday, October 28**
7:00am – 5:00pm  
EMF Council Challenge, Marriott, Marquis Ballroom Foyer, Level M2

**Sunday, October 29**
7:00am – 4:00pm  
EMF Major Donor Lounge, Marriott, Capitol Room, Level M4
9:00am – 4:00pm  
EMF Silent Auction, WCC, Level C, Concourse B
5:30pm  
WLS VIP Access to Making Wine, Music and Memories, Long View Gallery, 1234 Ninth St NW, Washington, DC 20001
6:00pm – 8:00pm  
Making Wine, Music and Memories, EMF Reception, Long View Gallery, 1234 Ninth St NW, Washington, DC 20001

**Monday, October 30**
7:00am – 4:00pm  
EMF Major Donor Lounge, Marriott, Capitol Room, Level M4
8:30am – 10:30am  
EMF Board of Trustees Meeting, Marriott, Liberty Ballroom Salon IJK, Level M4
9:00am – 4:00pm  
EMF Silent Auction, WCC, Level C, Concourse B
12:00pm – 1:00pm  
EMF Showcase Luncheon, WCC, Room 149 AB

**Tuesday, October 31**
7:00am – 3:00pm  
EMF Major Donor Lounge, Marriott, Capitol Room, Level M4
9:00am – 4:00pm  
EMF Silent Auction, WCC, Level C, Concourse B
12:00pm – 1:00pm  
EMF/GE Point-of-Care Ultrasound Challenge: Innovative Research with a Crowd Sourcing Twist, WCC, Room 149 AB
EMF Major Donors and Supporters

EMF thanks ACEP, the ACEP Council and Section Leaders for its Generosity! The ACEP Council is the largest and longest sustaining supporter of EMF.

Donations received between January 1 – August 30, 2017

Mentor Circle
Sanford H Herman, MD, FACEP
Brooks F Bock, MD, FACEP

Leadership Circle
Vidor E Friedman, MD, FACEP
Marvin A Wayne, MD, FACEP
David C Packo, MD, FACEP

1972 Club
Stephen H Anderson, MD, FACEP
Karolyn K Moody, DO, MPH
Charles B Cairns, MD, FACEP
Rick Murray, EMT-P
Carol L Clark, MD, MBA, FACEP
Andrew S Nugent, MD, FACEP
Marco Coppola, DO, FACEP
Robert E O’Connor, MD, MPH, FACEP
Wesley A Curry, MD, FACEP
Brian J O’Neil, MD, FACEP
James Michael Cusick, MD, FACEP
Rebecca B Parker, MD, FACEP
Carrie de Moor, MD, FACEP
Laura C Parnell, MD, FACEP
Kelly Ann Foley, MD, FACEP
Thomas B Pinson, MD, FACEP
Angela F Gardner, MD, FACEP
Ericka Powell, MD, FACEP
Andrea L Green, MD, FACEP
Ralph James Riviello, MD, FACEP
Hans Roberts House, MD, FACEP
John J Rogers, MD, FACEP
William Paul Jaquis, MD, FACEP
Mark S Rosenberg, DO, MBA, FACEP
Christopher S Kang, MD, FACEP
Cynthia A Singh, MS
Jay A Kaplan, MD, FACEP
Robert C Solomon, MD, FACEP
Paul D Kivela, MD, MBA, FACEP
Sara F Sutherland, MD, MBA, FACEP
Kevin Michael Klauer, DO, FACEP
K J Temple, MD, FACEP
Donald L Lum, MD, FACEP
Hemant H Vankawala, MD, FACEP
Angela F Mattke, MD, FACEP
David E Wilcox, MD, FACEP
Sonja R Montgomery, CAE

Friend of EMF
James B Aiken, MD, MHA, FACEP
R Carter Clements, MD, FACEP
Rashid J Baddoura, MD, FACEP
Kathleen Cowling, DO, FACEP
Dominic Joseph Bagnoli, Jr, MD, FACEP
Diana L Fite, MD, FACEP
Andrew I Bern, MD, FACEP
Juan Francisco Fitz, MD, FACEP
Michael D Bishop, MD, FACEP(E)
Jeffrey Michael Goodloe, MD, FACEP
Michael A Bohrn, MD, FACEP
Robert Heard, MBA, CAE
Jordan Celeste, MD
Doug Duart Jeffrey, MD
Jacob Keeperman, MD, FACEP
Michael D Smith, MD, MBA, CPE, FACEP
Jennifer L’Hommedieu Stankus, MD, JD, FACEP
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This item will be provided as soon as it is available.
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Mission

To ensure the highest standards in the specialty of Emergency Medicine.

Purposes

• To improve the quality of emergency medical care

• To establish and maintain high standards of excellence in Emergency Medicine and subspecialties

• To enhance medical education in the specialty of Emergency Medicine and related subspecialties

• To evaluate physicians and promote professional development through initial and continuous certification in Emergency Medicine and its subspecialties

• To certify physicians who have demonstrated special knowledge and skills in Emergency Medicine and its subspecialties

• To enhance the value of certification for ABEM diplomates

• To serve the public and medical profession by reporting the certification status of the diplomates of the American Board of Emergency Medicine

1 ABEM holds the interests of patients and their families in the highest standing, particularly with regard to the provision of the safest and highest-quality emergency care. ABEM addresses its commitment to patients by supporting the physicians who provide care to the acutely ill and injured, and by working to transform the specialty of Emergency Medicine.
It is no secret that medical certifying boards are under attack and that their legitimacy is being challenged. Historically, medical certifying boards certified physicians who passed an examination in a given specialty, and conferred lifetime certification on these physicians. Lifetime certification ended with the recognition of the American Board of Family Medicine (ABFM) and the American Board of Emergency Medicine (ABEM) by the American Board of Medical Specialties (ABMS) in 1969 and 1979 respectively. ABFM and ABEM ushered in the concept of recertification—every seven years for ABFM and every ten years for ABEM. ABMS later created the concept of lifelong learning in the 1990s and eventually introduced the four parts of Maintenance of Certification (MOC) in 1999. All 24 ABMS Member Boards have followed suit and have created MOC programs with time-limited certificates and, thus, recertification.

Over the past few years an anti-MOC movement has emerged that attacks the medical certifying boards, using several strategies. One strategy is to challenge the financial stewardship of the boards. ABEM annually reports its financial data for public review via its Form 990. The most recent report shows that for 2015, ABEM had $14,303,857 in revenue against $14,496,065 in expenses for a net loss of $124,826. ABEM also reported $32,506,265 in net assets, which had grown considerably after the market recovery this past decade. ABEM has used this corpus strategically to keep all fees fixed for the past five years (six years for the LLSA). Though the cost of administering the Oral Certification Examination has more than doubled with the introduction of the eOral format, these additional costs have not been passed on to physicians seeking initial certification.

Another approach is to promote a competing board, such as the National Board of Physicians and Surgeons, which requires only continuing medical education (CME) credits to remain “certified” after obtaining initial certification.

Another tactic is to devalue certification by supporting legislation that would make it illegal to use maintenance of certification for credentialing by various entities, such as hospital medical staffs and medical insurance companies. This would substantially weaken the credential for which emergency physicians had worked hard to obtain.
One specific form of legislation would limit recognition of a medical certifying board such as ABEM if the certifying board did not meet certain qualifications; for example, not requiring a recertification examination. These attacks on the strength of board certification have been variably received by state legislatures and will likely surface in more states during the next legislative session.

So, given this current environment, what should ABEM do to maintain a credential that emergency physicians value? How can ABEM counter the current environment in such a way as to continue to support self-regulation by the medical profession? Let’s be clear, the goal of the anti-MOC movement is not to simply eliminate MOC or the recertification examination—it is to return to the era of lifelong certification and the avoidance of public accountability.

I believe that ABEM must address the following issues in order to continue to have the support of the specialty:

• **Transparency.** ABEM will continue to be transparent and publicly report its financial activity. ABEM’s governance is led by physicians who must be clinically active. The directors on ABEM’s Board are well-known to the EM community and most have been nominated by major EM membership organizations. Moreover, ABEM responds to every individual inquiry made.

• **Flexibility and Adaptability.** ABEM is willing to address issues about which certified physicians have concerns. ABEM has made numerous modifications to the MOC Program. In recent years, ABEM has actually decreased the number of requirements that diplomates need to complete to remain certified.

• **Efficiency.** There will be increased review of ABEM financial activity. To the degree that it can, ABEM will try to minimize any increases in fees. The ability to maintain initial certification fees has been difficult, but successful. Finally, ABEM is indebted to the 500 physician volunteers who support ABEM activities.

• **Relevance.** Credentialers and diplomates insist that MOC activities must be relevant. Every question on every examination is part of *The Model of the Clinical Practice of Emergency Medicine* (EM Model). The LLSA articles are highly rated as relevant to EM. Improvement in Medical Practice activities are entirely self-directed by emergency physicians and include common CMS and The Joint Commission quality measures. The MOC process must be pragmatic. ABEM has built a risk management dimension into the LLSA. Nearly one-third of all articles involve high-risk conditions (based on med-mal insurance data) with a propensity for diagnostic error.

• **Responsiveness.** Diplomates can expect to have their concerns acknowledged. Diplomates want
to know that ABEM is listening. ABEM recently discontinued the patient satisfaction attestation requirement because diplomates did not find that the activity improved patient care. ABEM heard this valid concern and took action. ABEM values suggestions by diplomates. This conversation is the best mechanism through which ABEM certification can be made stronger and more valuable.

• **Convenience.** Diplomates want more convenience when being assessed. Delivering the ConCert™ Examination at Pearson VUE testing centers was a nearly ideal format when ABEM began computer-based testing. ABEM is exploring alternative methods of test delivery and has piloted alternative computer-based testing formats with the In-training Examination. ABEM must maintain the security of the examination process to maintain the value of certification, but we are exploring novel ways to accomplish this goal.

• **Value.** Certification will need to represent more value than the certificate itself. Not only do most ABEM diplomates enjoy more total compensation than non-certified physicians, there are greater job opportunities and learning benefits to remaining certified. As Emergency Medicine is faced with greater challenges with scope of practice issues, the stronger the ABEM credential, the stronger our bargaining position. Moreover, a strong credential is a starting point in conversations with CMS to argue for a more substantial contribution of ABEM certification toward the total composite score under MACRA. ABEM had tremendous success with this strategy with the PQRS MOC bonus that increased emergency physician revenue by $4 million. Finally, robust certification through ABEM is being used to combat medical merit badge requirements. ABEM is grateful for the support of the entire EM community in this effort.

• **Credibility.** Diplomates want to know that MOC requirements are supported by scientific evidence. Increasingly, research supports the favorable impact of MOC, and ABEM is undertaking a resource-intense initiative to provide yet stronger evidence supporting ABEM certification for our specialty.

• **Innovation.** Innovation goes beyond the need to be responsive. It requires ABEM to be proactive in making changes, not just reactive to concerns and criticisms. ABEM has invested ten years of effort and resources in developing and implementing the eOral format, making our initial certification experience state-of-the-art. With that effort well under way, it is time to devote our attention to MOC and look at innovative ways to assess the physician in mid- and late-career.

• **Communication.** To address these many issues, ABEM must provide clear, complete, and frequent communication. ABEM must always be asking for your ideas. We are committed to a never-ending conversation with you.
For the ABEM credential to be respected by the public and policy makers, it must involve an assessment of the physician against national standards. This assessment will have a consequence, and that consequence could lead to decertification. Despite this, ABEM aspires to have competent physicians continuously certified and staying up to date in recent medical advances in our specialty. ABEM is confident that if we address these issues as a specialty we can counter this current wave of anti-MOC sentiment and damaging legislation. ABEM diplomates have worked hard to obtain ABEM certification. The ABEM MOC Program is rigorous and continued certification is too valuable to have others diminish its worth. Much of the legislation that has been introduced surrenders medical self-regulation to the government and would have long-lasting and devastating effects. ABEM is committed to supporting the women and men who are dedicated to the care of the acutely ill and injured by providing them with the most valuable professional credential they will ever earn—ABEM certification.
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Involvement with the ABMS

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¹ Appointed by ABEM
² Elected by ABMS
³ Appointed by ABMS
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Michael V. Vance, M.D. 1986–1995
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<th>President</th>
<th>Years of Service</th>
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<tbody>
<tr>
<td>John G. Wiegenstein, M.D.</td>
<td>1982–1983</td>
</tr>
<tr>
<td>Ronald L. Krome, M.D.</td>
<td>1984–1985</td>
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<td>Harris B. Graves, M.D.</td>
<td>1985–1986</td>
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<td>James D. Mills, M.D.</td>
<td>1986–1987</td>
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<tr>
<td>Gail V. Anderson, Sr., M.D.</td>
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<tr>
<td>Joseph E. Clinton, M.D.</td>
<td>1989–1990</td>
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<tr>
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<tr>
<td>Michael D. Bishop, M.D.</td>
<td>1993–1994</td>
</tr>
<tr>
<td>Vincent J. Markovchick, M.D.</td>
<td>1999–2000</td>
</tr>
<tr>
<td>Gwendolyn L. Hoffman, M.D.</td>
<td>2001–2002</td>
</tr>
<tr>
<td>Jeffrey G. Graff, M.D.</td>
<td>2003–2004</td>
</tr>
<tr>
<td>John B. McCabe, M.D.</td>
<td>2004–2005</td>
</tr>
<tr>
<td>Lynnette Doan-Wiggins, M.D.</td>
<td>2006–2007</td>
</tr>
<tr>
<td>Rita Kay Cydulka, M.D.</td>
<td>2007–2008</td>
</tr>
<tr>
<td>Harold A. Thomas, M.D.</td>
<td>2008–2009</td>
</tr>
<tr>
<td>Debra G. Perina, M.D.</td>
<td>2009–2010</td>
</tr>
<tr>
<td>Mark T. Steele, M.D.</td>
<td>2010–2011</td>
</tr>
<tr>
<td>John C. Moorhead, M.D.</td>
<td>2012–2013</td>
</tr>
<tr>
<td>Francis L. Counselman, M.D.</td>
<td>2014–2015</td>
</tr>
<tr>
<td>Barry N. Heller, M.D.</td>
<td>2015–2016</td>
</tr>
<tr>
<td>Michael L. Carius, M.D.</td>
<td>2016–2017</td>
</tr>
</tbody>
</table>

### ABEM Executive Directors – Years Of Service

<table>
<thead>
<tr>
<th>Executive Director</th>
<th>Years of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benson S. Munger, Ph.D.</td>
<td>1979–1999</td>
</tr>
<tr>
<td>Mary Ann Reinhart, Ph.D.</td>
<td>2000–2010</td>
</tr>
<tr>
<td>Earl J. Reisdorff, M.D.</td>
<td>2010–Present</td>
</tr>
</tbody>
</table>
ABEM Staff

Earl J. Reisdorff, M.D.  Executive Director
Susan K. Adsit  Associate Executive Director, Organizational & Certification Services
John H. Diephouse, M.L.I.R., SPHR  Associate Executive Director, Operations
Anne L. Harvey, Ph.D.  Associate Executive Director, Evaluation & Research Services / Examination Development & Administration
Jennifer L. Kurzynowski  Associate Executive Director, Operations
Ashley N. Armstrong, M.A.  Administrative Coordinator, Examination Development & Administration
Melissa A. Barton, M.D.  Director of Medical Affairs
Ashleigh A. Booth  Administrative Coordinator, Organization Services
Cheryl P. Cardamoni, CMP  Meeting Services & Travel Specialist, Operations
Laura A. Clark-Roumpz  Coordinator, Certification Services
Andrea M. Coombs, M.S.  Senior Data Administrator, Evaluation & Research Services
Timothy J. Dalton  Assistant Director, Examination Development & Administration
Susan M. Dunsmore  Administrative Assistant, Organization Services
Lauretta J. Fortune, M.B.A.  Associate, Certification Program Development, Organization Services
DeShawn R. Graves  Business Analyst, Certification Services
Christa L. Hagelberger, CAP  Operations Coordinator, Operations
Erin G. Houlroyd  Data Administrator, Certification Services
Kelly R. Johnston  Organizational Services Specialist, Organization Services
Mary M. Johnston, Ph.D.  Psychometrician, Evaluation & Research Services
Kevin B. Joldersma, Ph.D.  Senior Psychometrician, Evaluation & Research Services
Marie E. Jonzun  Subspecialty Coordinator, Certification Services
Julia N. Kehbauch  Examination Development Specialist, Examination Development & Administration
Stephanie P. LaRue  Administrative Assistant, Certification Services
Sarah O. Lytle  Administrative Assistant, Certification Services
Angela J. McGoff  Specialist, Certification Services
Samantha A. McIlrath  Administrative Assistant, Certification Services
Stacy R. Mellor, SPHR  Operations Specialist, Operations
Michele C. Miller  Assistant Director, Certification Services
Shannon D. Miller  Administrative Assistant, Certification Services
Dawn M. Patterson  Examination Administrator, Examination Development & Administration
Robert G. Purosky  Data Administrator, Evaluation & Research Services
Shelby J. Reed  Administrative Coordinator, Organization Services
Julie A. Renner  Appeals Administrator, Certification Services
Mackenzie M. Robertson  Administrative Assistant, Operations
Joshua W. Salander, M.B.A., PMP  Business Analyst, Certification Services
Karen A. Sawyer, CMP  Meeting Services Specialist, Operations
Deborah L. Schultz  Administrative Assistant, Certification Services
Karen J. Shannon, CAP  Administrative Coordinator, Evaluation & Research Services
Caleb D. Seeley  Administrative Coordinator, Examination Development & Administration
Stephanie N. Sheehan  Meeting Services & Staff Travel Coordinator, Operations
Karly A. Skym  Business Analyst, Evaluation & Research Services
Jeffrey S. Smith  Systems Solutions Specialist, Operations
Frances M. Spring  Senior Communications Administrator, Organization Services
Christina L. Tisdale  Business Analyst, Evaluation & Research Services
Linda L. Wainwright  Operations Assistant, Operations
Kourtney A. Weidner  Operations Coordinator, Operations
Amy E. Will, CMP  Administrative Assistant, Examination Development & Administration
Jennifer D. Wise, CPA  Senior Financial Analyst, Operations
Andrea J. Wolf  Communications Coordinator, Organization Services

List includes all staff employed by ABEM during 2016-2017.
BOARD OF DIRECTORS ELECTIONS

At its winter 2017 meeting, the Board elected two new directors, Leon L. Haley, Jr., M.D., and James D. Thomas, M.D. Their terms will begin at the close of the summer 2017 Board of Directors meeting.

ADMINISTRATIVE SERVICES

First ABEM National Academy of Medicine Fellow Nears End of Term

The first physician to be awarded the ABEM National Academy of Medicine (NAM) Fellowship, Hanni Stoklosa, M.D., M.P.H., will complete her two-year fellowship in 2017. Dr. Stoklosa’s work to oppose human trafficking has attracted national and international attention, and has shed a spotlight on the crucial role Emergency Medicine can play in combating the activity. The second ABEM Fellow will be announced by the NAM in October 2017.

Coalition to Oppose Medical Merit Badges

The American Board of Emergency Medicine joined a group composed of nearly every major Emergency Medicine organization to form the Coalition to Oppose Medical Merit Badges. Coalition members include the following organizations:

- American Academy of Emergency Medicine
- American Academy of Emergency Medicine/Resident and Student Association
- American Board of Emergency Medicine
- American College of Emergency Physicians
- American College of Osteopathic Emergency Physicians
- Association of Academic Chairs of Emergency Medicine
- Council of Emergency Medicine Residency Directors
- Emergency Medicine Residents’ Association
- Society for Academic Emergency Medicine

The Coalition believes that board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certifications in, for example, 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 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 (ACGME)–accredited or American Osteopathic Association (AOA)–approved Emergency Medicine residency program. These “merit badges” add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process and fail to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program or the AOBEM Osteopathic Continuous Certification 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 acknowledges that opposing the requirements for medical merit badges will be a long and challenging struggle. It will take time to help administrators and regulatory bodies better understand the rigorous standards to which board-certified emergency physicians adhere. The Coalition plans to develop a long-term strategy to create success and a pathway to recognize clinical excellence.

Changing of the Guard in Operations

After 22 years of service to ABEM, John H. Diephouse, M.L.I.R., SPHR, retired from his position as the Associate Executive Director of Operations on January 11, 2017. John contributed significantly to ABEM and the specialty of Emergency Medicine. His vision and leadership will be sorely missed.

On February 20, 2017, Jennifer L. Kurzynowski came aboard as ABEM’s new Associate Executive Director of Operations. Jennifer has substantial senior leadership experience, including Vice President of Administration and Operations, Vice President of Virtual Solutions, Chief Information Officer, and Vice President of E-Commerce.

Diplomate Recognitions

ABEM recognized physicians who marked 30 years of being board certified in Emergency Medicine with a special certificate. This year’s recipients included 510 physicians who had been board certified for 30 years as of December 31, 2016. A list of the 2016 recipients was included in the spring 2017 issue of the ABEM Memo, and is posted on the ABEM website. Certificates are awarded annually to diplomates who achieve this milestone.

Also this year, ABEM provided lapel pins that include the ABEM logo surrounded by the words “Board Certified” to newly certified diplomates. The pins recognize all the physicians who provide high-quality, compassionate care to all, 24/7/365.
Residency Visitation Program (RVP)

For more than 20 years, current and senior ABEM directors have visited all ACGME-accredited EM residency programs on a rotating three- or four-year basis. The purposes of these visits are to enhance communication between ABEM and residents; to identify ABEM as the premier certifying body in EM; and to answer questions residents have about training, certification, and other issues in EM. In 2016-2017, the RVP expanded to include the formerly AOA-approved EM residency programs that became accredited by the ACGME. As formerly AOA-approved programs become ACGME accredited, they will be integrated into the RVP.

In 2016-2017, ABEM directors gave 62 RVP presentations. In addition to the RVP presentation, ABEM directors often meet with chief residents, faculty, department chairs, and others to discuss topics of interest. ABEM directors often work with faculty to present clinical information to residents on topics of their choice.

TRAINING PROGRAMS

Emergency Medicine

According to the ACGME, for the 2016-2017 academic year there were 209 ACGME-accredited EM categorical residency programs in the following formats:

- 155 PGY 1-3 (74 percent)
- 54 PGY 1-4 (26 percent)

An estimated 2,118 EM categorical residents will graduate on or before October 31, 2017.

Thirty-three of the 2016-2017 EM categorical programs were newly accredited during the 2016-2017 academic year. Twenty-one of the thirty-three EM programs were previously AOA-approved programs; the ACGME accredited them through the Single Accreditation System.

Combined Training Programs

There are currently five types of approved EM combined training programs:

- Emergency Medicine/Anesthesiology (EM/Anes)
- Emergency Medicine/Family Medicine (EM/FM)
- Emergency Medicine/Internal Medicine (EM/IM)
- Emergency Medicine/Internal Medicine/Critical Care Medicine (EM/IM/CCM)
- Emergency Medicine/Pediatrics (EM/Peds)

Successful graduates of an approved five-year training program in EM/Anes, EM/FM, EM/IM, and EM/Peds are eligible for certification in both specialties. Successful graduates of a six-year EM/IM/CCM training program are eligible for certification in EM and IM, and subspecialty certification in IM-CCM. Residents in these six-year programs can apply for EM certification in their fifth year of training (see Table 1).
INTERNAL OPERATIONS

Administrative Report

ABEM staff remained the same at 41 positions at the end of the year. Technology-related projects are a central component of ABEM’s operational activities. This expanding body of work is successfully supported through a partnership with NuWave Technology Partners for network infrastructure support, Latitude Consulting Group for database and web interface support and refinements, and Maestro eLearning for development of the enhanced Oral Examination software. This year, significant efforts resulted in refinements to the enhanced Oral Examination software, and substantial improvements were made to online processes used by certification candidates and diplomates.

Financial

At its February 2017 meeting, the Board of Directors reviewed the final audit report for the fiscal year ending June 30, 2016, prepared by Yeo and Yeo, P.C., ABEM’s external auditing firm. The positive audit report contained no qualifications of generally accepted procedures.

Gross revenue for the year totaled $14,324,783, which was derived from application and examination fees, and $47,722 from miscellaneous revenue. Net revenue for the year totaled ($170,548), which included investment income of $21,660, for a revenue margin from operations of –1.3 percent.

Investments for the year totaled approximately $32,800,000. For 2016-2017, ABEM strategically used these funds to hold ABEM initial certification fees, ConCert™ Examination fees, and Lifelong Learning and Self-assessment (LLSA) test fees fixed. Though the cost of administering the Oral Certification Examination has more than doubled with the introduction of the eOral format, none of these additional costs have been passed on to physicians seeking initial certification.

Fixed Fees

2016-2017 marked the fifth year that ABEM kept examination fees fixed. Additionally, LLSA test fees have remained the same for six years, and CME activity fees have remained unchanged for seven years.
Emergency Medicine Credentialing, Evaluation, and Examination Development Activities

As of December 31, 2016, there were 34,816 ABEM diplomates (see Chart 1). This includes 875 physicians who passed the fall 2016 Oral Certification Examination (OCE) and 79 former diplomates who regained certification. An additional 878 physicians earned certification by passing the spring 2017 OCE.

Chart 1. Total Number of Active ABEM Diplomates, 1984-2016

Chart based on calendar-year data. Detailed tables are available in the Appendix.

IN-TRAINING EXAMINATION

ABEM administered the In-training Examination (ITE) to 6,812 residents on February 22, 2017. There were 6,358 residents from 182 U.S. categorical programs, 186 residents from 22 combined programs, 181 residents from 11 Canadian programs, 83 residents from three Singapore programs, and four advance-match physicians.

Online Administration

The default administration method for the 2017 ITE was the computer-delivered online format, although residency programs were allowed to opt out of the online administration. The 2018 ITE will be administered only in the electronic format, over a five-day testing window.

INITIAL CERTIFICATION

Credentialing Activity

ABEM received 1,866 applications during the 2016 EM certification application period.

Evaluation Activity

Qualifying Examination

A total of 2,130 initial certification candidates took the Qualifying Examination (QE) in 2016-2017, of which 2,122 (99.6 percent) were residency trained, and eight were non-residency trained. Eighty-nine percent of the total initial certification group passed the examination, and 93 percent of residency-trained, first-time takers (the reference group) passed. Chart 2 illustrates the number of physicians in the reference group who took and who passed the QE by calendar year.
Oral Certification Examinations
ABEM administered two Oral Certification Examinations during 2016-2017. The October 8-11, 2016, examination was administered to 901 initial certification candidates, of whom all were residency trained. Of the 871 first-time takers, 849 (97 percent) passed the examination; 875 (97 percent) of all initial certification candidates passed the examination (see Chart 3).

The April 29-May 2, 2017, examination was administered to 906 initial certification candidates, of whom all were residency trained. Of the 889 first-time takers, 860 (97 percent) passed the examination; 875 (97 percent) of all initial certification candidates passed the examination.

MAINTENANCE OF CERTIFICATION
Constantly Innovating, Remaining Relevant

The clinical practice of Emergency Medicine is evolving rapidly, so ABEM strives to ensure that its certification and recertification processes remain clinically relevant and current. Over the past year, ABEM has introduced changes that reflect the goals of constant innovation and improvement.

Reasoning for LLSA Test Answers
In response to diplomate requests, ABEM is providing the reasoning behind the correct answers to EM LLSA test questions. The rationales will be available to test takers beginning with the 2017 EM LLSA test. Reasoning behind the correct answers to subspecialty LLSAs is being developed and will be available beginning in 2018. The rationales will be
available after the test is passed. In addition, score reports for all available ABEM LLSAs now show which questions were answered correctly or incorrectly.

**Pediatric Emergency Medicine LLSA**
A Pediatric Emergency Medicine LLSA was made available to all ABEM diplomates for the first time in June 2017.

**Patient Satisfaction Survey Not Required**
In 2016-2017, a pilot program was instituted to no longer require diplomates to attest to taking part in patient satisfaction surveys. In tandem with the pilot, a research project has been undertaken to examine how to more reliably measure professionalism as it relates to emergency physicians.

**No Self-assessment Attestation**
Diplomates no longer need to attest to completing eight self-assessment CME credits. Because LLSA tests are self-assessment activities, the annual requirement is automatically met when diplomates successfully complete the test.

**Self-service Status Verification Letter**
Diplomates now have the ability to print a customized letter that verifies ABEM certification or board eligibility status, and no longer have to call or email ABEM with their request.

**Lifelong Learning and Self-Assessment (LLS)**
There were 25,080 LLSA tests completed by 19,532 diplomates and former diplomates in 2016-2017. Of the 25,080 tests completed, 15,892 (63.4 percent) were associated with a completed optional LLSA CME activity. (Figures are for June 1, 2016, through May 31, 2017.)

**Assessment of Knowledge, Judgement, and Skills (ConCert™ Examination)**
ABEM administered the ConCert™ Examination on September 12-17, 2016, to 2,687 diplomates and former diplomates at Pearson VUE Professional Centers across the U.S. and Canada. Of the 2,687 test takers, 2,529 (94 percent) passed the examination (see Chart 4). In addition, 1,090 test takers (40 percent) took the examination early, that is, prior to their final year of certification.

**Chart 4. Number Who Took and Who Passed the ConCert™ or Recertification Examinations, 1996-2016**

*Chart based on calendar-year data. Detailed tables are available in the Appendix.*
**Improvement in Medical Practice (IMP)**

**Patient Care Practice Improvement**  
There were 4,720 IMP practice improvement (PI) attestations submitted by 4,270 ABEM diplomates in 2016-2017. The five most commonly reported quality initiatives are reported in Table 2.

**Table 2. Most Commonly Reported PI Activities, 2016-2017**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Attestations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time-related (throughput time, ED length-of-stay, and other process time measures)</td>
<td>1,258</td>
</tr>
<tr>
<td>Stroke-related</td>
<td>590</td>
</tr>
<tr>
<td>Infectious disease–related</td>
<td>508</td>
</tr>
<tr>
<td>Other</td>
<td>485</td>
</tr>
<tr>
<td>Cardiac-related</td>
<td>422</td>
</tr>
</tbody>
</table>

Figures are for June 1, 2016, through May 31, 2017

**Communication/Professionalism**  
Recognizing that over 90 percent of its diplomates already participate in a patient experience of care survey, in June 2016, ABEM implemented a pilot to no longer require attesting to a Communication/Professionalism activity. The pilot extends through December 31, 2018. Communication/Professionalism is included in other MOC activities, and ABEM is exploring alternative means of assessing professionalism.

**MOC Certification Activity**

In 2016, 79 former diplomates regained certification.

Beginning in September 2016, ABEM staff contacted diplomates whose certifications were set to expire at the end of the year and had outstanding ABEM MOC requirements. By late November, ABEM identified diplomates who had passed the ConCert™ Examination, but still had missing requirements (LSA tests, CME, and/or IMP activities). Each of these diplomates was notified personally by ABEM staff to let them know what MOC activities they needed to complete in order to renew certification, and to offer their assistance with navigating online processes. Of the diplomates contacted by ABEM, all but 12 completed their MOC activities and renewed certification by the end of 2016.

**EXAMINATION DEVELOPMENT ACTIVITIES**

ABEM has a rigorous examination development process intended to keep the examinations relevant and assure high-quality cases and questions. To that end, ABEM insists that the content of the examination be defined by the EM community, that only clinically active, ABEM-certified emergency physicians write and review cases and questions, that test takers are able to provide feedback, and that every case and question receives extensive quality checking throughout its life cycle.

**EM Community Defines the Content**

*The Model of the Clinical Practice of Emergency Medicine* (EM Model) forms the basis of each of ABEM’s examinations. The EM Model is reviewed every three years by nearly every major Emergency Medicine (EM) organization to be certain it reflects the current practice of EM. The EM Model Review Task Force is composed of representatives from ABEM and the following organizations:

- American Academy of Emergency Medicine
- American College of Emergency Physicians
- Council of Emergency Medicine Residency Directors
- Emergency Medicine Residents’ Association
- Residency Review Committee for Emergency Medicine
- Society for Academic Emergency Medicine

Developing Examination Questions

New question writers go through an intensive training process. In addition, all writers attend an annual workshop to hone their skills and receive feedback throughout the year from experienced examination editors. Each writer is assigned to work on a specific examination (ITE, QE, LLSA, or ConCert™ Examination), and each examination has its own editors. The requirement that item writers be clinically active, coupled with ongoing training and question revisions, keep examination content relevant and current.

Whenever a new question is used on an examination it is subject to statistical analysis to determine how well it assessed a physician’s cognitive skill and medical knowledge. In addition, before being used as a scored item, every test taker comment is reviewed by the editors. Before it is used to determine certification, every question will have been reviewed by trained, clinically active emergency physicians, staff editors, psychometricians, and the physicians taking the examination.

Oral Certification Examination Cases

Oral cases are developed by ABEM-certified physicians who are specifically trained for this purpose. The process of case development is led by editors who are experienced examiners.

Prior to each administration (spring and fall) of the OCE, cases are selected using content and statistical specifications. The selected cases undergo additional review and newly developed cases undergo mock administrations. Mock administrations are given to emergency physicians who are unfamiliar with the case, much like a candidate taking the exam would experience. Following the mock administration, cases may be revised to improve the content and delivery of the case. These procedures are in place to ensure that the examination measures, as accurately as possible, what an emergency physician should know and be able to do.

The OCE is not intended to reproduce a physician’s experience working in the emergency department, but to assess specific competencies in a controlled setting.

Activities Related to Examination Development

- Item Writers’ Workshop: July 14-16, 2016
- Knowledge, Skills, and Abilities Working Group, September 13, 2016
- Mock Administrations of Selected Field Test Cases: August 15, 2016; March 23, 2017
- New Writer Training and Orientation: April 11, 2017
- Case Selection Panel: December 5, 2016; June 4, 2017
- Case Development Panel: December 4-5, 2016; June 5-6, 2017
Subspecialty Credentialing, Evaluation, and Examination Development Activities

In 2016-2017, ABEM offered nine subspecialty certifications:

- Anesthesiology Critical Care Medicine (ACCM)
- Emergency Medical Services (EMS)
- Hospice and Palliative Medicine (HPM)
- Internal Medicine-Critical Care Medicine (IM-CCM)
- Medical Toxicology (MedTox)
- Pain Medicine
- Pediatric Emergency Medicine (PedEM)
- Sports Medicine (SPM)
- Undersea and Hyperbaric Medicine (UHM).

Chart 5 provides a breakdown of the 1,724 active ABEM diplomates (5.0 percent of all ABEM diplomates), by subspecialty, who held a subspecialty certificate issued by ABEM as of December 31, 2016.

This year, physicians certified by the American Osteopathic Board of Emergency Medicine (AOBEM) are able to sit for select ABEM subspecialty examinations if their fellowship training was Accreditation Council for Graduate Medical Education (ACGME) accredited. This is the result of a proposal made by the ABEM Board of Directors and approved by the American Board of Medical Specialties (ABMS). This is a time-limited, temporary eligibility pathway for subspecialty certification that expires June 30, 2022, and is only available to AOBEM diplomates who are applying through the accredited training pathway.

In addition to ABEM-issued subspecialty certification, ABEM diplomates can obtain subspecialty certification in Addiction Medicine, Brain Injury Medicine, Clinical Informatics, and Surgical Critical Care through other ABMS Member Boards. This section outlines the credentialing and examination administration activities for ABEM-approved subspecialties. Additional information is available in the Appendix.


ABEM-APPROVED SUBSPECIALTIES

Anesthesiology Critical Care Medicine

The American Board of Anesthesiology (ABA) and ABEM co-sponsor certification in the subspecialty of ACCM. Upon completion of an ACGME-accredited ACCM training program and additional ABA-approved training, ABEM diplomates are eligible to seek board certification in ACCM. ABEM diplomates submit applications for certification to ABEM, and ABEM issues ACCM certificates to its diplomates. There are two application pathways: a practice-plus-training pathway, which is time limited, and an ACGME-accredited training pathway. The practice pathway for ACCM will close in 2018 on the final date of the 2018 ACCM application cycle.
Credentialing Activity

2016-2017 ACCM credentialing activities are summarized in Table 3.

Table 3. ACCM Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Certification</td>
<td>January 4 – June 27, 2016</td>
<td>15</td>
</tr>
<tr>
<td>2017 Certification</td>
<td>February 6 – August 28, 2017</td>
<td>6*</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Evaluation Activity

The 2016 ACCM Certification Examination was administered August 13, 2016. The examination results are summarized in Table 4.

Table 4. ACCM Evaluation Activity, 2016 Certification Examination

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>212</td>
<td>200</td>
<td>12</td>
<td>94</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>17</td>
<td>17</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

The ACCM Certification Examination is administered annually; the next examination will be October 14, 2017.

Emergency Medical Services

ABEM is the sole sponsoring and administrative board for certification in EMS. To be eligible for the EMS Certification Examination, a physician must be certified by one of the 24 ABMS Member Boards and meet the eligibility criteria established by ABEM. There are three application pathways: a practice pathway and a practice-plus-training pathway, which are time limited, and an ACGME-accredited training pathway. The practice pathways for EMS will close July 1, 2019.

Credentialing Activity

2016-2017 EMS credentialing activities are summarized in Table 5.

Table 5. EMS Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Application Period</th>
<th>ABEM Diplomates</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Certification</td>
<td>January 3 – June 30, 2017</td>
<td>102</td>
<td>110</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Evaluation Activity

The EMS Certification Examination is administered every two years; the next examination will be September 25, 2017.

LLSA Activity

During 2016-2017, there were 190 EMS LLSA tests completed by 178 diplomates and former diplomates. Of the 190 EMS tests completed, 133 (70 percent) were associated with a completed optional LLSA CME activity. (Figures are for June 1, 2016, through May 31, 2017.)

Hospice and Palliative Medicine

Ten ABMS Member Boards, including ABEM, offer certification in HPM: American Board of Internal Medicine (ABIM), ABA, American Board of Family Medicine (ABFM), American Board of Obstetrics and Gynecology, American Board of Pediatrics (ABP), American Board of Physical Medicine and Rehabilitation (ABPMR), American Board of Psychiatry and Neurology (ABPN), American Board of Radiology, and American Board of Surgery. Successful completion of ACGME-accredited HPM fellowship training is the only pathway of application.
The HPM Certification and MOC examinations are administered every two years; the next examination will be November 20, 2018.

**Internal Medicine–Critical Care Medicine**

Certification in IM-CCM is co-sponsored by ABEM and ABIM. There were two application pathways for IM-CCM: a practice pathway, which is now closed, and an ACGME-accredited training pathway. Successful completion of ACGME-accredited IM-CCM fellowship training is now the only pathway of application for this subspecialty. ABEM diplomates apply to ABEM and their IM-CCM subspecialty certificates are issued by ABEM.

**Credentialing Activity**

2016-2017 IM-CCM credentialing activities are summarized in Table 10.

**Evaluation Activity**

The 2016 IM-CCM Certification Examination was administered October 6, 2016. The examination results are summarized in Table 11.

**Table 6. HPM Initial Certification Credentialing Activity, 2016-2017**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Certification</td>
<td>February 1 – May 16, 2016</td>
<td>31</td>
</tr>
</tbody>
</table>

**Table 7. HPM MOC Credentialing Activity, 2016-2017**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 MOC</td>
<td>February 1 – July 11, 2016</td>
<td>1</td>
</tr>
</tbody>
</table>

**Evaluation Activity**

The 2016 HPM Certification and MOC examinations were administered November 7, 2016. The examination results are summarized in Tables 8 and 9.

**Table 8. HPM Evaluation Activity, 2016 Certification Examination**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>610</td>
<td>470</td>
<td>140</td>
<td>77</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>34</td>
<td>32</td>
<td>2</td>
<td>94</td>
</tr>
</tbody>
</table>

**Table 9. HPM Evaluation Activity, 2016 MOC Examination**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>21</td>
<td>17</td>
<td>4</td>
<td>81</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

The IM-CCM Certification Examination is administered annually; the next examination will be October 18, 2017.
Medical Toxicology

ABEM, ABP, and the American Board of Preventive Medicine (ABPM) co-sponsor subspecialty certification in MedTox. Successful completion of ACGME-accredited MedTox fellowship training is the only pathway of application. Diplomates of other ABMS Member Boards who successfully complete MedTox fellowship training apply to ABEM to take certification examinations.

Credentialing Activity

2016-2017 MedTox credentialing activities are summarized in Table 12.

Table 12. MedTox Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>ABEM Diplomates</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Certification</td>
<td>January 11 – August 20, 2016</td>
<td>56</td>
<td>58</td>
</tr>
</tbody>
</table>

Evaluation Activity

The 2016 MedTox Certification Examination was administered October 28, 2016. The examination results are summarized in Table 13.

Table 13. MedTox Evaluation Activity, 2016 Certification Examination

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>74</td>
<td>57</td>
<td>17</td>
<td>77</td>
</tr>
<tr>
<td>Reference Group*</td>
<td>61</td>
<td>50</td>
<td>11</td>
<td>82</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>67</td>
<td>53</td>
<td>14</td>
<td>79</td>
</tr>
<tr>
<td>Reference Group*</td>
<td>58</td>
<td>48</td>
<td>10</td>
<td>83</td>
</tr>
</tbody>
</table>

* Reference Group: Residency-trained, first-time takers.

The MedTox Certification and Maintenance of Certification examinations are administered every two years; the next examinations will be in fall 2018.

LLSA Activity

During 2016-2017, there were 66 MedTox LLSA tests completed by 59 diplomates and former diplomates. Of the 66 tests completed, 40 (61 percent) had an associated MedTox LLSA CME activity completed as well.

Pain Medicine

Pain Medicine is co-sponsored by the ABA, ABEM, ABPMR, and ABPN. Successful completion of ACGME-accredited Pain Medicine fellowship training is the only pathway of application for this subspecialty.

Credentialing Activity

2016-2017 Pain Medicine credentialing activities are summarized in Table 15.
Table 15. Pain Medicine Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Certification</td>
<td>January 4 – August 3, 2016</td>
<td>1</td>
</tr>
<tr>
<td>2017 Certification</td>
<td>February 6 – July 24, 2017</td>
<td>0*</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

The Pain Medicine Certification Examination is administered annually; the next examination will be September 9, 2017.

Table 16. Pain Medicine Evaluation Activity, 2016 Certification Examination

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 MOC Cognitive Expertise</td>
<td>January 1 – March 14, 2016</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>January 1 – September 8, 2016</td>
<td></td>
</tr>
<tr>
<td>2017 MOC Cognitive Expertise</td>
<td>January 3 – March 10, 2017</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>January 3 – September 8, 2017</td>
<td></td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Pediatric Emergency Medicine

ABEM and ABP co-sponsor the subspecialty of PedEM. There are two pathways of application for the PedEM subspecialty: ACGME-accredited PedEM fellowship training and dual certification. To apply through the dual certification pathway, candidates must have completed the training to meet the primary specialty certification requirements of both ABEM and ABP before January 1, 1999.

Credentialing Activity

2016-2017 PedEM credentialing activities are summarized in Tables 17 and 18.

Table 17. PedEm Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Certification</td>
<td>September 6 – December 16, 2016</td>
<td>30</td>
</tr>
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</table>

Table 18. PedEm MOC Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 MOC Cognitive Expertise</td>
<td>January 1 – March 14, 2016</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>January 1 – September 8, 2016</td>
<td></td>
</tr>
<tr>
<td>2017 MOC Cognitive Expertise</td>
<td>January 3 – March 10, 2017</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>January 3 – September 8, 2017</td>
<td></td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Evaluation Activity

The PedEM Certification Examination is administered every two years; the last examination was administered April 3, 2017. The results are summarized in Table 19.

Table 19. PedEm Evaluation Activity, 2016-2017 Certification Examination

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>377</td>
<td>83</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>34</td>
<td>79</td>
</tr>
</tbody>
</table>

The fall 2016 PedEM MOC Cognitive Expertise Examination was administered August 15 – September 30, 2016, and the spring 2017 PedEM MOC Cognitive Expertise Examination was administered March 1-31, 2017. The results for both examinations are summarized in Table 20.
Table 20. PedEm Evaluation Activity, 2016-2017
MOC Cognitive Expertise Examinations

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016 MOC Cognitive Expertise</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Candidates</td>
<td>168</td>
<td>164</td>
<td>4</td>
<td>98</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>92</td>
</tr>
<tr>
<td><strong>2017 MOC Cognitive Expertise</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Candidates</td>
<td>26</td>
<td>24</td>
<td>2</td>
<td>92</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

The PedEM MOC Cognitive Expertise Examination is administered biannually; the next administration will be August 15 – September 30, 2017.

Sports Medicine

ABEM, ABFM, ABIM, ABP, and ABPMR offer certification in SPM. Successful completion of ACGME-accredited SPM fellowship training is the only pathway of application.

Credentialing Activity
2016-2017 SPM credentialing activities are summarized in Tables 21 and 22.

Table 21. SPM Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 July Certification</td>
<td>February 1 – May 25, 2016</td>
<td>10</td>
</tr>
<tr>
<td>2016 November Certification</td>
<td>February 1 – September 15, 2016</td>
<td>18</td>
</tr>
<tr>
<td>2017 July Certification</td>
<td>January 9 – June 16, 2017</td>
<td>6*</td>
</tr>
<tr>
<td>2017 November Certification</td>
<td>January 9, 2017 – September 8, 2017</td>
<td>0*</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Table 22. SPM Recertification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 July Recertification</td>
<td>February 1 – May 25, 2016</td>
<td>2</td>
</tr>
<tr>
<td>2016 November Recertification</td>
<td>February 1 – September 15, 2016</td>
<td>8</td>
</tr>
<tr>
<td>2017 July Recertification</td>
<td>January 9 – June 16, 2017</td>
<td>1*</td>
</tr>
<tr>
<td>2017 November Recertification</td>
<td>January 9, 2017 – September 8, 2017</td>
<td>0*</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Evaluation Activity
The 2016 SPM Certification and Recertification Examinations were administered July 13-16, and November 14-19, 2016; the results are summarized in Tables 23 and 24.

Table 23. SPM Evaluation Activity, 2016 Certification Examinations

<table>
<thead>
<tr>
<th>Examination</th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 July Certification</td>
<td>236</td>
<td>209</td>
<td>27</td>
<td>89</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>2016 November Certification</td>
<td>63</td>
<td>47</td>
<td>16</td>
<td>75</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>16</td>
<td>16</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 24. SPM Evaluation Activity, 2016 Recertification Examinations

<table>
<thead>
<tr>
<th>Examination</th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 July Recertification</td>
<td>123</td>
<td>110</td>
<td>13</td>
<td>89</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>2016 November Recertification</td>
<td>64</td>
<td>46</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>88</td>
</tr>
</tbody>
</table>
Undersea and Hyperbaric Medicine

ABEM and ABPM offer certification in UHM. Successful completion of ACGME-accredited UHM fellowship training is the only pathway of application.

Credentialing Activity

2016-2017 UHM credentialing activities are summarized in Tables 25 and 26.

Table 25. UHM Initial Certification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Certification</td>
<td>January 4 – June 21, 2016</td>
<td>5</td>
</tr>
<tr>
<td>2017 Certification</td>
<td>January 3 – May 27, 2017</td>
<td>2*</td>
</tr>
</tbody>
</table>

Table 26. UHM Recertification Credentialing Activity, 2016-2017

<table>
<thead>
<tr>
<th>Examination</th>
<th>Application Period</th>
<th>Applications Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Recertification</td>
<td>January 4, 2016 – 15 days before examination</td>
<td>2</td>
</tr>
<tr>
<td>2017 Recertification</td>
<td>January 5, 2017 – 15 days before examination</td>
<td>4*</td>
</tr>
</tbody>
</table>

* As of May 31, 2017

Evaluation Activity

The 2016 UHM Certification Examination was administered October 3-16, 2016. The examination results are summarized in Table 27.

Table 27. UHM Evaluation Activity, 2016 Certification Examination

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>11</td>
<td>10</td>
<td>1</td>
<td>91</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

The 2016 UHM Recertification Examinations were administered on various dates between August 25 and October 23, 2016. The examination results are summarized in Table 28.

Table 28. UHM Evaluation Activity, 2016 Recertification Examinations

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pass</th>
<th>Fail</th>
<th>Percent Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Candidates</td>
<td>13</td>
<td>13</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>ABEM Candidates</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

The UHM examinations are administered annually; the next Certification Examination will be October 16-28, 2017. The next two Recertification Examination administrations are August 24 and October 15, 2017.
EXAMINATION DEVELOPMENT ACTIVITY

Medical Toxicology Certification
Examination Standard Setting

The passing standard for the MedTox Certification Examination was revisited following the 2016 administration of the examination. The process for setting a passing score is based on several decades of study by specialists in testing science, and is considered a best practice in the field. To examine the passing standard, a diverse panel of MedTox-certified, clinically active physicians evaluated each examination question by considering how a physician meeting the threshold for certification in Medical Toxicology would perform. Their analysis provided the Medical Toxicology Subboard a recommended passing score, which the Subboard considered and approved.

All ABEM-administered examinations will continue to be criterion referenced; that is, curves, quotas, or percentage passing will not be used for setting any passing score. This process is used by nearly all major educational assessment organizations and by most ABMS Member Boards.

The passing standard for the MedTox MOC Examination will be revisited following the 2018 administration.
VALIDITY ANALYSIS OF THE ABEM ORAL CERTIFICATION EXAMINATION

The purpose of this study was to perform initial validity analyses of ABEM’s eOral examination format (Kowalenko et al. Acad Emerg Med 2017, 24(1):125-9.) The two hypotheses were: 1) the case content in the eOral format was sufficiently similar to clinical practice; and 2) the eOral case materials were sufficiently similar to clinical practice. The eOral and traditional formats were compared for these characteristics. Of the 1,746 physicians who took the oral examination, 1,380 physicians (79.0 percent) completed all or part of the study survey questions. The majority of respondents agreed the patient presentations in the cases were similar (strongly agreed or agreed) to cases seen in clinical practice, in both the traditional cases (95.1 percent) and eOral cases (90.1 percent). Likewise, the majority of respondents answered that the case materials (e.g., labs, radiographs) were similar (strongly agreed or agreed) to what they encounter in clinical practice, both in the traditional format (85.8 percent) and eOral cases (93.7 percent). This study provides early validity evidence for the eOral format.

RESIDENCY TRAINING INFORMATION

Each year, ABEM collects survey data from all Accreditation Council for Graduate Medical Education (ACGME)-accredited Emergency Medicine (EM) residency programs and accredited EM-sponsored fellowships, the ACGME, the National Resident Matching Program, and the Graduate Medical Education report published annually in the Journal of the American Medical Association. ABEM analyzes the data and reports selected items in a journal article. The annual publication serves the specialty of EM and the medical community-at-large by documenting the progress of training in Emergency Medicine. It serves as a reference tool for evaluating the status and growth of EM residency training.

The 2016-2017 study (Marco et al. Ann Emerg Med 2016;67(5):654-66.) reported the following findings:

• Although the number of females in EM residencies has risen over the last five years, their proportion continues to decline. In 2012, 2,156 (38 percent) of residents were women and 3,494 (62 percent) were men. In 2016, 2,326 (35 percent) of EM residents were women and 4,287 (65 percent) were men.
• Among the 121 ACGME-accredited, EM-sponsored fellowships, the largest number is Emergency Medical Services (53 fellowships), followed by Medical Toxicology (26), Pediatric Emergency Medicine (25), Sports Medicine (7), Undersea and Hyperbaric Medicine (7), and Clinical Informatics (3).

DUTY HOURS AND PERFORMANCE OF THE QUALIFYING EXAMINATION

This study (Counselman et al. J Grad Med Educ 2016;8(4):558-62.) examined whether the implementation of the 2003 and 2011 ACGME-instituted duty hour limits was associated with a change in EM residents’ performance on the
Qualifying Examination (QE). Although there was a small but statistically significant decrease in mean scores after implementation of the first duty hour requirements, the difference did not occur after implementation of the 2011 standards. The authors found no association between the 2003 and 2011 ACGME duty hour requirements and performance of test takers on the ABEM QE.

**EVOLUTION OF THE EM MODEL**

This article (Counselman et al. Acad Emerg Med 2017;24(2):257-64.) reviews the development of The Model of the Clinical Practice of Emergency Medicine (EM Model) from its inception in 1979 to today. The EM Model represents the culmination of nearly 40 years of evolution, from a simple listing of presenting patient complaints, clinical symptoms, and disease states into a three-dimensional representation of the clinical practice of Emergency Medicine.

**PUBLICATIONS**


Board Contributors: Emergency Medicine

The individuals listed below have contributed and volunteered their time and expertise to ABEM in a variety of ways during the past year. The Board of Directors recognizes and appreciates the contributions and commitment of these physicians to the specialty of Emergency Medicine and its subspecialties.

<table>
<thead>
<tr>
<th>EXAMINATION EDITORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerryann B. Broderick, M.D. (LLSA)</td>
</tr>
<tr>
<td>Carl R. Chudnofsky, M.D. (Oral)</td>
</tr>
<tr>
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</tr>
<tr>
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<tr>
<td>Barry N. Heller, M.D. (Oral)</td>
</tr>
<tr>
<td>James H. Jones, M.D. (LLSA)</td>
</tr>
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</tr>
<tr>
<td>O. John Ma, M.D. (LLSA)</td>
</tr>
<tr>
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</tr>
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<td>Catherine A. Marco, M.D. (ConCert™)</td>
</tr>
<tr>
<td>Lewis S. Nelson, M.D. (Qualifying and Stimuli)</td>
</tr>
<tr>
<td>Robert P. Wahl, M.D. (ConCert™)</td>
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<thead>
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<th>ORAL EXAMINATION CHIEF EXAMINERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill M. Baren, M.D.</td>
</tr>
<tr>
<td>Carl R. Chudnofsky, M.D.</td>
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<tr>
<td>Barry N. Heller, M.D.</td>
</tr>
<tr>
<td>Terry Kowalenko, M.D.</td>
</tr>
<tr>
<td>Mary Nan S. Mallory, M.D.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM WRITERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felix Ankel, M.D. Roseville, MN LLSA</td>
</tr>
<tr>
<td>Michael S. Beeson, M.D. Stow, OH In-training</td>
</tr>
<tr>
<td>Yvette Calderon, M.D. Bronx, NY Qualifying</td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
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</tr>
</tbody>
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Beverly Hills, MI

Gary S. Setnik, M.D.
Winchester, MA
### EXAMINATION AND RESEARCH PANEL APPOINTMENTS

#### Case Development Panel

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janet G. Alteveer, M.D.</td>
<td>Moorestown, NJ</td>
<td>June 2017</td>
</tr>
<tr>
<td>Jill M. Baren, M.D.</td>
<td>Bryn Mawr, PA</td>
<td>December 2016, June 2017</td>
</tr>
<tr>
<td>Michael S. Beeson, M.D.</td>
<td>Stow, OH</td>
<td>December 2016, June 2017</td>
</tr>
<tr>
<td>Steven H. Bowman, M.D.</td>
<td>Chicago, IL</td>
<td>December 2016</td>
</tr>
<tr>
<td>Kerryann B. Broderick, M.D.</td>
<td>Denver, CO</td>
<td>December 2016, June 2017</td>
</tr>
<tr>
<td>Carl R. Chudnofsky, M.D.</td>
<td>Los Angeles, CA</td>
<td>June 2017</td>
</tr>
<tr>
<td>Francis L. Counselman, M.D.</td>
<td>Norfolk, VA</td>
<td>December 2016</td>
</tr>
<tr>
<td>Jorge del Castillo, M.D.</td>
<td>Wilmette, IL</td>
<td>December 2016, June 2017</td>
</tr>
<tr>
<td>Jeff D. Disney, M.D.</td>
<td>Portland, OR</td>
<td>June 2017</td>
</tr>
<tr>
<td>John T. Finnell, II, M.D.</td>
<td>Zionsville, IN</td>
<td>December 2016</td>
</tr>
<tr>
<td>Diane L. Gorgas, M.D.</td>
<td>Worthington, OH</td>
<td>December 2016, June 2017</td>
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<tr>
<td>Barry N. Heller, M.D.</td>
<td>Rolling Hills Estates, CA</td>
<td>December 2016, June 2017</td>
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<tr>
<td>John L. Kendall, M.D.</td>
<td>Denver, CO</td>
<td>June 2017</td>
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<tr>
<td>Terry Kowalenko, M.D.</td>
<td>Brighton, MI</td>
<td>December 2016, June 2017</td>
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<tr>
<td>Mary Nan S. Mallory, M.D.</td>
<td>Louisville, KY</td>
<td>June 2017</td>
</tr>
<tr>
<td>Lewis S. Nelson, M.D.</td>
<td>Demarest, NJ</td>
<td>December 2016</td>
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<tr>
<td>Richard N. Nelson, M.D.</td>
<td>Westerville, OH</td>
<td>June 2017</td>
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<tr>
<td>Robert E. O’Connor, M.D.</td>
<td>Charlottesville, VA</td>
<td>June 2017</td>
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<tr>
<td>Kent T. Shoji, M.D.</td>
<td>Rolling Hills Estates, CA</td>
<td>December 2016</td>
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<tr>
<td>Mark T. Steele, M.D.</td>
<td>Olathe, KS</td>
<td>December 2016</td>
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<tr>
<td>Suzanne R. White, M.D.</td>
<td>Farmington, MI</td>
<td>December 2016, June 2017</td>
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<tr>
<td>Saralyn R. Williams, M.D.</td>
<td>Franklin, TN</td>
<td>June 2017</td>
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<tr>
<td>Allan B. Wolfson, M.D.</td>
<td>Pittsburgh, PA</td>
<td>December 2016, June 2017</td>
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### Mock Administrations of Selected Oral Certification Examination Field-test Cases

<table>
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<tr>
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<tr>
<td>Brigham R. Temple, M.D.</td>
<td>Highland Park, IL</td>
<td>August 2016, March 2017</td>
</tr>
<tr>
<td>Ernest E. Wang, M.D.</td>
<td>Chicago, IL</td>
<td>August 2016</td>
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## CME Task Force

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<thead>
<tr>
<th>Name</th>
<th>Chair</th>
<th>Location</th>
<th>Name</th>
<th>Location</th>
<th>Name</th>
<th>Location</th>
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<tbody>
<tr>
<td>O. John Ma, M.D.</td>
<td></td>
<td>Portland, OR</td>
<td>Michael L. Carius, M.D.</td>
<td>Stratford, CT</td>
<td>Lillian A. Oshva, M.D. (AAEM)</td>
<td>New York, NY</td>
</tr>
<tr>
<td>Kerryann B. Broderick, M.D.</td>
<td></td>
<td>Denver, CO</td>
<td>James H. Jones, M.D.</td>
<td>Zionsville, IN</td>
<td>Jeffrey A. Tabas, M.D. (ACEP)</td>
<td>San Francisco, CA</td>
</tr>
<tr>
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<td></td>
<td>O. John Ma, M.D., Chair</td>
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## KSA Task Force

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<th>Name</th>
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<td>Michael S. Beeson, M.D.</td>
<td>Stow, OH</td>
<td></td>
<td>Francis L. Counselman, M.D.</td>
<td>Norfolk, VA</td>
<td>Catherine A. Marco, M.D.</td>
<td>Beaver Creek, OH</td>
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<tr>
<td>Wallace A. Carter, Jr., M.D.</td>
<td>Bronxville, NY</td>
<td></td>
<td>Deepi G. Goyal, M.D.</td>
<td>Rochester, MN</td>
<td>Robert L. Muelleman, M.D.</td>
<td>Omaha, NE</td>
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<tr>
<td>Amy F. Church, M.D.</td>
<td>Stockton, NJ</td>
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## LLSA CME Reading Panel

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<th>Location</th>
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<tr>
<td>Aaron N. Barksdale, M.D.</td>
<td>Elkhorn, NE</td>
<td></td>
<td>Michael J. Bono, M.D.</td>
<td>Suffolk, VA</td>
<td>Liudvikas Jagminas, M.D.</td>
<td>E. Greenwich, RI</td>
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<tr>
<td>Andrew Beckman, M.D.</td>
<td>Indianapolis, IN</td>
<td></td>
<td>J.F. Donal Conway, M.B., B.CH</td>
<td>Northport, AL</td>
<td>Jillian L. McGrath, M.D.</td>
<td>Columbus, OH</td>
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## Stimulus Collection and Review Panel

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<th>Name</th>
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<tr>
<td>Lewis S. Nelson, M.D., Chair</td>
<td>Demarest, NJ</td>
<td></td>
<td>Gary S. Setnik, M.D.</td>
<td>Winchester, MA</td>
<td>Jason C. Wagner, M.D.</td>
<td>St. Louis, MO</td>
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<tr>
<td>Michael C. Murphy, M.D.</td>
<td>Winthrop, MA</td>
<td></td>
<td>Todd Thomsen, M.D.</td>
<td>Milton, MA</td>
<td>Benson Yeh, M.D.</td>
<td>Jerico, NY</td>
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<tr>
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<td>City/State</td>
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<tr>
<td>David J. Amin, M.D.</td>
<td>Greer, SC</td>
<td>May 2017</td>
<td></td>
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<tr>
<td>Heatherlee Bailey, M.D.</td>
<td>Chapel Hill, NC</td>
<td>May 2017</td>
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<td>Jill M. Baren, M.D.</td>
<td>Bryn Mawr, PA</td>
<td>May 2017</td>
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<tr>
<td>Kevin S. Barlotta, M.D.</td>
<td>Birmingham, AL</td>
<td>May 2017</td>
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<tr>
<td>Erik D. Barton, M.D.</td>
<td>Orange, CA</td>
<td>November 2016</td>
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<tr>
<td>Aveh Bastani, M.D.</td>
<td>Franklin, MI</td>
<td>November 2016</td>
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<td>Douglas M. Char, M.D.</td>
<td>St. Louis, MO</td>
<td>November 2016</td>
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<td>Lawrence Chu, M.D.</td>
<td>Bellevue, WA</td>
<td>November 2016</td>
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<td>Kathleen M. Cowling, D.O.</td>
<td>Saginaw, MI</td>
<td>November 2016</td>
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<tr>
<td>Catherine A. Cummings, M.D.</td>
<td>Providence, RI</td>
<td>May 2017</td>
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<tr>
<td>Carol A. Cunningham, M.D.</td>
<td>Kirtland, OH</td>
<td>November 2016</td>
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<tr>
<td>William H. Dice, M.D.</td>
<td>Colden, NY</td>
<td>May 2017</td>
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<tr>
<td>Michael A. Gertz, M.D.</td>
<td>Agoura Hills, CA</td>
<td>May 2017</td>
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<tr>
<td>Matthew C. Gratton, M.D.</td>
<td>Shawnee Mission, KS</td>
<td>November 2016</td>
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<tr>
<td>Stephen R. Hayden, M.D.</td>
<td>La Jolla, CA</td>
<td>November 2016</td>
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<tr>
<td>Barry N. Heller, M.D.</td>
<td>Rolling Hills Estates, CA</td>
<td>November 2016, May 2017</td>
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<tr>
<td>Cherri D. Hobgood, M.D.</td>
<td>Indianapolis, IN</td>
<td>November 2016</td>
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<td>Mark S. Holcomb, M.D.</td>
<td>Olathe, KS</td>
<td>November 2016</td>
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<tr>
<td>Margaret Hsieh, M.D.</td>
<td>Murrysville, PA</td>
<td>November 2016</td>
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<tr>
<td>Ilse M. Jenouri, M.D.</td>
<td>Providence, RI</td>
<td>May 2017</td>
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<tr>
<td>James H. Jones, M.D.</td>
<td>Zionsville, IN</td>
<td>May 2017</td>
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<tr>
<td>Sharhabeel M. Jwayyed, M.D.</td>
<td>Copley, OH</td>
<td>May 2017</td>
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<tr>
<td>Achyut B. Kamat, M.D.</td>
<td>Providence, RI</td>
<td>May 2017</td>
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<tr>
<td>Lawrence E. Kass, M.D.</td>
<td>Harrisburg, PA</td>
<td>November 2016</td>
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<tr>
<td>David C. Lee, M.D.</td>
<td>Manhasset, NY</td>
<td>May 2017</td>
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<tr>
<td>Kerri L. Mason, M.D.</td>
<td>Boulder, CO</td>
<td>November 2016</td>
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<tr>
<td>James Miner, M.D.</td>
<td>Minnetrista, MN</td>
<td>November 2016</td>
<td></td>
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<tr>
<td>Usamah Mossallam, M.D.</td>
<td>Bloomfield Hills, MI</td>
<td>November 2016</td>
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<tr>
<td>Richard N. Nelson, M.D.</td>
<td>Westerville, OH</td>
<td>May 2017</td>
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<tr>
<td>Debra J. Paulson, M.D.</td>
<td>Independence, WV</td>
<td>November 2016</td>
<td></td>
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</tbody>
</table>
E. Jedd Roe, III, M.D.
Neptune Beach, FL
May 2017

Sally A. Santen, M.D.
Ann Arbor, MI
May 2017

Osman R. Sayan, M.D.
Leonia, NJ
May 2017

John A. Tafuri, M.D.
Westlake, OH
May 2017

Josette A. Teuscher, M.D.
Colden, NY
May 2017

Michael A. Turturro, M.D.
Pittsburgh, PA
May 2017

Andrew S. Ulrich, M.D.
Guilford, CT
May 2017

Patricia L. VanDevander, M.D.
Denver, CO
November 2016

Lori D. Winston, M.D.
Exeter, CA
November 2016

Albert S. Yee, M.D.
Mequon, WI
May 2017

Gary D. Zimmer, M.D.
Bryn Mawr, PA
November 2016
EXAMINERS FOR THE 2016-2017 ORAL CERTIFICATION EXAMINATIONS

CE = chief examiner
TL = team leader
B = served in a back-up role but did not attend at ABEM's request
Awards received for 8,16,24,32,40, or 50 examinations are listed

<table>
<thead>
<tr>
<th>Azeemuddin Ahmed, M.D.</th>
<th>Kevin S. Barlotta, M.D.</th>
<th>Michael E. Boczar, D.O.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa City, IA</td>
<td>Birmingham, AL</td>
<td>Clarkston, MI</td>
</tr>
<tr>
<td>October 2016</td>
<td>April 2017</td>
<td>October 2016</td>
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<table>
<thead>
<tr>
<th>Saadia Akhtar, M.D.</th>
<th>James D. Barry, M.D.</th>
<th>Marc A. Borenstein, M.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flushing, NY</td>
<td>Long Beach, CA</td>
<td>Mt. Kisco, NY</td>
</tr>
<tr>
<td>October 2016 (8 exams)</td>
<td>April 2017</td>
<td>April 2017</td>
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</table>

<table>
<thead>
<tr>
<th>Janet G. Alteveer, M.D.</th>
<th>William G. Barsan, M.D.</th>
<th>Christina L. Bourne, M.D.</th>
</tr>
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<tbody>
<tr>
<td>Moorestown, NJ</td>
<td>Dexter, MI</td>
<td>Mount Pleasant, SC</td>
</tr>
<tr>
<td>April 2017 – TL</td>
<td>October 2016 (24 exams)</td>
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<tr>
<th>David J. Amin, M.D.</th>
<th>Joel M. Bartfield, M.D.</th>
<th>Steven H. Bowman, M.D.</th>
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<tbody>
<tr>
<td>Greer, SC</td>
<td>Slingerlands, NY</td>
<td>Chicago, IL</td>
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<td>October 2016</td>
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<table>
<thead>
<tr>
<th>James T. Amsterdam, M.D.</th>
<th>Erik D. Barton, M.D.</th>
<th>Michael J. Breyer, M.D.</th>
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<tbody>
<tr>
<td>Erie, PA</td>
<td>Orange, CA</td>
<td>Golden, CO</td>
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<tr>
<th>Eric Anderson, M.D.</th>
<th>Jeanne M. Basior, M.D.</th>
<th>Kerryann B. Broderick, M.D.</th>
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<tr>
<td>Highland Heights, OH</td>
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<td>April 2016, April 2017</td>
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<tr>
<th>James V. Antinori, M.D.</th>
<th>Aveh Bastani, M.D.</th>
<th>David S. Bullard, M.D.</th>
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<tbody>
<tr>
<td>Park City, UT</td>
<td>Franklin, MI</td>
<td>North Kingstown, RI</td>
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<td>October 2016, April 2017</td>
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<tr>
<th>Christian Arbelaez, M.D.</th>
<th>Ralph C. Battels, M.D.</th>
<th>David B. Burbulys, M.D.</th>
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<tbody>
<tr>
<td>Needham, MA</td>
<td>Bayfield, CO</td>
<td>Encino, CA</td>
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<td>October 2016</td>
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<tr>
<th>Nader Bahadory, D.O.</th>
<th>Beverly H. Bauman, M.D.</th>
<th>William P. Burdick, M.D.</th>
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<tbody>
<tr>
<td>Norwich, CT</td>
<td>Klamath Falls, OR</td>
<td>Philadelphia, PA</td>
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<td>April 2017</td>
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<thead>
<tr>
<th>Heatherlee Bailey, M.D.</th>
<th>Michael R. Baumann, M.D.</th>
<th>Brian E. Burgess, M.D.</th>
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</thead>
<tbody>
<tr>
<td>Chapel Hill, NC</td>
<td>Falmouth, ME</td>
<td>Hockessin, DE</td>
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<td>October 2016, April 2017</td>
<td>April 2017</td>
<td>April 2017 – TL</td>
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<tr>
<th>John Bailitz, M.D.</th>
<th>Michael S. Beeson, M.D.</th>
<th>Philip M. Buttaravoli, M.D.</th>
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<tbody>
<tr>
<td>River Forest, IL</td>
<td>Stow, OH</td>
<td>West Palm Beach, FL</td>
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<tr>
<th>Mari B. Baker, M.D.</th>
<th>Kenneth S. Bishop, D.O.</th>
<th>Stephen V. Cantrill, M.D.</th>
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<td>Morton, IL</td>
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<tr>
<th>Jill M. Baren, M.D.</th>
<th>Matthew D. Bitner, M.D.</th>
<th>Jeffrey P. Caporrossi, M.D.</th>
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<tr>
<td>Bryn Mawr, PA</td>
<td>Greenville, SC</td>
<td>Charleston, SC</td>
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<td>October 2016 – CE</td>
<td>October 2016, April 2017</td>
<td>April 2017 (8 exams)</td>
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<thead>
<tr>
<th>Aaron N. Barksdale, M.D.</th>
<th>Thomas H. Blackwell, M.D.</th>
<th>Michael L. Carius, M.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elkhorn, NE</td>
<td>Piedmont, SC</td>
<td>Stratford, CT</td>
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<td>April 2017</td>
<td>October 2016</td>
<td>October 2016 – TL (40 exams)</td>
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</table>
Wallace A. Carter, Jr., M.D.
Bronxville, NY
October 2016 – TL (16 exams), April 2017 – TL

Jennifer J. Casaletto, M.D.
Mount Holly, NC
April 2017

Douglas M. Char, M.D.
St. Louis, MO
October 2016

Robert Chavez, M.D.
Redondo Beach, CA
October 2016

David Cheng, M.D.
Strongsville, OH
October 2016, April 2017 – B

William K. Chiang, M.D.
Closter, NJ
April 2017

Michael C. Choo, M.D.
Centerville, OH
October 2016, April 2017

Edith P. Chu, M.D.
New Preston, CT
April 2017 (16 exams)

Lawrence Chu, M.D.
Bellevue, WA
October 2016, April 2017 – B

Carl R. Chudnofsky, M.D.
Los Angeles, CA
October 2016 – CE, April 2017 – CE

Amy F. Church, M.D.
Stockton, NJ
October 2016 – TL, April 2017

Carol L. Clark, M.D.
Bloomfield Hills, MI
October 2016, April 2017

Christopher B. Colwell, M.D.
Tiburon, CA
October 2016, April 2017 – B

James A. Comes, M.D.
Clovis, CA
April 2017

Alessandra Conforto, M.D.
Long Beach, CA
October 2016

William A. Conrad, M.D.
Los Angeles, CA
October 2016

Karen S. Cosby, M.D.
Naperville, IL
April 2017

Melissa W. Costello, M.D.
Mobile, AL
October 2016

Francis L. Counselman, M.D.
Norfolk, VA
April 2017

Robert Cowan, M.D.
Moorestown, NJ
October 2016

Kathleen M. Cowling, D.O.
Saginaw, MI
October 2016

Todd J. Crocco, M.D.
Morgantown, WV
October 2016 (8 exams)

Catherine A. Cummings, M.D.
Providence, RI
April 2017 (8 exams)

Carol A. Cunningham, M.D.
Kirtland, OH
October 2016, April 2017

Robert A. Czincila, D.O.
Lansdale, PA
October 2016

Mark J.K. Dalton, M.D.
Farmlandale, NJ
April 2017

Michelle M. Davitt, M.D.
Bellmore, NY
October 2016

Christian R. DeFazio, M.D.
Buffalo, NY
April 2017

Jorge del Castillo, M.D.
Wilmette, IL
October 2016 – TL

Mini R. DeLashaw, M.D.
Dallas, TX
April 2017

Luca R. Delatore, M.D.
Dublin, OH
April 2017

Theodore R. Delbridge, M.D.
Greenville, NC
October 2016, April 2017 – B

William H. Dice, M.D.
Colden, NY
April 2017

Arthur L. Diskin, M.D.
Miami Beach, FL
April 2017

Jeff D. Disney, M.D.
Portland, OR
October 2016 – TL, April 2017 – TL

David M. Donaldson, D.O.
Oakland, MI
October 2016

Steven C. Dronen, M.D.
Sevierville, TN
April 2017

Jeffrey P. Druck, M.D.
Aurora, CO
October 2016

Linda M. Druelinger, M.D.
Lemont, IL
October 2016

Susan E. Dufel, M.D.
Hartford, CT
October 2016

Joanne M. Edney, M.D.
Golden, CO
April 2017

Matthew T. Emery, M.D.
Grand Rapids, MI
October 2016 (16 exams)

Janet G.H. Eng, D.O.
Okemos, MI
October 2016, April 2017

Thomas B. Ettinger, M.D.
Cashmere, WA
October 2016

Susan E. Farrell, M.D.
Newton, MA
October 2016

Jeffrey P. Feden, M.D.
Warwick, RI
April 2017

Kim M. Feldhaus, M.D.
Lafayette, CO
October 2016

Richard M. Feldman, M.D.
Chicago, IL
October 2016
<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Dates</th>
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<tr>
<td>William B. Felegi, D.O.</td>
<td>Bridgewater, NJ</td>
<td>October 2016 (16 exams), April 2017</td>
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<tr>
<td>Madonna Fernandez-Frackelton, M.D.</td>
<td>Torrance, CA</td>
<td>October 2016</td>
</tr>
<tr>
<td>Anthony Ferrara, M.D.</td>
<td>Atlanta, GA</td>
<td>April 2017</td>
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<tr>
<td>Albert B. Fiorello, M.D.</td>
<td>Tucson, AZ</td>
<td>October 2016</td>
</tr>
<tr>
<td>James S. Fishkin, M.D.</td>
<td>Pacific Palisades, CA</td>
<td>October 2016</td>
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<tr>
<td>Michelle A. Flemmings, M.D.</td>
<td>Bayfield, CO</td>
<td>October 2016</td>
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<td>John L. Foggle, M.D.</td>
<td>Madison, CT</td>
<td>October 2016, April 2017 – B</td>
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<tr>
<td>Jordan C. Foster, M.D.</td>
<td>Brooklyn, NY</td>
<td>October 2016, April 2017</td>
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<td>Thomas W. Fowle, Jr., M.D.</td>
<td>Belle Mead, NJ</td>
<td>October 2016</td>
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<tr>
<td>Anthony J. Frank, Jr., M.D.</td>
<td>Greenville, NC</td>
<td>October 2016</td>
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<tr>
<td>Scott B. Freeman, M.D.</td>
<td>Grosse Pointe Woods, MI</td>
<td>April 2017</td>
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<tr>
<td>Lane E. Fresh, M.D.</td>
<td>Mt. Pleasant, SC</td>
<td>October 2016, April 2017</td>
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<td>H. Christian Fromm, M.D.</td>
<td>Brooklyn, NY</td>
<td>October 2016, April 2017</td>
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<tr>
<td>Fiona Gallahue, M.D.</td>
<td>Seattle, WA</td>
<td>October 2016</td>
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<tr>
<td>Gus M. Garmel, M.D.</td>
<td>San Francisco, CA</td>
<td>April 2017</td>
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<tr>
<td>Victoria E. Garrett, M.D.</td>
<td>Miami, FL</td>
<td>April 2017 – B</td>
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<tr>
<td>Marianne Gausche-Hill, M.D.</td>
<td>Hermosa Beach, CA</td>
<td>October 2016</td>
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<tr>
<td>Thomas G. Germano, M.D.</td>
<td>Barrington, RI</td>
<td>October 2016</td>
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<tr>
<td>Michael A. Gertz, M.D.</td>
<td>Agoura Hills, CA</td>
<td>April 2017</td>
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<tr>
<td>Susan L. Gin-Shaw, M.D.</td>
<td>Phoenix, AZ</td>
<td>October 2016 (16 exams)</td>
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<td>Gary T. Giorgio, M.D.</td>
<td>Wadsworth, OH</td>
<td>October 2016</td>
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<tr>
<td>Cai Glushak, M.D.</td>
<td>Chicago, IL</td>
<td>October 2016</td>
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<tr>
<td>Charles Goldstein, M.D.</td>
<td>Scottsdale, AZ</td>
<td>October 2016</td>
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<tr>
<td>Peter E. Gordon, M.D.</td>
<td>Chatham, NY</td>
<td>April 2017</td>
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<tr>
<td>Diane L. Gorgas, M.D.</td>
<td>Worthington, OH</td>
<td>October 2016 – TL, April 2017</td>
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<tr>
<td>Deepi G. Goyal, M.D.</td>
<td>Rochester, MN</td>
<td>April 2016 – TL, April 2017 – TL (16 exams)</td>
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<tr>
<td>Charles S. Graffeo, M.D.</td>
<td>Virginia Beach, VA</td>
<td>October 2016, April 2017 – B</td>
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<tr>
<td>Matthew C. Gratton, M.D.</td>
<td>Shawnee Mission, KS</td>
<td>October 2016</td>
</tr>
<tr>
<td>Richard O. Gray, M.D.</td>
<td>Minneapolis, MN</td>
<td>April 2017</td>
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<tr>
<td>Matthew Griffin, M.D.</td>
<td>Livonia, MI</td>
<td>October 2016, April 2017 – B</td>
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<tr>
<td>Eric A. Gross, M.D.</td>
<td>Roseville, CA</td>
<td>October 2016</td>
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<tr>
<td>Kama Guluma, M.D.</td>
<td>San Diego, CA</td>
<td>April 2017</td>
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<tr>
<td>Theresa M. Gunnarson, M.D.</td>
<td>Duluth, MN</td>
<td>October 2016</td>
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<tr>
<td>Dean E. Gushee, M.D.</td>
<td>Shelton, WA</td>
<td>April 2017</td>
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<tr>
<td>Gregory E. Hallert, M.D.</td>
<td>Los Angeles, CA</td>
<td>April 2017</td>
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<tr>
<td>Mary E. Hancock, M.D.</td>
<td>Elyria, OH</td>
<td>April 2017</td>
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<tr>
<td>Richard F. Handin, M.D.</td>
<td>Santa Barbara, CA</td>
<td>October 2016 (40 exams)</td>
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<tr>
<td>Kristin E. Harkin, M.D.</td>
<td>New Rochelle, NY</td>
<td>April 2017</td>
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<tr>
<td>Sari L. Hart, M.D.</td>
<td>Glencoe, IL</td>
<td>April 2017 (16 exams)</td>
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<tr>
<td>Stephen R. Hayden, M.D.</td>
<td>La Jolla, CA</td>
<td>October 2016, April 2017 (8 exams)</td>
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<tr>
<td>Barry N. Heller, M.D.</td>
<td>Rolling Hills Estates, CA</td>
<td>October 2016 – CE, April 2017 – CE</td>
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<td>Sean O. Henderson, M.D.</td>
<td>Brea, CA</td>
<td>October 2016, April 2017</td>
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<tr>
<td>Philip L. Henneman, M.D.</td>
<td>Sunapee, NH</td>
<td>October 2016 – TL</td>
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<tr>
<td>Glendon C. Henry, M.D.</td>
<td>Port Chester, NY</td>
<td>April 2017 (16 exams)</td>
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<tr>
<td>Aaron H. Hexdall, M.D.</td>
<td>Florence, MA</td>
<td>April 2017</td>
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<tr>
<td>Jeffrey D. Ho, M.D.</td>
<td>Minneapolis, MN</td>
<td>October 2016</td>
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<tr>
<td>Cherri D. Hobgood, M.D.</td>
<td>Indianapolis, IN</td>
<td>October 2016</td>
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<tr>
<td>Mark S. Holcomb, M.D.</td>
<td>Olathe, KS</td>
<td>October 2016, April 2017</td>
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</table>
Lynne M. Holden, M.D.
New Rochelle, NY
April 2017 (16 exams)

Laura Hopson, M.D.
Ann Arbor, MI
October 2016

Brian T. Hoyt, M.D.
Springfield, OR
October 2016

Margaret Hsieh, M.D.
Murrysville, PA
October 2016

John S. Huff, M.D.
Charlottesville, VA
April 2017 – B

Maria R. Hugi, M.D.
Dupont, WA
April 2017

F. Michael Jaggi, D.O.
Grand Blanc, MI
October 2016

Marynell Jelinek, M.D.
Culver City, CA
April 2017 (8 exams)

Andrew D. Jenis, M.D.
Ithaca, NY
April 2017 (8 exams)

Ilse M. Jenouri, M.D.
Providence, RI
April 2017

Ramon W. Johnson, M.D.
Laguna Niguel, CA
October 2016 – TL

James H. Jones, M.D.
Zionsville, IN
April 2017 (32 exams)

Kerin A. Jones, M.D.
Ann Arbor, MI
October 2016, April 2017 – B

Robert A. Jones, D.O.
Chagrin Falls, OH
April 2017

Nicholas J. Jouriles, M.D.
Moreland Hills, OH
October 2016

Sharhabeel M. Jwayyed, M.D.
Copley, OH
April 2017 (16 exams)

Achyut B. Kamat, M.D.
Providence, RI
April 2017

Kathryn E. Kampen, M.D.
Holland, MI
April 2017

Juliana Karp, M.D.
Tampa, FL
April 2017

Lawrence E. Kass, M.D.
Harrirburg, PA
October 2016

Samuel M. Keim, M.D.
Tucson, AZ
October 2016 – TL, April 2017 – TL

John L. Kendall, M.D.
Denver, CO
October 2016, April 2017 – B

Sorabh Khandelwal, M.D.
Dublin, OH
October 2016

Morris S. Kharasch, M.D.
Highland Park, IL
April 2017 (16 exams)

Barry J. Knapp, M.D.
Norfolk, VA
October 2016

Sanford H. Koltonow, M.D.
Beverly Hills, MI
April 2017 (24 exams)

Sarkis R. Kouyoumjian, M.D.
Bloomfield Hills, MI
October 2016

Terry Kowalenko, M.D.
Brighton, MI
October 2016 – CE, April 2017 – CE

Marc Kranz, M.D.
Ridgefield, WA
October 2016

Craig E. Krausz, M.D.
Kirkwood, MO
October 2016

Dick C. Ku, M.D.
Pearland, TX
October 2016, April 2017

David S. Lambert, M.D.
Philadelphia, PA
April 2017

Katherine E. Landen, M.D.
Portland, OR
April 2017

William B. Lauth, M.D.
Riverwoods, IL
April 2017 – B

Eric J. Lavonas, M.D.
Denver, CO
October 2016

Jonathan D. Lawrence, M.D.
San Juan Capistrano, CA
October 2016

David C. Lee, M.D.
Manhasset, NY
October 2016, April 2017

Ben A. Leeson, M.D.
Corpus Christi, TX
October 2016, April 2017

Cedric W. Lefebvre, M.D.
Winston-Salem, NC
October 2016

Penelope C. Lema, M.D.
Buffalo, NY
April 2017

Mark D. Levine, M.D.
St. Louis, MO
April 2017

Resa E. Lewiss, M.D.
Denver, CO
April 2017 (8 exams)

Horace K. Liang, M.D.
Sarasota, FL
October 2016 (16 exams), April 2017

Holly C. Liberatore, M.D.
Hattiesburg, MS
October 2016

G. Patrick Lilja, M.D.
Minneapolis, MN
April 2017

Louis J. Ling, M.D.
Chicago, IL
October 2016

Derek R. Linklater, M.D.
Belton, TX
October 2016, April 2017 – B

Y. Teresa Liu, M.D.
Redondo Beach, CA
April 2017
Knef V. Lizaso, M.D.  
Rancho Palos Verdes, CA  
October 2016

Heather Long, M.D.  
Stone Ridge, NY  
April 2017

Seth A. Lotterman, M.D.  
West Hartford, CT  
October 2016

Mark J. Lowell, M.D.  
Brighton, MI  
April 2017

Michael H. Lusczak, D.O.  
Carmichael, CA  
April 2017

Martin E. Lutz, M.D.  
Greenville, SC  
April 2017 – TL

Binh T. Ly, M.D.  
San Diego, CA  
April 2017 (8 exams)

O. John Ma, M.D.  
Portland, OR  
October 2016 – TL, April 2017 – TL

Richard S. MacKenzie, M.D.  
Allentown, PA  
April 2017 (16 exams)

Mary Nan S. Mallory, M.D.  
Louisville, KY  
April 2017 – CE

Michael A. Manka, M.D.  
East Amherst, NY  
April 2017

Jeffrey A. Manko, M.D.  
Rye Brook, NY  
April 2017

Catherine A. Marco, M.D.  
Beavercreek, OH  
October 2016 – TL

James D. Mark, M.D.  
Westlake, OH  
April 2017

John P. Marshall, M.D.  
Brooklyn, NY  
April 2017

Kerri L. Mason, M.D.  
Boulder, CO  
October 2016, April 2017 – B

Anthony S. Mazzeo, M.D.  
Penn Valley, PA  
October 2016, April 2017 – B

Brian D. McBeth, M.D.  
Saratoga, CA  
April 2017

Jane McCall, M.D.  
Spartanburg, SC  
April 2017

Richard M. McDowell, M.D.  
Holualoa, HI  
April 2017

James D. McGettigan, M.D.  
Annapolis, MD  
October 2016

Jillian L. McGrath, M.D.  
Columbus, OH  
October 2016

Abhishek Mehrotra, M.D.  
Durham, NC  
April 2017

Antonio Mendez, M.D.  
Valley Stream, NY  
April 2017

J. Mark Meredith, III, M.D.  
Chatsworth, NJ  
October 2016

James Miner, M.D.  
Minnetrista, MN  
October 2016, April 2017 (8 exams)

Hal J. Minnigan, M.D.  
Indianapolis, IN  
April 2017

Sameer D. Mistry, M.D.  
Rancho Palos Verdes, CA  
October 2016

John C. Moorhead, M.D.  
Portland, OR  
April 2017

Daniel S. Morrison, M.D.  
Belle Mead, NJ  
April 2017

Usamah Mossallam, M.D.  
Bloomfield Hills, MI  
October 2016, April 2017

Robert L. Muellem, M.D.  
Omaha, NE  
April 2017 – TL

Joseph G. Mueller, M.D.  
Glen Ellyn, IL  
October 2016

Robert A. Mulliken, M.D.  
Western Springs, IL  
October 2016 (16 exams)

Tiffany E. Murano, M.D.  
New City, NY  
October 2016

Daniel G. Murphy, M.D.  
Garden City, NY  
April 2017

Kathleen M. Myers, M.D.  
Portland, OR  
October 2016

Kris S. Narasimhan, M.D.  
Northbrook, IL  
October 2016 – TL, April 2017 – TL

Isam F. Nasr, M.D.  
Chicago, IL  
October 2016

Steven Nazario, M.D.  
Orlando, FL  
April 2017

Lewis S. Nelson, M.D.  
Demarest, NJ  
April 2017 – TL

Marc S. Nelson, M.D.  
Redwood City, CA  
October 2016, April 2017

Richard N. Nelson, M.D.  
Westerville, OH  
October 2016 – TL, April 2017 – TL

Donald L. Norris, M.D.  
Studio City, CA  
October 2016

Robert E. O’Connor, M.D.  
Charlottesville, VA  
October 2016, April 2017

David T. Overton, M.D.  
Kalamazoo, MI  
October 2016 – TL, April 2017 – TL

Edward A. Panacek, M.D.  
Mobile, AL  
October 2016

Peter D. Panagos, M.D.  
St. Louis, MO  
October 2016, April 2017
Salvatore R. Pardo, M.D.
Brooklyn, NY
October 2016, April 2017

Robert A. Partridge, M.D.
Needham, MA
April 2017

Debra J. Paulson, M.D.
Independence, WV
October 2016, April 2017

Christopher W. Pergrem, M.D.
Owensboro, KY
October 2016, April 2017

Debra G. Perina, M.D.
Ruckersville, VA
October 2016, April 2017

David B. Pianalto, M.D.
Winchester, VA
October 2016

Lauren Pipas, M.D.
Cazenovia, NY
April 2017

M. Scott Pirkle, M.D.
Carmel, IN
April 2017

Melissa A. Platt, M.D.
Louisville, KY
October 2016

Gary F. Pollock, M.D.
Oakdale, PA
October 2016

David C. Portelli, M.D.
Barrington, RI
April 2017

Les M. Puretz, D.O.
Monument, CO
October 2016, April 2017

Danielle S. Ray, M.D.
Summerfield, NC
April 2017

Robert F. Reardon, M.D.
Afton, MN
April 2017

Thomas A. Rebecchi, M.D.
Pine Hill, NJ
October 2016

Timothy J. Reeder, M.D.
Ayden, NC
October 2016

Lynne D. Richardson, M.D.
New York, NY
April 2017

David C. Riley, M.D.
New York, NY
October 2016 (8 exams)

Edgardo J. Rivera-Rivera, M.D.
Ocoee, FL
October 2016, April 2017

Albert J. Rocchini, M.D.
Birmingham, MI
April 2017

Daniel R. Rodgers, M.D.
Palmyra, PA
April 2017

E. Jedd Roe, III, M.D.
Neptune Beach, FL
April 2017

Christopher Ross, M.D.
Chicago, IL
April 2017

Philip N. Salen, M.D.
Bethlehem, PA
October 2016, April 2017 – B

Christopher S. Sampson, M.D.
Columbia, MO
October 2016

Leon Sanchez, M.D.
Cambridge, MA
October 2016, April 2017 – B

Sally A. Santen, M.D.
Ann Arbor, MI
April 2017

Osman Sayan, M.D.
Leonia, NJ
April 2017

Shari L. Schabowski, M.D.
River Forest, IL
October 2016, April 2017

Robert W. Schafermeyer, M.D.
Charlotte, NC
October 2016, April 2017

Jeffrey J. Schaider, M.D.
River Forest, IL
April 2017

Mary J. Schlaff, M.D.
Beverly Hills, MI
April 2017

Steven J. Schorer, M.D.
Granite Bay, CA
April 2017

C. Blake Schug, M.D.
Clovis, CA
October 2016

Jeffrey J. Schultz, M.D.
Phoenix, AZ
April 2017

Joseph A. Scott, M.D.
Coral Gables, FL
April 2017

Alok K. Sengupta, M.D.
St. Louis, MO
April 2017

Gary S. Setnik, M.D.
Winchester, MA
October 2016

Fred A. Severyn, M.D.
Littleton, CO
October 2016

Manish Sharma, D.O.
Brooklyn, NY
April 2017

Rahul Sharma, M.D.
New York, NY
April 2017

Miles Shaw, M.D.
Long Beach, CA
October 2016 – TL, April 2017 – TL

Peter L. Shearer, M.D.
New York, NY
October 2016 (8 exams), April 2017 – B

Kent T. Shoji, M.D.
Rolling Hills Estates, CA
October 2016 – TL

Mark A. Silverberg, M.D.
Brooklyn, NY
October 2016

Robert D. Slay, M.D.
Palos Verdes Estates, CA
October 2016, April 2017 – B

David H. Smile, M.D.
Cincinnati, OH
October 2016

Larry O. Smith, M.D.
Mazama, WA
April 2017 (8 exams)
<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>State</th>
<th>Date</th>
<th>Exams</th>
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<tbody>
<tr>
<td>Rebecca Smith-Coggins, M.D.</td>
<td>Saratoga, CA</td>
<td>CA</td>
<td>October 2016</td>
<td></td>
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<tr>
<td>Jeremy D. Sperling, M.D.</td>
<td>Mamaroneck, NY</td>
<td>NY</td>
<td>April 2017</td>
<td></td>
</tr>
<tr>
<td>Steven P. Spilger, M.D.</td>
<td>Granger, IN</td>
<td>IN</td>
<td>October 2016</td>
<td></td>
</tr>
<tr>
<td>Keith D. Stampler, M.D.</td>
<td>Palos Verdes Peninsula, CA</td>
<td>CA</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Stephen C. Stanfield, M.D.</td>
<td>Hugo, MN</td>
<td>MN</td>
<td>October 2016</td>
<td></td>
</tr>
<tr>
<td>Richard L. Stennes, M.D.</td>
<td>La Jolla, CA</td>
<td>CA</td>
<td>October 2016–B</td>
<td></td>
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<tr>
<td>Lawrence M. Stock, M.D.</td>
<td>Malibu, CA</td>
<td>CA</td>
<td>October 2016 (16 exams)</td>
<td></td>
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<tr>
<td>David M. Sullivan, M.D.</td>
<td>Charlotte, NC</td>
<td>NC</td>
<td>October 2016 (8 exams)</td>
<td></td>
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<tr>
<td>John A. Tafuri, M.D.</td>
<td>Westlake, OH</td>
<td>OH</td>
<td>October 2016, April 2017 (8 exams)</td>
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<tr>
<td>Vivek S. Tayal, M.D.</td>
<td>Charlotte, NC</td>
<td>NC</td>
<td>October 2016, April 2017</td>
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<tr>
<td>Brigham R. Temple, M.D.</td>
<td>Highland Park, IL</td>
<td>IL</td>
<td>October 2016</td>
<td></td>
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<tr>
<td>Ralph N. Terpolilli, M.D.</td>
<td>San Antonio, TX</td>
<td>TX</td>
<td>October 2016, April 2017–B</td>
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<tr>
<td>Josette A. Teuscher, M.D.</td>
<td>Colden, NY</td>
<td>NY</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>James D. Thomas, M.D.</td>
<td>Wareham, MA</td>
<td>MA</td>
<td>October 2016–TL, April 2017–TL</td>
<td></td>
</tr>
<tr>
<td>Todd Tomesen, M.D.</td>
<td>Milton, MA</td>
<td>MA</td>
<td>October 2016</td>
<td></td>
</tr>
<tr>
<td>Christian A. Tomaszewski, M.D.</td>
<td>La Jolla, CA</td>
<td>CA</td>
<td>April 2017</td>
<td></td>
</tr>
<tr>
<td>Sam S. Torbati, M.D.</td>
<td>Encino, CA</td>
<td>CA</td>
<td>October 2016</td>
<td></td>
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<tr>
<td>Albert K. Tsai, M.D.</td>
<td>Minneapolis, MN</td>
<td>MN</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Danielle E. Turner-Lawrence, M.D.</td>
<td>Franklin, MI</td>
<td>MI</td>
<td>October 2016</td>
<td></td>
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<tr>
<td>Michael A. Turturro, M.D.</td>
<td>Pittsburgh, PA</td>
<td>PA</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Andrew S. Ulrich, M.D.</td>
<td>Guilford, CT</td>
<td>CT</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Henry D. Unger, M.D.</td>
<td>Wyncote, PA</td>
<td>PA</td>
<td>October 2016</td>
<td></td>
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<tr>
<td>Phyllis A. Vallee, M.D.</td>
<td>Grosse Pointe Park, MI</td>
<td>MI</td>
<td>October 2016, April 2017 (16 exams)</td>
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<tr>
<td>Patricia L. VanDevander, M.D.</td>
<td>Denver, CO</td>
<td>CO</td>
<td>October 2016, April 2017</td>
<td></td>
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<tr>
<td>Vikram M. Varma, M.D.</td>
<td>Holmdel, NJ</td>
<td>NJ</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Michael C. Wadman, M.D.</td>
<td>Omaha, NE</td>
<td>NE</td>
<td>October 2016, April 2017</td>
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<tr>
<td>Robert P. Wahl, M.D.</td>
<td>Dearborn Heights, MI</td>
<td>MI</td>
<td>October 2016–TL, April 2017–TL</td>
<td></td>
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<tr>
<td>Gregory L. Walker, M.D.</td>
<td>Mason, MI</td>
<td>MI</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Ernest E. Wang, M.D.</td>
<td>Chicago, IL</td>
<td>IL</td>
<td>April 2017 (8 exams)</td>
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<tr>
<td>Anthony J. Weekes, M.D.</td>
<td>Weddington, NC</td>
<td>NC</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>Jennifer L. White, M.D.</td>
<td>Rochester, MN</td>
<td>MN</td>
<td>April 2017</td>
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<tr>
<td>Susan Wilcox, M.D.</td>
<td>Charleston, SC</td>
<td>SC</td>
<td>October 2016, April 2017</td>
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<tr>
<td>Joseph A. Wilkinson, M.D.</td>
<td>Greenwich, CT</td>
<td>CT</td>
<td>October 2016 (8 exams)</td>
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<tr>
<td>Sarah R. Williams, M.D.</td>
<td>San Mateo, CA</td>
<td>CA</td>
<td>April 2017</td>
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<tr>
<td>Saralyn R. Williams, M.D.</td>
<td>Franklin, TN</td>
<td>TN</td>
<td>April 2017 (8 exams)</td>
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<tr>
<td>Lori D. Winston, M.D.</td>
<td>Exeter, CA</td>
<td>CA</td>
<td>October 2016</td>
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<tr>
<td>Andrew G. Wittenberg, M.D.</td>
<td>Long Beach, CA</td>
<td>CA</td>
<td>October 2016</td>
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<tr>
<td>Michael D. Witting, M.D.</td>
<td>Millersville, MD</td>
<td>MD</td>
<td>October 2016</td>
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<tr>
<td>Allan B. Wolfson, M.D.</td>
<td>Pittsburgh, PA</td>
<td>PA</td>
<td>October 2016 (24 exams), April 2017</td>
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<td>John B. Woodland, M.D.</td>
<td>Vail, CO</td>
<td>CO</td>
<td>October 2016</td>
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<tr>
<td>Charles C. Worrilow, M.D.</td>
<td>Fogelsville, PA</td>
<td>PA</td>
<td>April 2017</td>
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<tr>
<td>Barbara N.wynn, M.D.</td>
<td>E. Grand Rapids, MI</td>
<td>MI</td>
<td>April 2017–T L (16 exams)</td>
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<tr>
<td>Donald M. Yealy, M.D.</td>
<td>Pittsburgh, PA</td>
<td>PA</td>
<td>April 2017</td>
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<tr>
<td>Albert S. Yee, M.D.</td>
<td>Mequon, WI</td>
<td>WI</td>
<td>October 2016, April 2017</td>
<td></td>
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<tr>
<td>Benson Yeh, M.D.</td>
<td>Jericho, NY</td>
<td>NY</td>
<td>April 2017 (8 exams)</td>
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<tr>
<td>William V. Yount, M.D.</td>
<td>Knoxville, TN</td>
<td>TN</td>
<td>April 2017</td>
<td></td>
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<tr>
<td>James M. Ziadeh, M.D.</td>
<td>Northville, MI</td>
<td>MI</td>
<td>October 2016 (8 exams)</td>
<td></td>
</tr>
<tr>
<td>Gary D. Zimmer, M.D.</td>
<td>Bryn Mawr, PA</td>
<td>PA</td>
<td>October 2016, April 2017</td>
<td></td>
</tr>
</tbody>
</table>
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- John L. Kendall, M.D. (ACEP)
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  - Certification Co-editor
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  - LLSA Co-editor
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  - Certification Co-editor
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- Joshua G. Schier, M.D. (ABEM)
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  - ABEM Liaison

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- Larry B. Mellick, M.D.
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- Tracy L. LeGros, M.D.
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Board of Directors

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)

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Kerryann B. Broderick, M.D.
Michael L. Carius, M.D.
Robert W. Strauss, M.D.

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Michael S. Beeson, M.D. (Observer)

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Board of Directors
Carol D. Berkowitz, M.D.

RESIDENCY REVIEW COMMITTEE FOR EMERGENCY MEDICINE

Diane L. Gorgas, M.D. ³
Philip H. Shayne, M.D. ³
Mary Jo Wagner, M.D. ³
Melissa A. Barton, M.D.
Ex-Officio

1 Appointed by ABEM
² Appointed by ACGME

¹
The following milestones highlight recent events in ABEM’s history. 2016-2017 activities are reported in the appropriate sections within this annual report. Activities are added to history the year after they are initially reported. A full history is available at www.abem.org.

**ABEM IN THE 2010s**

In January 2010, Assessment of Practice Performance (APP), the fourth component of the ABEM MOC Program, was introduced.

On March 31, 2010, after almost 23 years of service to ABEM, Mary Ann Reinhart, Ph.D., retired her position as the second ABEM Executive Director. On May 1, 2010, Earl J. Reisdorff, M.D., began as the third ABEM Executive Director.

On April 1, 2011, ABEM diplomates were able to receive CME credit for completing the 2011 LLSA CME Activity. This opportunity was the result of an unprecedented collaboration between AAEM, ABEM, and ACEP.

On September 21, 2011, the ABMS unanimously approved a joint program between the American Board of Internal Medicine (ABIM) and ABEM to allow emergency physicians to become subspecialty certified in Internal Medicine–sponsored Critical Care Medicine (IM-CCM). Following their EM residency training, physicians can participate in IM-CCM-sponsored fellowships. Upon completion of fellowship training, these individuals can seek board certification.

In November and December 2011, a pilot multiple choice question examination was administered to explore the use of new stimulus types on ABEM examinations. A pilot oral examination was administered in June 2012 to test the eOral format.

In January 2012, the ABMS adopted a new policy defining “board eligibility.” The policy required all ABMS Member Boards to define the acceptable period of time between the completion of residency training and the attainment of board certification, during which, physicians could refer to themselves as being board eligible. ABEM established five years as its time limit. Beginning January 1, 2015, board eligible physicians have requirements they must meet to maintain board eligible status.

In June 2012, ABEM was approved by the Centers for Medicare and Medicaid Services to participate in the Physician Quality Reporting System (PQRS) MOC additional incentive program. ABEM diplomates who participated in the program received an additional 0.5 percent reimbursement on their Medicare billings if they met their basic PQRS reporting requirements. ABEM was approved to participate in the program again in 2013 and 2014.

In September 2012, the Emergency Medicine Milestones were approved. The EM Milestones are a matrix of the knowledge, skills, abilities,
attitudes, and experiences that should be acquired at different points during EM training. The EM Milestones Project was a joint initiative of the ACGME and ABEM, and was supported by representatives of the Association of Academic Chairs of Emergency Medicine (AACEM), AAEM, ACEP, CORD, EMRA, RRC-EM, and SAEM.

Beginning in 2013, the ConCert™ Examination was no longer the final step in renewing certification; the four parts of MOC became de-linked. Diplomates could therefore register for and take the ConCert™ Examination in any of the last five years of certification, even if they have not completed all of their MOC requirements. However, at the end of a diplomate’s ten-year certification, any outstanding MOC requirements would result in loss of certification.

In May 2013, the Board of Directors of the ACGME approved allowing emergency physicians to formally enter Surgical Critical Care (SCC) fellowships, thus providing a pathway for EM diplomates to train for and take the SCC subspecialty certification examination. Certification in SCC is through the American Board of Surgery (ABS).

On June 26, 2013, the ABMS Board of Directors unanimously approved joint sponsorship between the American Board of Anesthesiology (ABA) and ABEM of certification in Anesthesiology Critical Care Medicine (ACCM). Emergency physicians can now apply for ACGME-accredited ACCM fellowship training after their Emergency Medicine residency training, and when qualified by completing a 24-month ABA-approved CCM fellowship, be able to seek Board certification.

The first certification examination in EMS took place in October 2013. The first EMS LLSA reading list was posted in July 2013, and the first EMS LLSA test was posted in June 2014.

The first certification examination in Clinical Informatics, which was open to diplomates of all ABMS Member Boards, took place in the fall of 2013, and 44 ABEM diplomates took the exam.

Subspecialty certification in Pain Medicine, which had been open to diplomates of any ABMS Member Board, became available only to diplomates of a co-sponsoring board. In April 2014, ABEM was approved by the ABMS to become a co-sponsor, thus allowing ABEM diplomates to continue to have access to the examination.

In spring 2014, ABEM launched a Patient Safety LLSA, jointly developed by ABEM and ACEP. The activity, which has an optional CME activity, is required during the first five years of certification, counts toward the LLSA test requirement, and can be used toward fulfilling the Part II CME requirement.

In the fall of 2014, ABEM recognized physicians who had marked 30 or more years of being certified in Emergency Medicine by ABEM with a special certificate. Over 950 diplomates had accomplished this milestone. Special certificates are awarded annually to diplomates who achieve this milestone.

In October 2014, ABEM convened a summit of representatives from AACEM, AAEM, AAEM Resident Student Association, ACEP, CORD, EMRA, RRC-EM, and SAEM to review the ABEM MOC Program. The summit provided current information about the ABEM MOC Program to the EM community, and solicited ways in which the program might be improved.
The EMS Task Force transitioned to the EMS Examination Committee and held its first meeting on November 18, 2014. The Committee is charged with writing the EMS Certification Examination and EMS LLSA tests, overseeing the EMS certification eligibility criteria, crafting the EMS MOC Program, and maintaining the Core Content of EMS Medicine.

2014 marked the third and final year of ABEM’s participation in the PQRS MOC additional incentive program. During the three-year period, ABEM diplomates made over 11,500 applications to the program, and received an estimated $3.8 million in additional Medicare reimbursement.

The Policy on Board Eligibility took effect on January 1, 2015. Physicians who have applied to ABEM but have not achieved certification are considered board eligible on that date or, going forward, the date that a physician graduates from an ACGME-accredited EM program. They remain board eligible for five years after that date whether or not they have applied for certification. Physicians who delay any certification activity have additional requirements (LLSA tests and CME) until they become board certified.

A new format integrating dynamic stimuli into the testing process was introduced in the November 2014 Qualifying Examination and the spring 2015 Oral Certification Examination. In addition, the examinations incorporated new specifications, grounded in the EM Model and a detailed description of what a board-certified emergency physician knows and is able to do (their knowledge, skills, and abilities, or KSAs).

The revised testing formats and specifications warranted reconsideration of the existing passing score criteria. After deliberation on several factors, the Board approved a new passing score of 76 percent on a scale of 0 to 100 for the Qualifying Examination. Standard-setting studies were also conducted following the fall 2015 and spring 2016 administrations of the Oral Certification Examination, and will continue to be conducted in the near future. Both examinations continue to be criterion referenced.

During 2014-2015, ABEM endowed a fellowship within the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM). The ABEM Fellowship is a two-year fellowship that provides early-career, health-science scholars the opportunity to experience and participate in evidence-based health care or public health studies that affect the nation’s health. The first ABEM NAM fellowship was offered in 2015 and awarded to Hanni B. Stoklosa, M.D., M.P.H.

In response to feedback from EM residents, ABEM expanded its website to include a section devoted to residents. The website provides residents information and resources to use during the course of their training.

The 2015 ConCert™ Examination incorporated the 2013 EM Model and a detailed description of what a board-certified emergency physician knows and is able to do (their knowledge, skills, and abilities, or KSAs). The revised testing specifications warranted reconsideration of the existing passing score criteria. Following a standard-setting study, the Board set a passing score of 75 percent on a scale of 0 to 100.
Beginning in fall 2015, diplomates certified in Emergency Medicine or any ABEM-sponsored subspecialty could take any ABEM LLSA test (EM, EMS, or Medical Toxicology) and use it toward meeting the requirements of any ABEM MOC Program.

ABEM convened a summit of EM organizations November 22-23, 2015, to explore ways in which the “additional training” requirement within the board eligibility policy could be met. The purpose of the Summit was to explore the potential design and implementation of additional training. The Summit was led by ABEM directors, with participant representatives from AACEM, AAEM, AAEM/RSA, ACEP, CORD, EMRA, RRC-EM, and SAEM.

The 2016 administration of the In-training Examination (ITE) included an online pilot. The online version was successfully given to 2,010 residents at 62 U.S. residency programs.

In March 2016, Addiction Medicine was approved by the ABMS as another subspecialty that will be available to ABEM diplomates.

In 2016, the ABA and ABEM approved guidelines for a combined training program in Anesthesiology and Emergency Medicine. Upon completion of these training programs, physicians can access the certification examinations in both specialties.

The following subspecialties were made available to ABEM diplomates in the 2010s: Addiction Medicine, Anesthesiology Critical Care Medicine, Clinical Informatics, Emergency Medical Services, Internal Medicine-Critical Care Medicine, Pain Medicine, and Surgical Critical Care.
### APPENDIX: APPLICATION AND EXAMINATION ACTIVITY

#### Certification

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<th>Oral Certification Examination</th>
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<td><strong>EM Residency-eligible</strong></td>
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<td><strong>Total</strong></td>
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1. 1995 was the first year that a reference group of EM residency-eligible, first-time test takers was used to construct the written certification examination, now known as the qualifying examination.
2. Number indicates the percent of the total that passed.
3. Candidates do not include former diplomates attempting to regain certification through the qualifying and/or oral examination.
Recertification

Prior to the implementation of MOC, diplomates were required to pass a recertification examination to maintain their certification. Following are the statistics for the recertification examinations taken between 1989 through 2003.

| Date       | App’s Rec’d | # Took | # Pass | % Pass | # Took | # Pass | % Pass | # Took | # Pass | % Pass | # Took | # Pass | % Pass |
|------------|-------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 1989 and prior | 275        | 88     | 83     | 94     | 67     | 61     | 91     | 0      |       |       | 0      |       |       |       |
| 1990       | 258        | 247    | 239    | 97     | 22     | 22     | 100    | 9      | 9      | 100    | 1      | 1      | 100    |
| 1991       | 306        | 304    | 295    | 97     | 20     | 17     | 85     | 10     | 10     | 100    | 1      | 1      | 100    |
| 1992       | 438        | 372    | 357    | 96     | 17     | 17     | 100    | 10     | 8      | 80     | 10     | 7      | 70     |
| 1993       | 716        | 583    | 548    | 94     | 33     | 30     | 91     | 13     | 9      | 69     | 19     | 15     | 79     |
| 1994       | 743        | 795    | 748    | 94     |        |        |        |   12   | 9      | 75     | 34     | 24     | 71     |
| 1995       | 792        | 755    | 709    | 94     |        |        |        |   11   | 8      | 73     | 46     | 33     | 72     |
| 1996       | 910        | 929    | 852    | 92     |        |        |        |   10   | 8      | 80     | 54     | 40     | 74     |
| 1997       | 1,011      | 1,088  | 1,007  | 93     |        |        |        |   19   | 13     | 68     | 54     | 36     | 67     |
| 1998       | 1,260      | 1,248  | 1,181  | 95     |        |        |        |   3    | 2      | 67     | 65     | 48     | 74     |
| 1999       | 1,267      | 1,247  | 1,133  | 91     |        |        |        |   2    | 2      | 100    | 55     | 36     | 65     |
| 2000       | 1,379      | 1,301  | 1,203  | 92     |        |        |        |   6    | 4      | 67     | 49     | 32     | 65     |
| 2001       | 1,432      | 1,399  | 1,263  | 90     |        |        |        |   0    | 0      | 0      | 53     | 39     | 74     |
| 2002       | 1,298      | 1,234  | 1,070  | 87     |        |        |        |   4    | 1      | 25     | 40     | 27     | 68     |
| 2003       | 1,518      | 1,420  | 1,298  | 92     |        |        |        |   3    | 2      | 67     | 49     | 32     | 65     |
| Total      | 13,603     | 13,080 | 11,986 | 92     | 159    | 147    | 92     | 112   | 85     | 76     | 530    | 371    | 70     |

ConCert™ Examination

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1 Number indicates the percent of the total who passed.

Statistics are reported by calendar year. The statistics accurately reflect the examinations administered during the designated periods, and all examination data are included. Candidates who took more than one examination are included more than once.

Total number of active diplomates on 12/31/2016 was 34,816.
## Application and Examination Activity
### Subspecialties

Number of ABEM Diplomates Achieving ABEM-issued Subspecialty Certification by Subspecialty, 1993-2016

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ACCM: Anesthesiology Critical Care Medicine  
EMS: Emergency Medical Services  
HPM: Hospice and Palliative Medicine  
IM-CCM: Internal Medicine – Critical Care Medicine  
MedTox: Medical Toxicology  
Pain: Pain Medicine  
PedEM: Pediatric Emergency Medicine  
SPM: Sports Medicine  
UHM: Undersea and Hyperbaric Medicine

Statistics are reported by calendar year.
Acronyms Used in this Report

AAEM                  American Academy of Emergency Medicine
AACEM                Association of Academic Chairs of Emergency Medicine
ABA                      American Board of Anesthesiology
ABEM                  American Board of Emergency Medicine
ABIM                   American Board of Internal Medicine
ABMS                   American Board of Medical Specialties
ABP                      American Board of Pediatrics
ABPM                  American Board of Preventive Medicine
ABPMR               American Board of Physical Medicine and Rehabilitation
ABPN                  American Board of Psychiatry and Neurology
ACCM                  Anesthesiology Critical Care Medicine
ACEP                  American College of Emergency Physicians
ACOEP               American College of Osteopathic Emergency Physicians
ACGME               Accreditation Council for Graduate Medical Education
AOA                    American Osteopathic Association
AOBEM                  American Osteopathic Board of Emergency Medicine
CME                  Continuing Medical Education
ConCert™             Continuous Certification Examination
CORD              Council of Emergency Medicine Residency Directors
C/P                     Communications/Professionalism
EM                      Emergency Medicine
EM/Anes               Emergency Medicine/Anesthesiology
EM/FM                 Emergency Medicine/Family Medicine
EM/IM                   Emergency Medicine/Internal Medicine
EM/IM/CCM       Emergency Medicine/Internal Medicine/Critical Care Medicine
EM Model            The Model of the Clinical Practice of Emergency Medicine
EM/Peds               Emergency Medicine/Pediatrics
EMRA                    Emergency Medicine Residents’ Association
EMS                     Emergency Medical Services
HPM                    Hospice and Palliative Medicine
IMP                      Improvement in Medical Practice
IM-CCM              Internal Medicine-Critical Care Medicine
ITE                     In-training Examination
KSA                    Knowledge, Skills, and Abilities
LLS                   Lifelong Learning and Self-Assessment (component of MOC)
LLSA                  Lifelong Learning and Self-Assessment (MOC activity)
MedTox            Medical Toxicology
MOC                    Maintenance of Certification
NAM                     National Academy of Medicine
OCE                  Oral Certification Examination
PedEM                 Pediatric Emergency Medicine
PGY                     Post-Graduate Year
PI                        Practice Improvement
QE                       Qualifying Examination
RVP                  Residency Visitation Program
SAEM                   Society for Academic Emergency Medicine
SPM                     Sports Medicine
UHM                  Undersea and Hyperbaric Medicine
MEMO

To: ACEP Council 2017  
From: Alicia Kurtz, MD - EMRA President  
Date: October 2017  
Re: EMRA FY 2017 Year-End Report

The Emergency Medicine Residents’ Association (EMRA) and the American College of Emergency Physicians (ACEP) continue to enjoy a mutually beneficial relationship that is strengthened by collaboration and respect. This report details our activities, strategies, and vision for fiscal year 2017 focusing on those ways we worked with ACEP to support the college and fulfill our shared services agreement.

In FY17, EMRA’s total membership increased 9.48% (December 2016) to 14,618. Our joint membership comprises about one-third of ACEP’s total membership. This collaboration continues to grow and strengthen both organizations.

Leadership Stipend Update

EMRA invested the FY17 $35,000 leadership stipend with the goal of maximizing leadership opportunities, and increasing exposure for EMRA and emergency medicine. In this spirit, EMRA Board leaders and members advocated for members by attending national conferences and holding meetings with organizations to advance resident and emergency medicine interests.

This year, EMRA and ACEP Boards of Directors launched a mentorship program where EMRA Board members are matched with ACEP Board members. This program has already yielded...
productive conversations to give guidance for our young leaders as they continue their leadership path and career in emergency medicine.

Our leadership development efforts included leadership sessions with the EMRA Board conducted by Dr. Jay Kaplan and Dr. Angela Siler-Fisher. We also secured a facilitator to work with our Committee & Division leaders on meeting management and personal presentations.

To further expand EMRA/ACEP’s footprint in the specialty, we collaborated with the ACOEP Resident/Student Chapter by bring the EMRA Quiz Show to their Annual Meeting and by adding their Airway Shootout to our events at the SAEM Annual Meeting. Because single accreditation was causing anxiety among our osteopathic members, we wanted to show unity among physicians in training this year.

EMRA leaders also attended the CORD Academic Assembly where they met with the CORD leadership as well as EMARC and ALiEM leadership. The networking, collaboration, and relationship building were invaluable. To foster unity and collaboration, EMRA co-hosted a resident reception with AAEM RSA and CORD.

The EMRA Board elected to align our spring meetings and events with the CORD Academic Assembly starting in 2018. We look forward to providing even more member value and access to our programming with this move.

Further, EMRA leaders not only participated in the ACEP Leadership and Advocacy Conference but coordinated and facilitated the Health Policy Primer session, which was very well attended. EMRA Board members also provided input on the Leadership Summit portion of the Conference.

ACEP, SAEM, AAEM, AAEM-RSA, CORD and EMRA collaborated on a joint booth at the Student National Medical Association, representing emergency medicine as a specialty rather than representing each individual organization. We also co-hosted an emergency medicine reception to better introduce the specialty to students. EMRA and ACEP also co-hosted the SNMA Leadership Summit at the ACEP Headquarters and assisted with meeting expenses.

EMRA continued to support Wellness Week through social media and a parody video “The Twelve Days of Wellness.”
EMRA and ACEP continued its strong collaboration on EMRA Match, the premier medical student EM resource endorsed by ACEP, CORD, CDEM and EMRA. The collaboration continues in FY18 with the addition of Clerkship programs. The American Society of Association Executives (ASAE) awarded EMRA Match the 2017 Power of A Silver Award for our innovative, effective and broad-reaching program.

**Promotion of Resident Registration at ACEP Events**

EMRA promoted ACEP16 registration and helped grow resident and medical student attendance, exceeding our resident attendance goal with 1,710 residents registered for ACEP16. More than 300 students attended the Medical Student Forum which offers ideal exposure to both EMRA and ACEP. We also had the largest Residency Program Fair and Job & Fellowship Fair in EMRA’s history. These events added value for our joint members and exhibit partners.

The EMRA 20 in 6 Resident Lecture competition was a home run! This EMRA event identifies the next generation of EM lecturers, hopefully jump-starting a new cadre of emergency medicine lecturers.

The EM Physician Resiliency and Wellness Summit included EMRA leaders who contributed to the white paper to move forward the objectives and projects from the Summit.

EMRA’s monthly electronic newsletter, *What’s Up in Emergency Medicine*, promotes most ACEP meetings and resident/student opportunities. Each edition highlights a different ACEP Section as well, explaining and encouraging participation in the Sections.
Highlight ACEP Member Leaders in EMRA Publications

The EMRA•CAST EMPOWER series highlights inspiring stories from accomplished EM leaders who have shaped and influenced our specialty. In FY17, we posted podcasts with Drs. Kaplan, Parker, Rogers, Liferidge, Cirillo, and Carr. You can listen to these interviews here.

EMRA continues to feature ACEP leaders in the EMPOWER article series in EM Resident. This fiscal year, we featured interviews with Drs. Angela Siler Fisher, Alison Haddock, Bill Jaquis, John Rogers, and Mike Caudell. Click here to read them.

Other ACEP leaders contributed articles to EM Resident, including Becky Parker as a subject matter expert to the Diversity & Inclusion article in Aug/Sept 2016 issue. Dr. Nida Degesys highlighted the ways EMRA and ACEP work together.

EMRA Hangouts was launched with the goal of delivering extraordinary education and advisement to EMRA members using video and audio streaming technology. For EMRA medical student members, EMRA Hangouts increases access and engagement with EM program directors to provide relevant information to help them match in emergency medicine. EMRA Hangouts are recorded and posted on emra.org and feature Drs. Epter, Hillman, Lovell, Lefebvre, Lufty-Clayton, Arnold, Riddle, Charney, Wagner, Sampson, Eastin, Pierce, Takacs, Mendiratta, Finefrock, Gallahue, Hopson and Gisondi.

EMRA President Dr. Kurtz co-hosted an EMRA Hangout with Dr. Parker on “Leadership and Women in Medicine.” To further our joint goal on diversity, EMRA hosted “The Importance of Diversity in Emergency Medicine” with Drs. Esther Choo and Dowin Boatright. Approximately 100+ medical students attend each EMRA Hangout with even more accessing the recordings asynchronously. Our largest EMRA Hangout covered the topic “The SVI and ERAS.”
EMRA is collaborating with Dr. Kevin Klauer and ACEP Now to cross-promote the “What I Wish I Knew...” article series in EMResident.org.

**Encourage Resident Participation in NEMPAC, EMF, 911 Network, ACEP Chapters and Sections**

EMRA funded $20,000 in grants to ACEP Chapters and others in FY17 to support state/regional resident and student educational meetings and initiatives.

The ACEP Government Services Chapter and EMRA created resources for military-bound students including a document demystifying the military match and FAQs. Members of the ACEP Government Services Chapter served on an EMRA Hangout Panel on “The Military Match and EM Bound HPSP Students & More.”

EMRA continues to support EMF with a contribution of $25,000, and EMAF with a contribution of $25,000. To continue our tradition, 100% of EMRA Board members donated to EMF at the Resident VIP level. In addition, 100% of EMRA Board members also contribute at the resident Give A Shift Level to NEMPAC.

To increase our voice in NEMPAC, Dr. Rachel Solnick, our EMRA Director of Health Policy, attends NEMPAC Board calls. EMRA appreciates NEMPAC including our resident member “at the table” on the NEMPAC Board of Trustees.

EMRA collected data from ACEP Chapters as a follow up to the [2015 survey](#) to identify opportunities for residents and students at the chapter level. The data is currently being analyzed and will be reported in a future EM Resident article.

EMRA supported ACEP’s legislative efforts on mental health reform legislation. We also promoted ACEP’s Congressional visits to resident members.

In an effort to keep ACEP Chapters apprised of new EMRA products and communications, we sent each chapter our new critical care products (Critical Care Dosage cards, a Vent Management Card and the new EMRA Antibiotic Guide).
Encourage Young Physicians to Transition to Active ACEP Membership

EMRA leaders reached out to recently graduated colleagues through personal phone calls, emails and face-to-face conversations to encourage them to renew their ACEP membership. This was an effective approach resulting in more transitioning members.

EMRA is working with ACEP to create a My EMRA profile portal so that candidate members can easily join/unjoin EMRA Committees and Divisions, as well as ACEP Sections. This portal will visually remind candidate members of their joint membership.

Through ACEP’s request, EMRA recommended residents to serve on the CEDR Subcommittees to further introduce them to the work of the College.

EMRA created EMRA/ACEP Chit Chat, a new quarterly e-flier sent to Program Coordinators sharing best practices to sign up their residents for EMRA/ACEP membership. This effort has helped increase the number of paying programs by 138%. We have a 287% increase in resident lists received and a 125% increase in invoices generated over the same period as last year!

EMRA is building a relationship with the Emergency Medicine Association of Residency Coordinators (EMARC) to strengthen membership and the membership application process.

The ACEP Section brochure is included in new member kits to encourage participation by transitioning members in ACEP Sections.

Collaboration between EMRA’s 18 Committees and Divisions and ACEP Sections continue to be a priority. Our Committee and Division leaders schedule their meetings at ACEP so that members can attend both meetings. ACEP Section leaders are now speaking at our Committee and Division Meetings. For ACEP16, the ACEP Wilderness Medicine Section and the EMRA Wilderness Medicine Division collaborated on the first EMRA MedWAR at Red Rock Canyon near Las Vegas. It was a huge success!
In collaboration with ACEP, we continue to execute the emCareers.org campaign and will continue to showcase the fact that EMRA and ACEP support members throughout their career.

EMRA looks forward to future collaborations and initiatives to continue to offer extraordinary member value and benefits to strengthen our member training, joint membership and the specialty.
**EMRA YEAR IN REVIEW**

**MEMBERSHIP**
EMRA’s strength is in our people. Our students, our residents, our alumni — you’re the reason we do what we do, and why we succeed.

**STEWARDSHIP**
We count every penny and make every penny count, ensuring a fiscally sound and effective association advocating for you.

**SCHOLARSHIP**
If you don’t grow, we don’t grow. So we award $97,000+ to make our members the most well-rounded emergency physicians they can be.

---

**Members**
2016–2017

This year our total membership increased 10.8%, and we counted 14,382 people as part of the EMRA family.

![Memberships Graph]

**Fiscal Year 17 Accomplishments**
- Critical Medications reference cards
- Rosh Review member benefit
- EMRA + PolicyRx Health Policy Journal Club
- Ventilator Management card
- EMRA Match 3.0
- EMRA MedWAR
- Leadership Training
- Critical Care Conference award
- Airway Lab awards
- All-new EMRA website
- EMRA PressorDex®, 3rd ed.
- Simulation Guide
- Splint Card
- EMRA EKG Guide
- Basics of EM, 3rd ed.
- Wellness Guide
- Fellowship Guide, 2nd ed.
- Ultrasound Card
- “Chaos in the ED” Skills Competition
- Art Therapy Experience
- EMRA moves to CORD Academic Assembly
- EMRA Simulation Research Grant

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**Fiscal Year 18 Plans**
This item will be provided as soon as it is available.
This item will be provided as soon as it is available.